Does Choice Deliver? Public Satisfaction with the Health Service

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Abstract

In this article we examine how much the public say they want choice in the provision of public services, and how far their perceptions of the amount of choice they feel they should and do have are related to satisfaction with public services. Our findings cast critical light on some of the claims made by both opponents and advocates of choice about the value the public place on choice. The claim of opponents that the public do not want choice is not supported. Citizens say they want choice and the more they say they want it the less satisfied they are with the service they receive. However, the claim that citizens value choice for its own sake is also not supported. Public perceptions of how much choice people have over which hospital they attend are not associated with higher satisfaction with NHS hospital services once we take into account perceptions of how much patients are involved in their treatment and their views respected. Satisfaction with hospital services is more likely to be delivered by ensuring that patents are fully appraised of their treatment options than by providing patients with choice between different service providers

Does Choice Deliver? Public Satisfaction with the Health Service

It is frequently asserted that users of public services do not want choice; they just want a good local service (Levett, 2003; Schwarz, 2004).[i] However, advocates of choice argue this is a false dichotomy and users not only value choice as a desirable good in its own right, but also that in the long run the provision of choice will result in better local services (Minister of State for Department of Health et al 2005; for a review of these debates see Dowding and John, 2009). In this article we examine what the public think about choice in the provision of public services, and how attitudes to choice and perceptions of choice are related to satisfaction with public services. We provide a clear evidential basis on which to evaluate, for the first time, some of the key claims that have been made about one of the most controversial and far reaching processes of public service reform in Britain.

We address two claims in particular. The first is that people do not want choice. We examine how much choice people think they should have when accessing public services, and whether those expectations make any difference to how satisfied someone is with the provision of a service. If choice really matters to people then those with higher expectations should be more difficult to satisfy. The second claim we test is whether people intrinsically value choice independently of whatever impact it may have on the provision of a service. If people intrinsically value choice then we should find that people who think they are being provided with choice have higher levels of satisfaction, even after we have taken into account their evaluations of other aspects of a service. We pursue both these tasks by focusing in particular on the provision of in-patient hospital services. We begin, however, by describing in more detail the debate about choice and public service reform in the UK.

Public service reform in the UK

Under the Blair-led Labour government a series of reforms were introduced that dramatically changed the way in which public services are delivered. Public services were increasingly encouraged to provide greater choice in order to meet the personal needs and preferences of individual users. Moreover, users were not only able to choose among different public sector providers, but could opt for private sector ones

too, thereby turning the delivery of public services into a quasi-market environment. It is this quasi-market mechanism, it is argued, that ensures providers have every incentive to meet users' preferences while keeping costs down (Bartlett and Le Grand, 1993; Le Grand, 2003; 2007).

This process of reform has been continued (and expanded) by the Cameron-led coalition government, most notably in plans for reform of the NHS in England. These plans regard patient choice together with the involvement of patients in decisions about their care as key mechanisms for creating a better NHS (Department of Health, 2010). Patients would now not only be able to choose which hospital to attend, but would also be offered choice of specialist team, choice of general practice, and choice of treatment (Coulter, 2010). Although proposals for placing the responsibility for commissioning NHS services entirely in the hands of general practitioners - on the grounds that they were closest to patients - have been watered down following widespread criticism (Department for Health, 2011), the new structure is still intended to deliver a greater element of quasi-market competition into the way the NHS is run.

Two main arguments have commonly been put forward in support of these kinds of reforms (Dowding and John, 2009). The first emphasises the alleged *extrinsic* benefits of choice. These refer to the ways in which choice and competition may have a beneficial impact on the quality of the services that are provided. If services are required to respond to the preferences of users, they will become more efficient and effective at meeting their needs. In one of his first speeches as Prime Minister, David Cameron (2010) argued that 'wherever possible, we want to give people the freedom to choose where they get treated and where they send their child to school...Because when people can vote with their feet……it's going to force other providers to raise their game – and that's good for everyone'. As a result, he argued, more people should be satisfied with the service they receive, while the costs of delivering public services would be contained.

The second main argument supporters of the reforms have tended to emphasise is that choice provides *intrinsic* benefits. These refer to the ways in which choice may enhance users' experience of using services. One such claim is simply that the public 'expects' choice. People are used to having choice in the private sector, between for example, brands, insurance companies, and shops, and thus now expect choice in the public sector too. So in order to satisfy the public they are meant to

serve, public services have to meet the changed expectations of a consumerist society. At the start of the reform process Tony Blair (2002) argued that one of the four key principles of public service reform should be 'more choice for the consumer', and that public services should be 'rebuilt around the consumer'. A year later he justified the introduction of choice by arguing 'Public services were just not moving rapidly enough with the times to meet rising expectations in a modern consumer society.' (Blair, 2003).

Choice may also be valued intrinsically because it enhances individual autonomy, or at least allows people to feel that they are autonomous (Sugden 2003; Bavetta 2003). As Dowding and John (2009) suggest, treating people like autonomous human beings able to make decisions for themselves – once the alternatives, risks, and possibilities are explained to them – might be regarded as preferable by most people to simply being told by a doctor where, when and how they are going to be treated. Gordon Brown (2009) presented choice in terms of representing a transfer of power to the public. 'In the next phase of reform we will further empower citizens and communities through stronger rights and entitlements to core services, with clear redress mechanisms for citizens if those entitlements are not delivered'.... 'These reforms mean we can now extend power to the public over their services.'..... 'offer greater choice and control for users'.....and 'put power in the hands of users.'

Previous research has tended to support the broad claim that there is a strong public demand for choice. People say they value choice in service provision (Curtice and Heath 2009, Dixon et al 2010). But this does not mean that people necessarily give a high priority to choice (Curtice and Heath, 2009), and indeed given the option people overwhelmingly prioritise quality over choice. In a survey of patients carried out by MORI (2004), patients rated choice of 'where and when they were treated' as the 11th most important aspect of their health care among 16 items, below car parking but above hospital food. Similarly, Coulter (2010) reports that although patient surveys show a large and persistent unmet demand for greater involvement in treatment decisions, only a small minority want to switch service providers.

