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A bitter aftertaste? The effects of privatisation reforms on evaluations of health systems across Europe

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ABSTRACT

What is the effect of healthcare privatisation on citizens' views of the health system? Using an original data set of legislative changes in health policy and European Social Survey data on healthcare system evaluation, we analyse the link between healthcare privatisation reforms and citizens' evaluations of health systems across 30 European countries. Our results show that after an initial positive reaction, privatisation is associated with the worsening of attitudes towards the health system. Partisanship of the government enacting privatisation matters for evaluations, but this effect of partisanship is relatively short-termed. Most importantly, results point to the critical importance of proximity. Privatisation reforms with more direct effects on healthcare use are evaluated more negatively compared with those with indirect effects, demonstrating the importance of policy proximity to beneficiaries. Similarly, an individual's proximity to policy, which refers to direct exposure to health policy based on health status, has a more immediate and extended effect on evaluations compared to characteristics unrelated to care use, such as ideology. Overall, the results demonstrate that citizens react to privatisation in a dynamic way and discriminate between different types of privatisation reforms, contributing to a better understanding of the individual and the temporal dimension of policy effects.

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KEYWORDS Healthcare privatisation; health system evaluations; partisanship; ideology; policy proximity

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Introduction

Reforms privatising healthcare provision have been high on governments' agendas of policy reforms across Europe for the last several decades. Starting from the 1990s and, particularly, in the 2000s, all European countries have introduced a variety of measures aimed at reducing the role of the state and the public sector and shifting to private and market-oriented elements of healthcare provision (Immergut *et al.*, 2021). However, publicly and politically healthcare privatisation has often been highly controversial (Bayle & Cal, 2001; Naumann, 2018; Thomas & Tunney, 2023). Despite the various studies of attitudes towards healthcare (e.g., Martinussen & Rydland, 2022; Missinne *et al.*, 2013; Wendt *et al.*, 2010), little is known about the effects of privatisation on public opinion on healthcare. It remains unclear whether and if so, how the public reacts to privatisation and which factors shape these reactions.

In this article, we analyse evaluations of health systems in the context of healthcare privatisation reforms in 30 European countries, which is in line with one of the main topics of this special issue – the consequences of welfare reforms on public opinion. More specifically, we ask: What is the effect of privatisation reforms on evaluations of health systems? Is this effect stable or does it change over time? Which factors moderate this effect? Our results show, first, that health evaluations of Europeans display a discernible temporal pattern of positive initial effect of privatisation reforms on evaluations, followed by a worsening perception of the health system as these reforms set in. The results also show that contextual factors such as partisanship of the government that passed the reform have strong effects on health system evaluations, but also that this effect of partisanship is short termed. Most importantly, the results point to the importance of proximity. Privatisation reforms with more direct effects on health services use are evaluated more negatively than reforms with indirect effects, demonstrating the importance of policy proximity to beneficiaries. Similarly, an individual's proximity to policy, which refers to direct exposure to health policy based on health status, also has a more immediate and extended effect on evaluations compared to characteristics unrelated to care use, such as ideology.

These findings have theoretical, empirical and policy relevant contributions. Theoretically, they add to the scholarly debate on the relationship between welfare policy and public attitudes (see Béland *et al.*, 2022; Kumlin & Stadelmann-Steffen, 2014; Soss & Schram, 2007). The findings point out that policy effects have a strong temporal dimension as healthcare attitudes in the context of privatisation change over time. This questions the view that public attitudes towards policy remain stable over time (see Kumlin, 2002; Laenen *et al.*, 2020) and contributes to a better understanding of policy

feedback effects (Béland *et al.*, 2022; Busemeyer *et al.*, 2021). The findings of our study also provide new insights into the role of proximity vis-à-vis politics in shaping public reaction to policy change (see Larsen, 2018; Rönnerstrand & Oskarson, 2020). We show that the effect of political factors is either limited only to the citizens' immediate reactions to policy change (government partisanship) or happens latter during the implementation and is short-lived (individual ideology). In contrast, the proximity of policy to potential beneficiaries, determined by its direct effects on their use of health services, and the individual's proximity to policy, determined by the individual's need for healthcare, plays a key mediating role in shaping these evaluations. This suggests that the individual's personal experiences with policies are highly relevant to the public views on the health system and its performance (see Larsen, 2020).