Meanwhile research on the extrinsic benefits of choice is only just beginning to emerge (Coulter, 2010), and to date has tended to produce weak or inconsistent results (see Dowding and John, 2009 for a summary). Moreover, even if choice does (or can) lead to an improvement in a service, it may do so at the expense of equity, primarily because of the differential access to information (and therefore ability to

make informed choices) by the affluent and educated (see Fotaki et al 2008 for a review).

Meanwhile, many questions remain unanswered. Despite the many different reasons given for providing choice, previous research has not examined in much detail how much or why it is valued. It is one thing to show that the public say they want choice, but it is something else to show that it makes a difference to what they think about a service when they feel they actually have choice. How much difference does the perception that choice is available actually make to service evaluations? And if the public do value choice, why do they do so? Is it apparently valued for its intrinsic benefits as well as its possible extrinsic ones? And in health in particular how important is choice in the provision of supplier as opposed to the willingness of health professionals to involve patients in their treatment decisions? These are the questions we address in this paper.

Choice and Satisfaction

In order to examine whether or not choice is valued by the British public, and if so why, we examine the impact of choice on the level of satisfaction with public services. Spending on public services such as health and education has consistently been prioritised by the public when asked which areas of government activity most merit extra spending (Sefton, 2003). However, it is also often thought, particularly among politicians, that the public are unwilling to endure higher taxation in order to fund extra expenditure on such services (Taylor-Gooby and Hastie, 2003). If there is a demand for choice and it is regarded as a desirable aspect of public service delivery, then, even if the instrumental pay-off from doing so were not particularly high, there would arguably be a strong justification for introducing greater choice as a relatively inexpensive way of increasing citizen satisfaction with a politically salient aspect of public policy. Moreover, the delivery of public services is often seen as a key 'valence issue' in elections, where satisfaction with these services influences vote choice (James and John 2007), which in turn influences policy.

Examining the association between choice and satisfaction not only allows us to explore the extent to which choice really is valued by the public, but also enables us to exploit some of the lessons of previous research on the determinants of satisfaction with the delivery of public services. In recent years there has been growing academic research into that subject (Choi et al., 2004; Van Ryzin, 2004,

2006; James, 2007, 2011), research that in turn has built on a much more extensive literature on consumer satisfaction with private goods and services (Anderson, 1973; Johnson et al., 1996; Parasuraman, et al., 1988; Westbrook and Reilly 1983). One of the key findings of this body of research is that user expectations of what a service should deliver have a strong impact on how satisfied users are with the service in question (Parasuranam et al., 1985; 1989). Consumers form judgments about products or services based on their expectations about what the service in question should offer (Oliver 1980), and after experiencing the product's actual performance, these expectations then serve as a reference point in the formation of a satisfaction judgment (Oliver 1997, Van Ryzin 2004). Expectations are thus defined in 'normative terms' (James 2011: 1420) and refer to 'subjective beliefs' about what citizens think 'should happen under particular circumstances'. Such measures have been developed to examine citizens' expectations of how well different public services should perform, including health care services (Appleby and Alvarez-Rosete 2003), household waste collection services (James 2009) and state highway services (Poister and Thomas 2011).

High levels of satisfaction can simply be a product of low expectations, while in turn low levels of satisfaction can be a consequence of high expectations (James, 2007). More formally, this relationship is often specified in terms of expectation/disconfirmation, where satisfaction is positively related to performance (as perceived by users) minus expectations. Thus satisfaction with a product or service is not a consequence of its quality alone, but how well its quality compares with consumers' prior expectations.

Citizens' expectations about what a public service should offer are shaped by information from many sources, including personal experience, word of mouth, the media, public auditors and public service providers themselves (Heinrich 2003; Moynihan 2008; James 2011). As noted earlier, one of the main justifications for introducing choice into the delivery of public services has been to meet the expectations of a modern consumer society (e.g. Blair 2003). As Dowding and John (2009: 224) suggest, since people have become habituated to having choice in the private sector, they may now come to expect choice in the public sector too, and be disappointed if they then do not encounter the range of choice that they were expecting. But expectations about how much choice should be on offer may also have been shaped by the politicians themselves. Research in other areas suggests that, for

example, local authorities can play a strategic role in shaping citizens' expectations about local services, and in particular can attempt to lower expectations (and hence increase satisfaction) by informing local publics about difficulties in providing services, such as problematic socioeconomic conditions or budget and other constrains imposed by outside actors such as central government (Hood 2002; James 2004). In a similar vein, one consequence of the political rhetoric on the provision of choice in public services over the last 10 years may have been to increase public expectations about how much choice should be on offer. If the public is repeatedly told that public services are being reformed to offer them more choice, they may come to expect choice when they encounter these services.

At the same time, it should be borne in mind that individuals tend to be more satisfied with specific services of which they have direct personal experience than they are with public services in general (see Appleby and Alvarez Rosete 2003). If experience matters, then perhaps personal experience of NHS hospitals has a moderating effect on the relationship between choice and satisfaction. If choice really is valued as an intrinsic good then we should anticipate that when citizens encounter hospital services they are satisfied and unsatisfied as a result of the choices they experience. Meanwhile, citizens without direct personal experience of NHS hospitals should be less affected by the amount of choice they perceive to be on offer since they will not have been personally pleased or disappointed. By contrast, if what matters to patients is more to do with other aspects of service delivery, such as the degree to which they are involved in decisions about their treatment, than we should anticipate that when citizens encounter hospital services they are satisfied and unsatisfied primarily as a result of those aspects of their experience and not by their experience of choice..