Empirically, our study provides a new data approach to the study of public health system evaluations. Previous studies have predominantly relied on data for public or private spending to gauge factors influencing public views on healthcare (Busemeyer *et al.*, 2021; Larsen, 2020; Missinne *et al.*, 2013; Popic & Schneider, 2018). Using a new dataset of legislative changes in 30 European countries that privatised different aspects of medical care allows for a more fine-grained view of how concrete policy measures affect citizens' view of the health system and for understanding which of the specific measures are most relevant for the formation of public attitudes.

From a policy perspective, our findings provide insights into what shapes Europeans' views of the health system. The findings on the role played by individual health needs in shaping these views are particularly relevant in the context of recent studies evidencing a decline in health outcomes of the most vulnerable social groups and a related increase in health inequalities across Europe (Bambra *et al.*, 2020; McGowan & Bambra, 2022). As health declines and health inequalities rise, the policy relevance of health status in shaping evaluations of the European health system can be expected to grow. Reactions to new health policies are also politically relevant. If privatisation reforms are perceived badly by the most vulnerable social groups (i.e., the sick), these negative perceptions can contribute to the erosion of the social contracts based on solidarity and of the legitimacy of the government's health policies in the eyes of the wider public (Kumlin & Stadelmann-Steffen, 2014; Roosma *et al.*, 2013). This political aspect of health reforms is pertinent not only in the national but also in the broader EU context, given the increasing role of the Union in influencing national governments on health policy which, as recent evidence shows, demonstrates market-oriented trends (Stan & Erne, 2023).

The article proceeds as follows. The first section provides the theoretical background to the topic of healthcare attitudes and formulates our hypotheses on the effect of privatisation on health system evaluations. The second

section presents our data and methods, and the third section reports our results. A discussion of these results is available in section four. The article concludes with a summary of the main findings and suggestions for future research.

Healthcare attitudes: stability and change

Citizens' attitudes towards healthcare have been an object of different theoretical approaches and lively academic debates. One approach focuses on drivers of attitudes by assigning different degrees of relevance to an individual's background or broader socioeconomic context (see Part 1 of this special issue). The importance of individual and contextual factors in shaping attitudes assumes that citizens hold welfare views as individuals with a certain set of socio-economic characteristics and that these views are not formed in a vacuum but situated in a broader context. At the individual level, scholars have analysed the effects of values or ideological orientations, or materialistic self-interest determined by individuals' socio-economic profile (Gevers *et al.*, 2000; Lau & Heldman, 2009; Missinne *et al.*, 2013; Naumann, 2018; Popic & Burlacu, 2024; Tavares & Ferreira, 2020). At the contextual level, they considered social, political, or economic factors as shaping attitudes towards healthcare (Azar *et al.*, 2018; Gollust & Lynch, 2011; Meijer *et al.*, 2023; Naumann, 2018). Overall, even though the research on factors shaping attitudes often provided divergent findings, it assumes that due to their grounding in the individual's background and context, if these factors do not change, attitudes will remain relatively stable over time (see Laenen *et al.*, 2020).

Another approach to research on health attitudes, 'the policy feedback approach', seeks to provide a more dynamic view of attitudes formation focusing on the relationship of attitudes to policy. This approach assumes a double dynamic between policies and citizens' attitudes – while policy design is seen as the result of public attitudes, these attitudes are also considered to be shaped by policy design (see Béland *et al.*, 2022). A more specific mechanism through which social policies feed into attitudes assumes that the policy-specific design creates an environment in which citizens interact with welfare as this design represents a structure of direct encounters between citizens and the welfare state. In other words, the policy design affects citizens' experiences with welfare provision and in turn, serves as the basis for the formation of their attitudes towards welfare (Kumlin, 2002).

The policy feedback approach has been tested in the healthcare domain, with studies showing that views on healthcare are shaped by the broader institutional setup of the health system (Curran *et al.*, 2021; Jordan, 2010, 2013; Larsen, 2020; Popic & Schneider, 2018; Zhu & Lipsmeyer, 2015). These studies found, for example, that financial resources invested in the health

system and supply of health services shape healthcare system evaluations (Popic & Schneider, 2018) and that institutional arrangements of the healthcare system influence views on government responsibility and spending on healthcare (Curran *et al.*, 2021). In contrast to research on individual and contextual drivers of attitudes, the feedback effect approach considers 'real' institutional arrangements of the country's specific health policies and systems as factors shaping attitudes (see Burlacu *et al.*, 2018). Yet, despite its experience-based and interactive view of the link between policy and attitudes, the feedback effect approach also perceives this link in relatively static terms, pointing to stickiness and path dependency of institutions and polices, and therefore, consequently, attitudes (see Béland *et al.*, 2022).

This static view of attitudes led recent studies to inquire more closely into the effects of change in the existing design of policies on attitudes (Burlacu *et al.*, 2018; Busemeyer *et al.*, 2021; see also Riekhoff, 2010). Burlacu *et al.* (2018) for example show that citizens react positively to health policies that secure their healthcare rights, such as the right to timely treatment. Another, more recent study by Busemeyer *et al.* (2021) focused on the dynamic temporal effects of change on attitudes and distinguished between immediate, mid-term and long-term effects of change on attitudes. More specifically, the study investigated time-lagged effects of changes in healthcare spending (measures as percentage of GDP) on attitudes on government spending for healthcare and found negative long-term effects, labelled as 'self-undermining feedback' effect which shows that individuals respond to high levels of health spending by demanding less of it and react to low levels by demanding more spending (Busemeyer *et al.*, 2021, p. 154). Overall, these findings point out that attitudes are reactive to changes in policy, thus underlying the importance of looking at dynamic and temporal dimension of attitudes in the context of policy reform.

Privatisation and health system evaluations

As mentioned in the introduction, the last several decades witnessed a series of radical health policy changes involving a shift from public to private healthcare provision across Europe. Despite cross-country and regional differences in the pace and specific design of the privatisation reforms, what these reforms entailed was increasing the scope of private healthcare financing and private delivery, often encouraging the use of market forces in the delivery of medical care (Immergut, 2021). While the range of privatisation reforms differed across countries, the types of measures that changed the public-private mix in European health systems were relatively similar in healthcare provision involving measures such as privatisation of primary care and hospitals, and in the financing of healthcare, measures including the introduction of private health insurance and patients' out-of-pocket (OOP) payments.[1]

Based on the previously discussed literature on the relationship between policy change and attitudes, we assume evaluations of the health system in the context of these privatising reforms to be dynamic and react to change. More specifically, we assume that citizens will rely on their experiences when evaluating the health system in the context of privatisation as previous research underlines the importance of individuals' experiences with welfare in forming their attitudes (Burlacu *et al.*, 2018; Gevers *et al.*, 2000; Kumlin, 2002; Larsen, 2020). In the context of policy change, this would imply that when the privatisation reform has been only passed as a legislative measure and not yet implemented, citizens would not react to privatisation as they still do not have experience with the introduced reform. Once the policy measure has been implemented, that is, once it has been put into practice so that citizens can experience it, we expect public opinion to react to change. Even though (to our knowledge) there are no studies to date on the effect of privatisation reforms on evaluations of the health systems, studies of evaluations in the context of differentially privatised health system provide helpful clues for our hypotheses building. Previous studies for example found high public spending for healthcare and supply of healthcare services to be associated with positive healthcare system evaluations (Kohl & Wendt, 2004; Mossialos, 1997; Wendt *et al.*, 2010). More specifically, health systems with higher OOP are associated with more negative evaluations of the health system (Missinne *et al.*, 2013; Popic & Schneider, 2018). In line with these findings, we would expect that reforms that increase the private component in the healthcare provision once implemented would be negatively associated with the evaluations of the health system.

H1 Health system evaluations are negatively associated with reforms that privatize healthcare.

Next, we formulate expectations based more specifically on the type of privatisation reforms, assuming that citizens' evaluations would also depend on the specific character of policy measures and their effect on citizens as beneficiaries of healthcare programmes, that is, its proximity to users. We can distinguish between two types of healthcare privatisation reforms, those that have a direct effect and those with more indirect effect on beneficiaries of medical services (see Careja *et al.*, 2016). The reforms with direct effects imply legislative changes that explicitly and almost universally target the recipients of services, while indirect reforms do not target the recipients but introduce changes with limited or negligible impact on the use of services from the recipient's point of view. For example, a difference between healthcare privatisation policies with direct and indirect effects would be the one between policies that introduce private OOP which require users to pay to obtain service and policies that allow primary care physicians (GPs) to open

private practice while still being regulated by the state, with no direct effect on the use of health services. Based on our previous assumption of the importance of experience and on this distinction between direct and indirect measures, we would expect that, once implemented, privatisation reforms with a more direct effect on beneficiaries to have a more negative effect on public evaluation compared to the reforms with indirect effects.