To address these issues we test three key hypotheses about the link between choice and satisfaction, doing so by looking in particular at the link between choice of hospital and satisfaction with inpatient services. Firstly, if, as argued by Blair and others, people have come to expect choice and it matters to them, we should find that expectations about choice are associated with satisfaction. Accordingly, high expectations would be associated with lower levels of satisfaction and low expectations with higher levels of satisfaction.

H_1 Expectations of choice are directly and negatively related to satisfaction with services

Alternatively, if 'people don't want choice, they just want a good local service', then whatever expectations people have about choice should be unrelated to satisfaction.

Following on from this first hypothesis we examine what difference it makes if people's expectations are met. If citizens value choice we would expect those who think that patients have a lot of choice to be more satisfied with the provision of NHS hospital services than people who think patients only have little or no choice.

H_2 Perceptions of choice are directly and positively related to satisfaction with services

Thirdly, we try to understand why the public might value choice. Following the cry of 'No decisions about us without us', we might expect people who think they would be respected and involved in decisions about their treatment to be more satisfied with the service on offer.[ii] One of the extrinsic benefits of providing a choice of hospital might be to make this more likely. However, if choice is valued for its own sake we should find that it is positively related to satisfaction above and beyond perceptions of patient involvement.

H_3 Perceptions of how much choice is provided are related to satisfaction even after taking into account the possible extrinsic benefits of choice (such as and, in particular, greater patient involvement).

Alternatively, we might find that any relationship between perceptions of choice and satisfaction disappears when we take perceptions of involvement into account. In that event the provision of choice would only seem to matter in so far as it is associated with such involvement.

Data, Measures and Methods

To test these hypotheses we draw on data collected as part of the 2007 British Social Attitudes Survey (Park et al., 2009). This survey both contained a module of questions on attitudes towards public service reform in the UK, including questions on how

much choice citizens think patients ought to be able to have over which hospital they attend and how much choice they think patients actually have, and a module of questions on attitudes towards the health service, including questions on perceptions of patient involvement and satisfaction with hospital services. Fieldwork for the survey was carried out by NatCen Social Research between June and November 2007, and involved interviewing face to face a probability sample of adults aged 18 plus resident across Great Britain (south of the Caledonian canal). Overall, the survey interviewed 4,124 people, representing a response rate of 52 per cent. The questions that we analyse here, however, were administered to only half the sample, or 2,022 respondents.

The dependent variable in our analysis is satisfaction with hospital inpatient services. Respondents were asked on a five point scale how satisfied or dissatisfied they were 'with the NHS as regards being in hospital as an in-patient'. In line with James's (2007) analysis of satisfaction with public services, the original data are recoded into a binary variable that denotes whether people are satisfied or not. Satisfied corresponds to being either 'very satisfied' or 'satisfied' on the original five point scale, while not satisfied corresponds to one of 'neither satisfied nor dissatisfied', 'dissatisfied', or 'very dissatisfied'.

Expectations about choice were gathered by asking respondents, 'How much choice do you think NHS patients should have about which hospital to go to if they need treatment?'. Responses were recorded on a four point scale ranging from 'none' (scored as 1) to 'a great deal' (scored as 4). Perceived choice was measured, using the same scale, by asking, 'How much choice do you think NHS patients actually have about which hospital to go to if they need treatment? A respondent's disconfirmation score is simply the difference between those two measures (James, 2007; Van Ryzin, 2004). Thus that variable ranges from –3 (where perceived choice falls a long way short of expectations) through 0 (where expectations are met but no more) to 3 (where expectations are vastly exceeded). In practice few respondents feel their expectations have been exceeded.

In research on satisfaction with services, the performance of a service is usually measured via consumers' subjective evaluations of specific features of a service (Oliver, 1997; Van Ryzin, 2004).[iii] However, the strength of the relationship between performance evaluations and overall satisfaction could be inflated if performance evaluations are also measured on a satisfaction scale. Thus none of our

indicators of perceived performance, which focus on the degree to which professionals are thought to respect and involve patients, have been measured using such a scale.[iv] Instead respondents were asked to use a four point scale to indicate whether they thought various things definitely or probably would or would not happen if they were a hospital in-patient. The specific items were: (1) the hospital doctors would take seriously any complaints you may have; (2) the nurses would take seriously any complaints you may have; (3) the hospital doctors would tell you all you feel you need to know; and (4) the hospital doctors would take seriously any views you may have on the sorts of treatment available. These items are combined into a single standardised indicator of patient involvement and respect that has a mean of zero and a standard deviation of one.

In addition to these key variables, we also deploy in our modelling a number of theoretically relevant controls and interaction terms (Appleby and Robertson, 2010). Firstly, since those people who have firsthand experience of using a service commonly have a more positive perspective towards it, we control for whether or not the respondent (or close family member) had experience of using hospital inpatient services in the last year. Overall 43 per cent of our sample reported such personal experience with inpatient services.[v] At the same time we also bear in mind that if choice is valued intrinsically, then we might anticipate that it is amongst recent users above all that the degree to which perceptions match expectations of choice should be of import to their levels of satisfaction. We thus also test whether there is an interaction between choice and recent experience – and given that much the same argument can be applied to perceptions of patient involvement we interact that with recent experience too.

Secondly, since attitudes towards public services in general and the NHS in particular tend to be shaped by party preference, we also control for party identification. In particular, since Labour were in office at the UK level when the survey was conducted, Labour partisans can be expected to view the NHS more positively than supporters of the principal opposition party, the Conservatives, since it was 'their party' in charge. Thirdly we control for age, since older people tend to be more satisfied with the NHS, doubtless because they are more reliant upon it. Finally, we control for class, since this is a predictor of whether or not people value choice in the first place (Le Grand, 2007; Curtice and Heath, 2009).