H2 Health system evaluations are more negatively associated with privatization reforms that have direct effects on users compared to privatization reforms that have indirect effects on users.

Further, we are interested in contextual and individual factors that dynamically moderate the relationship between attitudes and policy change. One of the contextual factors expected to have a dynamic effect on attitudes in the context of privatisation is government partisanship. Healthcare reform is a highly salient political issue, and partisanship is expected to shape attitudes on welfare state performance because partisanship is used by voters to make sense of the political world, including their judgments on the achievements and failures of government (see Tilley & Hobolt, 2011). Existing studies show that the partisanship of the government is relevant for the introduction of health privatisation, showing that left and centrist governments are found to be less likely to introduce privatisation reforms compared to right-wing governments (Falkenbach *et al.*, 2020; Lindh & Johansson Sevä, 2018).

With respect to attitudes, we assume that for citizens the partisanship of the government would be crucial in providing legitimacy to reforms (see Tavits & Letki, 2009) and therefore also influence how they evaluate the reforms introduced by the governments of different partisan orientations. Citizens as voters have different expectations towards parties with regards to policies they expect them to implement. When a right-wing government passes a privatisation reform, citizens tend to justify its reform choices in positive terms, as this is in accordance with the government's ideological profile. When left-wing governments privatise, this is seen less favourably as these choices are considered opposite to the government's ideological commitment (Langsæther *et al.*, 2022). More specifically, as left-wing governments are less likely to introduce privatisation reforms, we assume that public reaction to the privatisation introduced by the left-wing government would be more negative compared to privatisation by right-wing governments, where these types of reforms are in line with the government profile.

H3 Health system evaluations are more negatively associated with privatization reforms when left-wing governments introduce these reforms, compared to when these reforms are introduced by right-wing governments.

Lastly, on the individual level, studies show that individual ideology plays a role in moderating citizen attitudes towards welfare and more specifically

healthcare (Missinne *et al.*, 2013; Popic & Burlacu, 2024; Tavares & Ferreira, 2020). Scholars found that there are substantive ideology-driven changes in attitudes towards healthcare and suggested that while both left – and right-oriented citizens may support well-functioning healthcare systems and ask for better health services, their views on the appropriate way to achieve these goals might be different. The left-wing oriented might be more strongly in favour of the public and the right-wing oriented citizens in favour of the private system of healthcare provision (see Popic & Burlacu, 2024). Based on these findings, we would expect an individual's ideology to shape evaluations depending on their left-wing or right-wing ideological orientation.

H4 Health system evaluations are more negatively associated with privatization for individuals with left-wing ideology compared to those who have a right-wing ideological orientation.

Yet, studies have considered the role of another individual factor in shaping individual welfare attitudes, proximity to the policy issue. Scholars have argued that being proximate to policy by being a beneficiary of a specific policy programme or having a need and therefore experiences with specific policy moderate public reaction to the change of that policy (Hedegaard, 2014; Larsen, 2018; Rönnerstrand & Oskarson, 2020; Soss & Schram, 2007). The effect of proximity on attitudes implies that having more experience with the policy increases the likelihood that the policy change will affect their attitudes. Applied to the healthcare context, proximity to policy would imply having experiences with the health system, which is linked to an individual's need for medical care (Rönnerstrand & Oskarson, 2020). As those who are more vulnerable, i.e., those with worse health and those of old age most often use the public health system (Stuckler *et al.*, 2017) and as privatisation reforms reduce public provision, we expect that, due to their proximity to health policy, they would react to privatisation of healthcare in more negative terms compared to the healthier and younger individuals.

H5 Health system evaluations of the individuals who are more vulnerable (i.e., older and sicker individuals) are more negatively associated with privatization reforms compared to evaluations of those wo are less vulnerable (i.e., younger and healthier).

Data and methods

Our survey data come from the European Social Survey (ESS), a well-established comparative survey study of representative European country samples, run biannually since 2002. Our main dependent variable, *health system evaluations*, asks respondents what they 'think overall about the

state of health services in their country nowadays'. The variable is an 11-point scale, ranging from 0, extremely bad to 10, extreme good.

Our main independent variable of interest looks at privatisation reforms of the health system. Healthcare privatisation is usually operationalised by using expenditure data. Healthcare spending, however, tracks prices in a system more than aspects that are directly relevant for citizens, such as access to care. Consequently, in contrast to previous research that has largely focused on healthcare spending (e.g., Missinne *et al.*, 2013; Popic & Schneider, 2018), we base our analysis on data that measures substantive legislative outputs, which allows us to draw more definitive conclusions about the relationship between privatisation reforms as policy outputs and evaluations of the health system. More specifically, for our independent variable we use a direct measure of healthcare privatisation relying on a novel dataset, *Healthdox Health Politics in Europe,* which covers health reforms enacted in 36 European countries (Immergut *et al.*, 2021).

We operationalise privatisation reforms by creating a yearly count indicator for reforms that privatised the health system in any given country. This includes different types of reforms that privatise healthcare financing and provision, which we divide into two groups. One group includes privatisation reforms that have only an indirect effect on users. Reforms introducing voluntary private health insurance, or those privatising outpatient or inpatient care do not necessarily reduce access and availability of public healthcare.[2] Reforms that effectively reduce access and availability, including measures such as those that increase out-of-pocket payments (OOP) for medical goods and services, cut existing healthcare benefits, or introduce mandatory private insurance – form another group that has more direct effects. The count variable is a sum of these sub-indicators, and ranges from 0 to 9. The variable is right-skewed, as most country-years have zero or few reforms. As robustness, we also create a dichotomous indicator taking the value 1 for a country-year in which there is at least 1 reform, and 0 otherwise. Results remain substantially identical (see Appendix Table A1).[3] In our dataset we have a total of 247 privatisation reforms, out of which 46 increase out-of-pocket expenditure, 52 cut existing healthcare benefits, 29 increase or introduce voluntary private insurance, 5 do so for mandatory private insurance,[4] 55 privatise outpatient care, and 60 do so for inpatient care.

All models are three-level mixed effects models (individual, survey wave, and country) with a random intercept for country and survey wave.[5] Interaction models with individual characteristics include a random slope for the variable in question. We control for several factors on the individual level, in line with similar studies (Missinne *et al.*, 2013; Popic & Schneider, 2018), including satisfaction with life, satisfaction with the government, subjective health status, whether the individual reports a physical impairment,

left-right ideological self-positioning of the individual, economic ideology of the individual, subjective income perception, employment status, whether they were born in the country they live in, gender, age, and education. When matching our survey data with our privatisation data, we are left with 30 overlapping countries, and a sample size of approximately 300 000 observations.[6]

On the country level, to account for the financial arrangements of the health system at the time of the reform, we control the share of private expenditure out of total expenditure on healthcare, using data from the World Health Organization (WHO, 2021). We also control for differences between Eastern and Western region of Europe, given the stronger intensity of health reforms in the East following the fall of communism. To account for the partisanship of the government that passed the reform, we control the economic ideology of the prime minister at the time. We construct our measure of economic ideology by using the Manifesto Project (Lehmann *et al.*, 2022). We follow Benoit and Laver's (2007) (ECO) right-left index, which captures those sub-dimensions that relate to the economy.[7] In order to create a symmetrical measure without boundaries, we log-scale the measure (Lowe *et al.*, 2011). We focus on the government's economic ideology as healthcare privatisation is directly related to economic ideology and less related to cultural differences among parties.[8] To account for individual proximity to healthcare, we use two proxies for respondents' experiences and involvement with the health system, their subjective health status and age (see Rönnerstrand & Oskarson, 2020).[9] For individual ideology, we rely on the respondent's left-right ideological self-positioning.

To model the general effects of reforms on evaluations of the health system we include first our aggregate measure for privatisation. Because we expect these effects to have a time delay (as reforms need time to be implemented, and citizens need time to experience their effects) and to distinguish between the immediate and mid-term effect of policy on attitudes (Busemeyer *et al.*, 2021), we include six lags for the six years after the passing of the reform in the models.[10] Based on previous studies, we know that reforms are not independent from one another, as governments can have strategic aims in the timing and sequencing of reforms (see Falleti, 2010; Jacobs, 2008). We therefore include all lags together, to account for the fact that individuals in a country that introduced only one reform will react differently from those in countries that introduced multiple reforms over the years.[11]

Results

Figure 1 shows the coefficient plot for our model on the number of privatisation reforms.[12] We include all lags in the model, thus controlling for previous