The demand for choice

We begin, however, by examining how much choice people say they should have about which hospital they attend, and how the level of expressed support for such choice compares with that in respect of other aspects of public services. As Table 1 shows, this exercise suggests that not only is choice of hospital relatively popular, but so also is choice in general. Three quarters say that patients should have either 'a great deal' or 'quite a lot' of choice about which hospital they attend. This is rather less than the just over four in five who think that parents should have plenty of choice about which secondary school their children attend, but rather more than the slightly less than two-thirds who feel that parents should have a lot of choice about what their children actually learn at school. Meanwhile, it appears that support for choice of hospital is on a par with support for giving patients choice about the treatment they receive. Overall then, choice in the provision of public services seems to be relatively popular, both within and beyond the NHS.

Table 1 about here

Still, perhaps the table also suggests the need for a little caution. In each case around twice as many say there should be 'quite a lot' of choice as say there should be 'a great deal'. Perhaps while choice is widely regarded as desirable it is not necessarily considered to be a high priority. People might want choice, but they may not attach much value to it. This is certainly the impression that is gained when people are asked to consider how important choice is as opposed to a variety of other objectives that might be pursued by a public service. For example, when asked to state which of a set of four possible priorities for the NHS was 'most important for the NHS to achieve', as many as 78 per cent choose 'make sure people who are ill get treatment quickly'. Just six per cent say 'make sure people have a lot of choice about their treatment and care', slightly less than the seven per cent who opt for 'make sure that people on low incomes are as healthy as people on high incomes', though rather more than the two per cent who choose 'get the number of people aged under 50 with heart disease down as low as possible'. It should thus come as no surprise that the UK Labour government's attempts to reduce waiting times appear to have played a particularly important role in generating increased levels of satisfaction with the NHS (Appleby and Robertson, 2010).

The perception of choice

We now turn to how much choice people think they actually have. Table 2 looks at how much choice of hospital people actually think there is, and shows how that compares with perceptions of other aspects of choice in the public services. The perceived reality of how much choice of hospital users think they are able to exercise falls some way short of their expectations about how much choice they should have. Whereas 75 per cent thought that patients *should* be able to exercise 'quite a lot' or 'a great deal' of choice about which hospital they go to for treatment, only 19 per cent thought that patients could actually exercise this amount of choice.

Choice of hospital is far from unique in this respect. Just 14 per cent feel that people get a great deal or quite a lot of choice about who provides them with personal care, well below the 80 per cent who feel they should do so. This result might be thought quite surprising given that the choice agenda has been rolled out most extensively in personal care services. Even in the case of the service where choice is thought to be most common in practice, that is which secondary school children attend, only 24 per cent feel that at least quite a lot of choice is available, again well below the 81 per cent who reckon it should be.

Table 2 about here

Do Expectations and Perceptions Matter?

There is thus clearly a big gap between expectations of how much choice people think patients should have and perceptions of how much choice they think is actually available. People say there should be choice, but do not think they are getting it. Following the expectations/disconfirmation approach we would expect that people whose perceptions of choice fall short of their expectations will be less satisfied than people whose expectations are met – so long as choice does actually matter to them. Our next task then is to examine the link between both expectations and perceptions of choice on the one hand and levels of satisfaction on the other. We focus on satisfaction with hospital inpatient services, since this is the aspect of health service performance that relates most obviously to choice of hospital. Table 3 shows the results.

People do not just say they want choice. Whether or not they actually have it is significantly strongly related to how satisfied they are with a service (p=<0.0005). Around 70 per cent of those who say that patients have quite a lot or a great deal of choice are satisfied with the provision of inpatient services, compared with just 50 per cent of those who say that patients do not have any choice at all. On the other hand at first glance, expectations about choice do not appear to be related to satisfaction. Although those with the highest expectations are slightly less satisfied with NHS hospitals than those with the lowest, the difference is only one of eight points, and the relationship between expectations and satisfaction is not significant (p=0.344). This might be thought to cast some doubt on whether those apparently high expectations about choice are actually of much import at all.

This, however, is a misleading impression. The relationship between expectations and satisfaction is confounded by that between perceptions and satisfaction. Once we take that into account the link between expectations and satisfaction becomes much clearer. For example, among all those who do not think they have any choice about which hospital they can go to for treatment, only 49 per cent are satisfied with provision of inpatient services. However, this figure rises to 67 per cent if we look only at those who have low expectations about how much choice there should be. In other words, expectations matter in that the link between choice and satisfaction does not simply depend on how much choice people think they have but whether their perceptions match their expectations. This can be seen quite clearly in the bottom third of Table 3 where we apply the expectation/perception disconfirmation approach. The relationship is highly significant (p=<0.005). No less than two-thirds of those whose expectations are met or exceeded are satisfied with the provision of hospital inpatient services compared with little more than two in five of those whose expectations are not met at all.

Table 3 about here

At a bivariate level then these results confirm that the public not only say they want choice, but that its provision in health care is valued. Most members of the public have high expectations of the amount of choice that should be on offer, and those who feel that their expectations are met tend to be more satisfied with the provision of in-patient services than those whose experience falls some way short. There is a demand

for choice of hospital, and the more that demand is met the more likely it is that people are satisfied with the provision of inpatient services. Thus, given that most people's expectations are not met, it would seem that much could be done to improve levels of satisfaction by providing as much choice of hospital as possible. But such a conclusion would be rash. In order to establish whether the association between choice and satisfaction is robust, and to gain a better understanding of why the association exists, we need to examine whether it still holds up when we control for other relevant variables.

Modelling the relationship between choice and satisfaction

We now, therefore, undertake some multivariate modelling of the determinants of satisfaction with hospital services. In order to understand the relationship between choice and satisfaction more fully we run a series of models in which we look separately at the relationship between satisfaction and (a) expectations about how much choice people think patients should have, (b) perceptions of how much choice they think patients do have, and (c) the degree to which expectations about choice are met, exceeded or fall short. Since our dependent variable of interest is 'satisfied' or 'not satisfied' with the provision of NHS hospital services, we use binary logistic regression, which is the appropriate technique for binary dependent variables. As indicated earlier, our control variables are age, social class, party identification, and previous experience of using hospital services (that is whether the respondent or a close family member has been an inpatient during the last 12 months). Importantly though, for the time being, we do not control for evaluations of patient involvement in treatment decisions.

Results from the series of baseline models are reported in Table 4. From these we can see that all of the choice terms are highly significant. In Model 1 we only include perceptions of choice. It shows that the amount of choice people think patients have has a positive and significant impact on satisfaction. This affirms our initial finding that choice is valued and those who think patients have a choice of hospital are more likely to be satisfied than those who do not. However, when, as in Model 2, we also include expectations of choice, we secure a slightly better fit to the data (χ^2 is 19 higher in Model 2 than in Model 1 for the loss of just one degree of freedom). Now that we are examining the link between expectations and satisfaction systematically

alongside that between perceptions and satisfaction, we can see that, contrary to our initial impression, expectations clearly matter. People who think that patients should have a lot of choice about which hospital they go to are significantly less likely to be satisfied with the provision of inpatient services than those who think that patients should not have any choice, presumably because they are less likely to have their expectations met.

A more formal test of the role of failure to meet expectations is provided in Model 3. This proves to have a slightly better fit to the data than Model 2 (χ^2 is the same, but this model saves one degree of freedom.) The disconfirmation term is positive and significant. People are evidently more likely to be satisfied with the quality of care that hospitals provide to inpatients the closer that their perceptions of choice match (or even exceed) their expectations.

Meanwhile, we should also note that in Model 3 at least one element of all of the control variables is significant - and in the expected direction. Those aged over 60 years old are more likely to be satisfied that those aged less than 30. Levels of satisfaction are significantly higher among those engaged in more working class occupations (that is lower supervisory and technical, semi-routine or routine jobs) than among higher professionals and managers, while those who recently have had some experience of inpatient services are also more likely to be satisfied. At the same time partisanship also makes a difference – Labour identifiers are significantly more likely to be satisfied than Conservative partisans. Yet even when we take into account all of these anticipated associations, the gap between expectations and perceptions of choice still matters.

Table 4 about here

So our first two hypotheses have been substantiated. Both expectations and perceptions of choice are associated with satisfaction. This strongly suggests that the idea that people do not want choice, or do not value it is misplaced. However, this does not tell us why the public value choice or what this association is based on. Do people value being provided with a choice of hospital for its own sake, or do they value choice because of what it might be thought to help deliver, such as greater patient involvement in decisions about treatment?

Modelling the relationship between choice, performance and satisfaction

In order to answer this question, we investigate in this section the robustness of the relationship between choice and satisfaction once we control for perceptions of other aspects of hospital provision, and in particular evaluations of the degree to which health professionals are thought to respect the views of patients and involve them in decisions about their treatment. When we take this aspect of delivery into account, is there still a positive relationship between perceptions of the degree to which people can choose the hospital they attend and satisfaction with in-patient services? If there is, that would still leave open the possibility that choice of hospital is valued above and beyond whatever extrinsic benefits it might bring. If not, then it would seem that those who think that choice is available are also inclined to think that health professionals involve patients in decisions about treatment and respect their views – perhaps because this is indeed one of the consequences of delivering choice of hospital – and that it is this feature of in-patient provision, not choice of hospital *per se*, that matters so far as people's satisfaction is concerned.

Table 5 about here

In Table 5 we repeat the models in Table 4, but this time also including our summary indicator of willingness to respect patients' views and involve them in decisions about their treatment. From the Chi-square statistics we can see that by including this term each model in Table 5 provides a significantly better fit to the data than the equivalent model in Table 4. Moreover, we can also see that there are some substantial changes in the magnitude of the coefficients of some of our choice variables. In particular in Model 4, the coefficient for perceptions of choice is a non-significant b=0.12, compared with a significant b=0.34 in the equivalent model in Table 4, Model 1. This indicates that the impact of choice on satisfaction is significantly mediated by whether or not patients feel involved in their treatment decisions.[vi] This finding casts doubt on the claim that choice is valued as an intrinsic good. Rather, it appears that those who think that people do have plenty of choice about which hospital they attend are also inclined to believe that health professionals involve patients in decisions about their treatment and show respect for their views, and that, contrary to our third hypothesis,

choice is valued only in so far as its existence is linked in the public mind with the delivery of that consequential benefit.

None of this negates our conclusion that people want choice. As we might expect, including our indicator of patient involvement and respect in a model makes little difference to the link between expectations of choice and satisfaction. The coefficient for expectations (b=-0.30) in Model 5 (Table 5) is much the same as it was (b=-0.34) in model 2 (Table 4), indicating that the impact of expectations about choice on satisfaction is not significantly mediated by whether or not patients feel involved in their treatment decisions.[vii]

People who expect a lot of choice are more difficult to satisfy than those who do not expect it at all. However, what creating the impression that patients are involved in their treatment and their views respected helps to do is to meet the high expectations of the health service that those who want a lot of choice evidently have. This is illustrated clearly in Model 6, where, when we control for our measure of patient involvement and respect, we see that the magnitude of the coefficient for choice disconfirmation is significantly lower (b=0.25) than it was in Model 3 above (b=0.37).[viii] In our earlier model, our disconfirmation variable was evidently partly tapping into the fact that those who felt that their expectations of choice were not being fulfilled were also inclined to doubt the degree of patient involvement and respect, and it was that perceived lack rather than the lack of choice of hospital that was primarily responsible for their lower level of satisfaction.