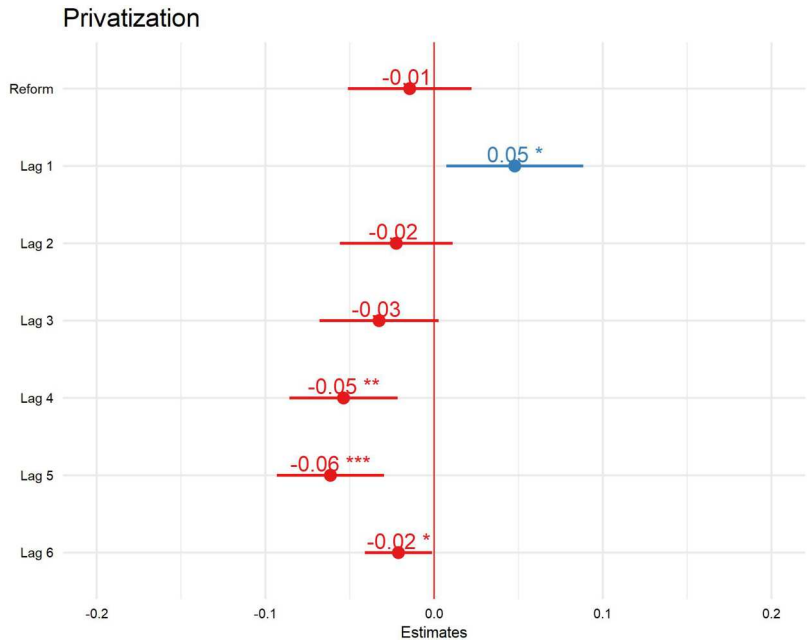

Figure 1. Effects of privatization on evaluations of the health system.

reforms. We see that there is no contemporaneous effect of privatisation on evaluations of the health system (the Reform coefficient). One year after the passing of a reform we see an improvement in evaluations (significant at the 10% level). Following this, we see that each successive year leads to a worsening of evaluations, peaking 5 years after the reform, then slightly dropping. Substantively, four years after the passing of a reform, we see a 0.05 drop in evaluations on the 11-point scale. While this effect may seem small, it cumulates with a similar (0.06) effect in the fifth lag and a smaller (0.02) effect in the sixth lag. Together, the effects sum up to the size of the negative effect of the initial share of private expenditure in the health system when standardised for comparability (a 0.06 decrease in the standard deviation of evaluation for every standard deviation increase in the private share of expenditure).

Overall, this finding confirms our expectation that privatisation reforms are associated with worsening of evaluations (*H1*). We note however that evaluations do not worsen immediately after the reforms are introduced, but two years after and continue to be negative, with results being significant for years 4 and 5 after the reform. We also note that the negative effect becomes weaker in the sixth year after the reform, suggesting that the additional negative impact of privatisation reforms diminishes over time. However, this does not mean that attitudes revert to their pre-reform

levels, which would imply a positive coefficient. The cumulative effect of privatisation reforms on evaluations remains negative.

To further understand the dynamics of the impact of reforms on public opinion, we disaggregate our privatisation indicator into its individual components, to see which type of reforms are driving the public opinion dynamics and test our expectation on the difference between privatisation reforms that that have direct or indirect effects on patients (*H2*). Figure 2 shows the results, including the same set of controls as before (full tables, including all controls and model fit are available in Appendix Table A2).