This is borne out by the results from model 7 reported in the last column of Table 5. If choice was really valued as an intrinsic good in its own right then we would anticipate that the relationship between choice disconfirmation and satisfaction would be stronger for people who have had firsthand experience of NHS hospital services than for people who have not, and who hence have not been personally disappointed. To see if choice is particularly valued by patients who come into contact with hospitals we specify an interaction between choice disconfirmation and inpatient status. The interaction term is not significant (p=0.70).[ix] This implies that people who encounter the NHS hospital services directly, and whose perceptions of choice are based on recent firsthand experience, are no more likely to be satisfied if their expectations are met or exceeded than people who have not had this direct contact, and whose perceptions of choice are therefore based on less personal experience.

In contrast, the interaction effect between patient involvement and inpatient status is significant and positive. Perceptions about patient involvement are important in general for satisfaction, but they are more important for people whose perceptions are based on recent firsthand experience than for people whose perceptions are based on information from other sources (such as, word of mouth, media, public auditors and public service providers themselves). This implies that people who have recently encountered NHS hospitals are particularly more likely to be satisfied if they have had a positive experience in this regard (see Figure 1, which plots the marginal effects of the interactions, holding other variables at their mean).

Figure 1 about here

Together these findings suggest that patient involvement and respect are much more closely related to satisfaction than are views about choice. This is further illustrated in Figure 2, which shows the change in the predicted percentage of people who are satisfied if there were a one standard deviation change in the value of each independent variable in Model 6, while holding all the other variables at their mean. By far the biggest predicted change is associated with evaluations of patient involvement and respect. A one standard deviation increase in those evaluations is associated with a 22 percentage point increase in the proportion who are satisfied. This is in line with previous research in the US that suggests the patient–practitioner relationship plays an important role in service evaluations (Bowers et al., 1994; Ettinger, 1998; Donabedian, 1988). By contrast, a one standard deviation increase in the choice disconfirmation variable is associated with less than a six percentage point increase in satisfaction. This association is weaker than that of age, and no greater than that of class or experience of being an inpatient. It appears that in terms of creating a service that modern society values, the direct payoff at least from providing choice may well be no more than modest.

Figure 2 about here

Conclusion

In this article we have examined what the public think about choice, and how perceptions of choice are related to satisfaction with public services. Our findings help to shed light on how much the public value choice and why. In so doing they cast doubt on two key claims, one made both by supporters and one by opponents of choice. Contrary to the claims of opponents people do want choice. But contrary to the arguments of some proponents, they want it not so much for itself as for what it is associated with.

People expect choice and this expectation seems to matter. Most citizens think people should be given a choice of hospital, and the amount of choice they think they should have is clearly associated with their level of satisfaction with hospital services: the more choice they want, the more difficult they are to satisfy. This finding is robust and stands up even when we take into account many possible controls. But choice is not valued for its intrinsic benefits. Once we take into account the degree to which it is thought patients are involved in their treatment and their views are respected, the relationship between perceptions of whether people can choose the hospital they attend and satisfaction with in-patient services disappears. Perceptions of choice are evidently linked to evaluations of patient involvement and respect, but it is those evaluations, not choice, that are associated with satisfaction, and particularly so for people who have recently encountered hospital services. On its own the provision of choice seems not to make much difference to levels of satisfaction with hospital services at all.

Given these two findings, we would suggest that the widespread demand for choice is not so much a demand for choice *per se* as a wish to see the NHS organised in a way that will meet people's high expectations of what constitutes a good service. But what they regard as a good service is an NHS that they believe would ensure they were consulted, listened to, and have their treatment options clearly explained to them if and when they were in hospital. It may be that introducing choice and competition between hospitals encourages doctors to explain the different options to patients, not least so that they can make a decision about which hospital they attend. But the focus of the politician who wishes to maximise satisfaction with the health service should not be on choice, but rather on identifying the best ways of ensuring that health professionals are attentive to the needs and wishes of their patients.

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Table 1 Attitudes towards exercising choice (row percentages)

How much choice should users of public services have about …	**None**	**A little**	**Quite a lot**	**A great deal**
… which state secondary school their children attend	2	16	50	31
… who provides them with personal care	3	16	51	29
… which hospital to go to if they need treatment	4	21	49	26
… what kinds of medical treatment they receive	3	22	52	21
… what their children learn at state secondary school	6	28	44	20

Source: British Social Attitudes survey 2007. N=2022. Percentages do not sum to 100 because the proportion saying 'Don't know' is not reported.

Table 2 Perceptions of the availability of choice (row percentages)

How much choice do users of public services have about …	**None**	**A little**	**Quite a lot**	**A great deal**
… which state secondary school their children attend	15	56	22	2
… who provides them with personal care	22	54	13	1
… which hospital to go to if they need treatment	23	54	17	2
… what kinds of treatment they receive	16	60	18	1
… what their children learn at state secondary school	28	47	17	2

Source: British Social Attitudes survey 2007. N=2022. Percentages do not sum to 100 because the proportion saying 'Don't know' is not reported.

Table 3 Satisfaction with NHS Hospital by perceptions of choice

	Satisfied (%)	**N**
Perceived choice		
A lot	72	47
Quite a lot	70	319
A little	55	984
None	49	422
Chi-square = 38.1; 3 df; p=<0.0005		
Expected choice		
A lot	55	484
Quite a lot	56	882
A little	60	383
None	63	68
Chi-square = 3.3; 3 df; p=0.344		
Expectations-perceptions (Disconfirmation)		
Perception meet or exceed expectations	66	551
Perceptions fall a little short of expectations (-1)	55	706
Perceptions fall quite a lot short of expectations (-2)	51	413
Perceptions fall a long way short of expectations (-3)	41	100
Chi-square = 36.9; 3 df; p=<0.0005		

Source: British Social Attitudes survey 2007.

Table 4 Logistic regression of Choice of Hospital and Satisfaction with Hospital Inpatient care, log odds ratios

	Model 1	Model 2	Model 3
Perceived choice	0.34*** (0.09)	0.41*** (0.09)	
Expected choice		-0.34*** (0.08)	
Perceived-Expected Choice			0.37*** (0.06)
Been inpatient	0.35** (0.12)	0.34** (0.12)	0.34*** (0.12)
Been inpatient * Perceived-Expected Choice			
Age			
18-29 years‡	-	-	-
30-44 years	0.10 (0.19)	0.14 (0.19)	0.14 (0.19)
45-59 years	0.21 (0.20)	0.26 (0.19)	0.27 (0.19)
60+ years	0.84*** (0.20)	0.89*** (0.20)	0.90*** (0.20)
Class			
Higher professionals‡	-	-	-
Lower professionals	0.03 (0.21)	0.15 (0.21)	0.16 (0.21)
Intermediate	0.04 (0.25)	0.21 (0.24)	0.23 (0.24)
Employers in small Organisations	0.19 (0.27)	0.34 (0.27)	0.36 (0.27)
Lower supervisory and technical	0.40 (0.25)	0.59* (0.26)	0.61* (0.25)
Semi-routine	0.27 (0.23)	0.47* (0.24)	0.49* (0.23)
Routine	0.42 (0.27)	0.63* (0.28)	0.65* (0.27)
Party ID			
Conservative‡	-	-	-
Labour	0.33* (0.15)	0.33* (0.15)	0.33* (0.15)
Liberal Democrat	0.09 (0.21)	0.11 (0.21)	0.12 (0.21)
Other party	0.49 (0.25)	0.51* (0.25)	0.50 (0.25)
None	0.26 (0.19)	0.33 (0.19)	0.28 (0.19)
Constant	-1.22 (0.32)	-0.64 (0.35)	-0.38 (0.27)
Nagelkerke R^2	0.08	0.09	0.09
-2*Log Likelihood	1630	1610	1610

Wald χ^2 (degrees of freedom)	71 (15)	90 (16)	89 (15)
N	*1250*	*1250*	*1250*

standard errors reported in brackets
‡ Reference Category
* p < 0.05; ** p < 0.01; *** p < 0.001
Source: British Social Attitudes Survey 2007
.

Table 5 Logistic Regression of Choice of Hospital, Perceptions of Patient Involvement and Satisfaction with Hospital Inpatient care, log odds ratios

	Model 4	Model 5	Model 6	Model 7
Perceived choice	0.12 (0.09)	0.19 (0.10)		
Expected choice		-0.30** (0.09)		
Perceived-Expected Choice			0.24*** (0.07)	0.25** (0.09)
Patient involvement and Respect	0.94*** (0.08)	0.94*** (0.08)	0.93*** (0.08)	0.69*** (0.11)
Been inpatient	0.39** (0.13)	0.38** (0.13)	0.39** (0.13)	0.43* (0.20)
Been inpatient * Patient involvement				0.49** (0.16)
Been inpatient * Per-Exp choice				-0.01 (0.14)
Age				
18-29 years‡	-	-	-	-
30-44 years	0.07 (0.20)	0.09 (0.21)	0.09 (0.21)	0.05 (0.21)
45-59 years	0.15 (0.21)	0.20 (0.21)	0.19 (0.21)	0.15 (0.21)
60+ years	0.72*** (0.21)	0.76*** (0.22)	0.75*** (0.21)	0.71*** (0.22)
Class				
Higher professionals‡	-	-	-	-
Lower professionals	-0.03 (0.23)	0.08 (0.23)	0.06 (0.23)	0.03 (0.24)
Intermediate	0.04 (0.27)	0.17 (0.28)	0.15 (0.28)	0.12 (0.27)
Employers in small organisations;	0.26 (0.29)	0.40 (0.30)	0.37 (0.29)	0.36 (0.29)
Lower supervisory and technical	0.53 (0.30)	0.71** (0.28)	0.68* (0.28)	0.66* (0.28)
Semi-routine	0.30 (0.25)	0.45 (0.26)	0.42 (0.26)	0.41 (0.26)
Routine	0.52 (0.30)	0.69* (0.30)	0.66* (0.30)	0.63* (0.30)
Party ID				
Conservative‡	-	-	-	-
Labour	0.25 (0.16)	0.25 (0.16)	0.25 (0.16)	0.25 (0.16)
Liberal Democrat	0.08 (0.23)	0.11 (0.23)	0.10 (0.23)	0.13 (0.23)
Other party	0.53 (0.27)	0.56* (0.28)	0.57 (0.28)	0.61 (0.28)
None	0.19 (0.21)	0.20 (0.21)	0.21 (0.21)	0.20 (0.21)
Constant	-0.70	-0.15	-0.38	-0.35

	(0.34)	(0.39)	(0.29)	(0.29)
Nagelkerke R^2	0.25	0.26	0.26	0.27
Wald χ^2 (degrees of freedom)	257 (16)	268 (17)	268 (16)	277 (17)
-2*Log Likelihood	1445	1432	1432	1423
N	*1250*	*1250*	*1250*	*1250*

standard errors reported in brackets
‡ Reference Category
* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$
Source: Derived from British Social Attitudes Survey 2007.