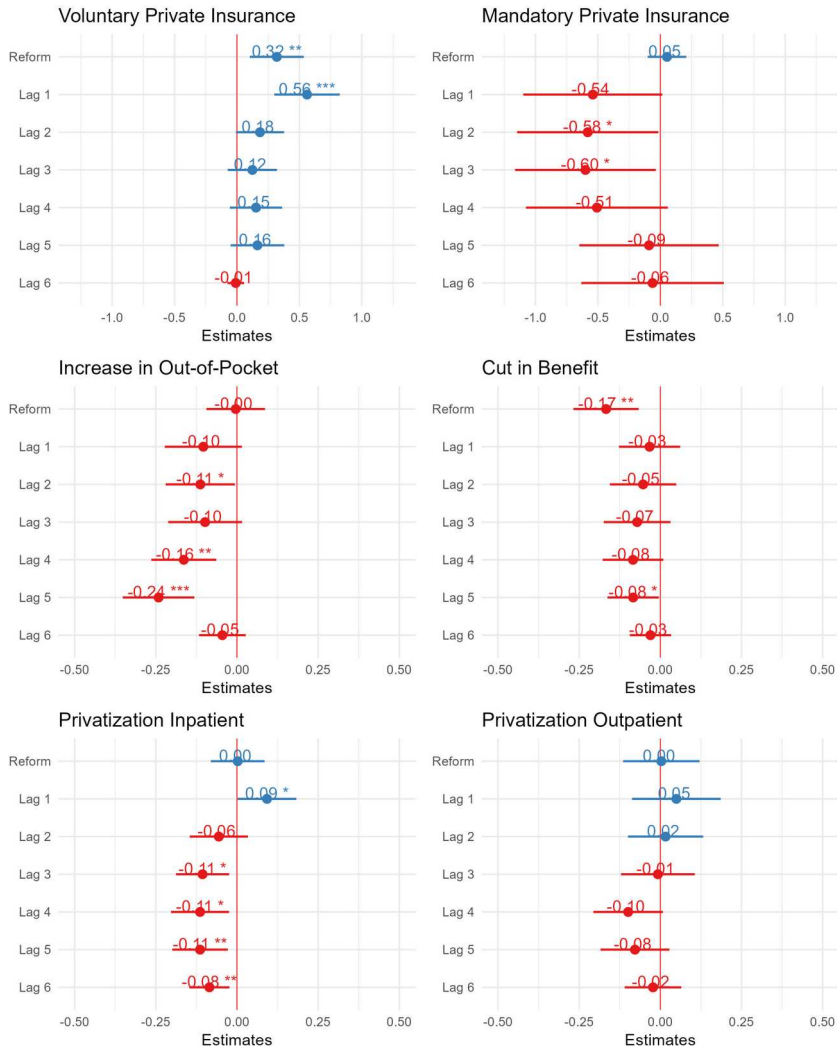

Figure 2. Disaggregated effect of privatization on evaluations of the health system.

The top row shows the effect of two types of reforms that privatise insurance or introduce private insurance: voluntary private insurance (Figure 2, first row, left – indirect impact) and mandatory private insurance (Figure 2, first row, right – direct impact). Voluntary private insurance is often introduced as an optional, additional, layer of insurance, on top of the existing system of healthcare financing and is offered to the recipients of healthcare as a choice. Mandatory private insurance, on the other hand, is often a replacement of state health insurance or social health insurance, and while implies substantial changes in the financing mix of the health system, it also implies administrative costs for beneficiaries. We see that voluntary private insurance has a positive contemporaneous effect (0.32 on the 11-point scale) and a positive effect (0.52) a year after passing the reform, with no significant effect afterwards. In contrast, mandatory private insurance has a strong negative effect in the first four years after the passing of reform (0.5 on the 11-point scale, however, with a large confidence interval).

The next row in the figure shows results for the two types of reforms with direct effects on patients. One type increases out-of-pocket payments (OOP) for medical goods and services, which shift the burden of healthcare financing onto patients and lead to increase in private health financing, therefore directly affecting recipients of care. The other type of reforms involves cuts in benefits provided by the health system, also directly affecting beneficiaries. As shown in the figure, both types of reforms worsen evaluations, with the cut in benefits showing up earlier, already in the year when the reform is passed (Figure 2, second row, right), while the effect of the increased OOP takes longer to manifest (Figure 2, second row, left).

The last row shows results for the effects of the privatisation reforms that imply changes in healthcare provision. These are reforms that privatise either provision of the inpatient or the outpatient care but usually do not have direct effects on the beneficiaries with respect to the terms and conditions of the care use. Reforms that privatise inpatient care show a positive effect in the first year after privatisation, which turns into negative effects further down the line (Figure 2, third row, left). Privatisation of outpatient care in contrast shows no effect (Figure 2, third row, right).

Overall, our disaggregated results show that the initial positive effect of privatisation reforms is due to indirect measures introducing voluntary private insurance and privatising inpatient care,[13] while the stronger, negative, and long-term effect is due to direct measures of cuts in benefits and the introduction of out-of-pocket payments. Mandatory private insurance also shows a negative effect, although we remain cautious in interpreting it, given that these reforms take place in only two countries. These results provide support for our expectations of citizen's evaluating healthcare system more negatively in the context of reforms that have a more direct impact on patients (*H2*).

In the next step, we explore the dynamics between privatisation and evaluations by considering the possible moderating effect of politics – by looking at the partisanship of the government passing the reform, as well as the ideology of the respondents. We run the same models as before and include an interaction between the two measures, partisanship of the government and ideology of respondents, and all of our lags, showing the interaction plots in the figures (full models are shown in Appendix Table A3).