Figure 1: Predicted probability of satisfaction with hospital services

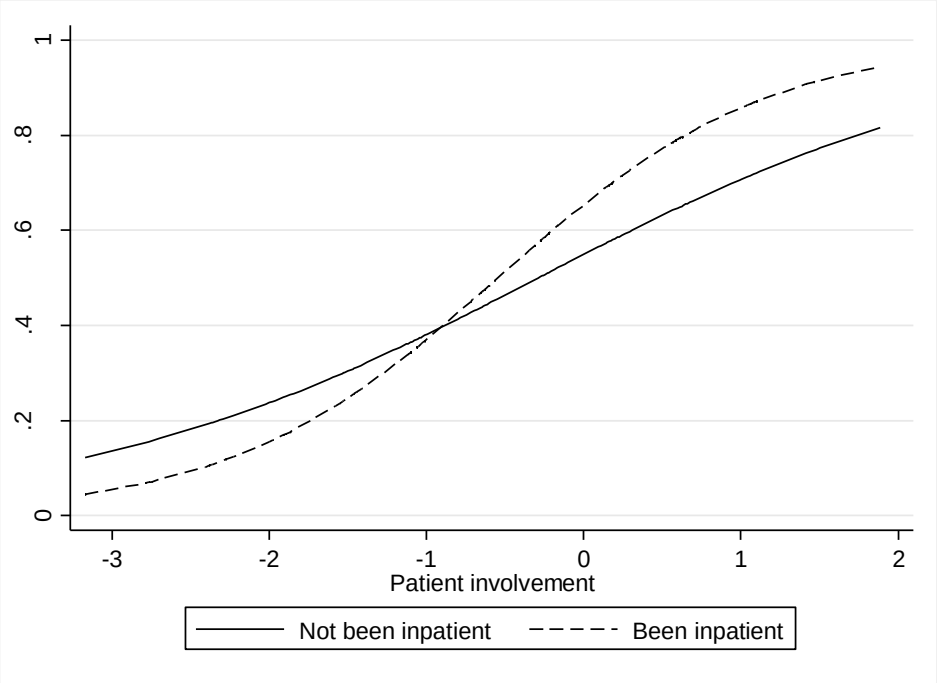
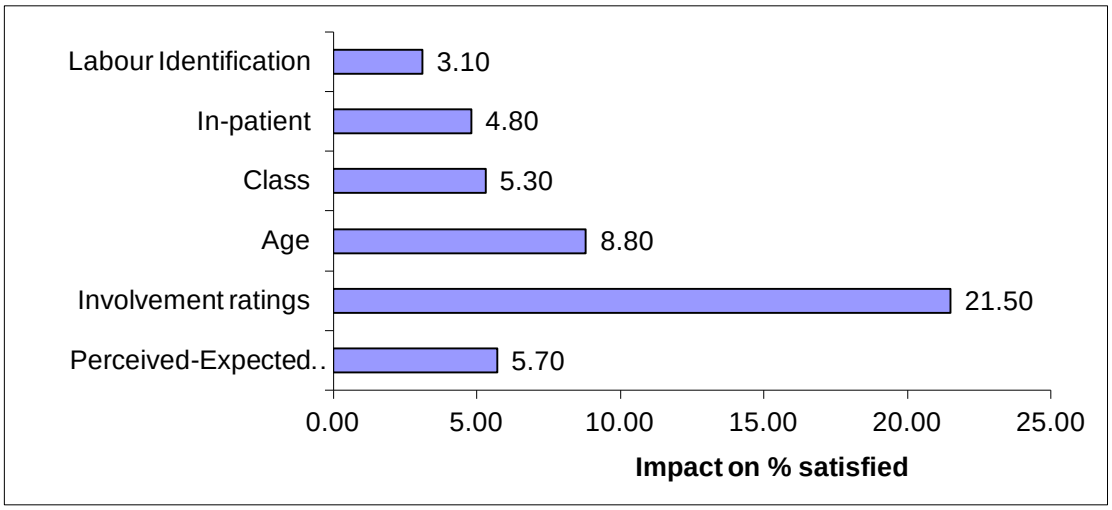


Fig 2. Total direct effects on Satisfaction: Impact of a one standard deviation change in the value of the independent variables on predicted satisfaction



Source: Calculations derived from Table 5, Model 6

[i] This point has also frequently been made by health professionals, politicians and journalists. For example, at the 2006 British Medical Association annual meeting, doctors accused their leadership of failing patients, the profession and the country by putting up an inadequate fight against what they considered to be the government's destabilising NHS reforms (Boseley, 2006), and told their leaders 'that patients don't want choice' (Titmuss, 2006).

[ii] "Nothing about me without me" was the guiding principle adopted by 64 participants from 29 countries at a 1998 Salzburg global seminar convened to develop ideas for improving the quality of health care by involving patients. See Delbanco et al (2001).

[iii] In the literature on satisfaction with different services, performance measures are viewed as a cognitive judgment, whereas satisfaction is viewed more as an affect-laden evaluation (Oliver, 1993, 1997; Gooding, 1995). This suggests a causal order that positions performance measures as an antecedent to satisfaction. There is substantial empirical evidence to support this causal linkage between health care service quality and patient satisfaction (Bowers et al., 1994; Reidenbach and Sandifer-Smallwood, 1990;Woodside et al., 1989).

[iv] We examine whether the performance indicators, choice measures and satisfaction measure all tap into a single underlying 'satisfaction' variable by carrying out confirmatory factor analysis. The fit measures indicate that they do not (chi square = 287 on 14 df; p=<0.0005).

[v] According to NHS figures, around 3 million people are treated in the NHS in England every week, and in England there are around 17 million hospital visits per year (NHS 2012).

[vi] In order to test whether the impact of choice on satisfaction is mediated by the inclusion of patient involvement ratings we calculate the indirect or mediated effects using the product of coefficients approach (Ender 2011). The results of the analysis indicate that it is: the bias corrected confidence interval for the mediated effect {0.06, 0.12} is significant and does not contain zero. Moreover, the proportion of the total effect of choice on satisfaction which is mediated by the inclusion of patient engagement ratings is 0.65, which is substantial.

[vii] The results of the mediation analysis indicate that the impact of expected choice on satisfaction is not mediated by patient involvement ratings: the bias corrected confidence interval for the mediated effect {-0.051, 0.003} is not significant and contains zero.

[viii] The results of the mediation analysis indicate that the impact of choice disconfirmation on satisfaction is mediated by patient involvement ratings: the bias corrected confidence interval for the mediated effect {0.06, 0.11} is significant and does not contain zero. The proportion of the total effect which is mediated by the inclusion of patient engagement ratings is 0.37.

[ix] We also specify interaction effects between choice disconfirmation and inpatient status when we do not control for treatment decisions, and this is not significant either. Nor is the interaction effect between perceived choice and inpatient status.