We first investigate the differential impact of privatisation reforms according to the partisanship of the government at the time of the passing of the reform. All variables are standardised, which also centres them, which is necessary in mixed effects interactions (Enders & Tofighi, 2007). We include all lags in our analysis and find only an immediate interaction effect of the privatisation reform with the measure of partisanship, economic ideology of the prime minister, in the year the reform is passed and one year after. Figure 3 shows the results for the interaction effect for the contemporaneous effect as well as the first three lags. Just as lags 2 and 3, the remaining lags

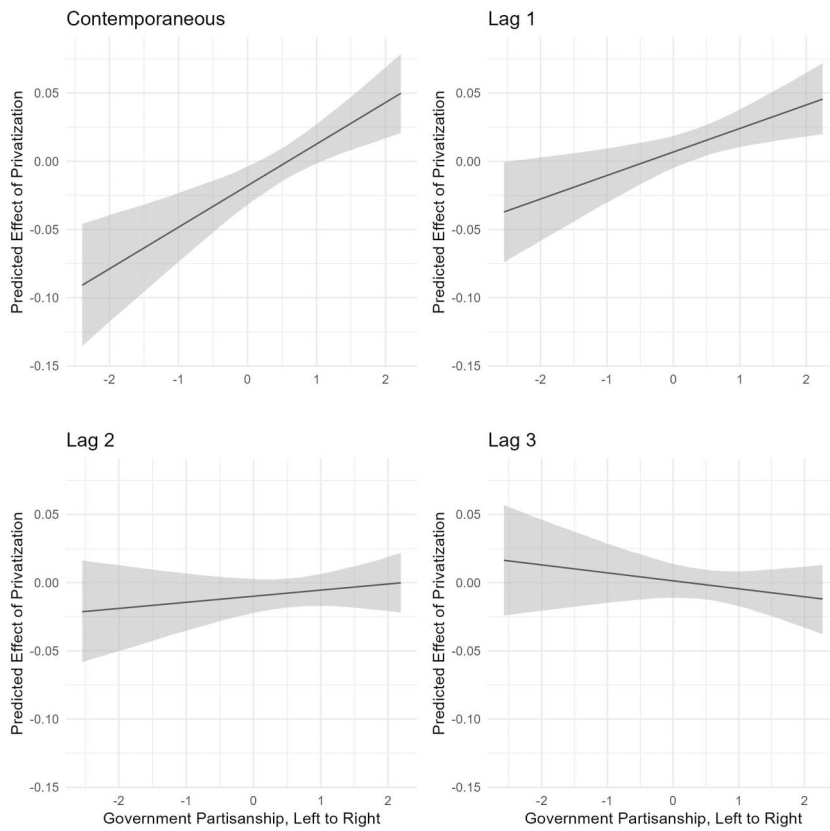

Figure 3. Interaction of privatization and government partisanship.

were not significant (full results are available in the Appendix Table A3). The figure shows the effect of privatisation reforms on evaluations according to the partisanship of the government (x-axis, negative values indicate left-wing and positive indicate right-wing partisanship). The results show that when left-wing or centrist governments pass privatisation reforms, evaluation of the health system decreases. Instead, when right-wing governments introduce privatisation, evaluations increase, at least in the short term: contemporaneously and one year after the passing of the reform. These findings provide support for our expectation of the different association between privatisation and evaluations in the reform context of the left-wing and the right-wing governments (*H3*).[14]

This suggests that in the short term, when they still do not have substantial experience with the reform, citizens are likely to filter their understanding of the impact of reform based on the colour of the government passing it. In the longer term, this association grows weaker as citizens gain experiences with the reform. Thus, while their evaluations decrease, this is no longer dependent on the partisanship of the government. To further probe the moderating role of partisanship on the relationship between evaluations and privatisation, and to test how far it depends on individual ideological orientations, we run a triple interaction between privatisation, partisanship of the government, and the ideology of the individual. For ease of interpretation, we present a figure with two panels in the Appendix (Figure A2), showing the effect for left-wing respondents and right-wing respondents. The results in Figure A2 show that both left-wing and right-wing respondents have more positive evaluations of the health system for a reform passed by a right-wing government, while left-wing voters are more negative than right-wing ones for privatisation reforms passed by left-wing governments.

To test the moderation effect of the ideology of the respondent, we again run the same model with interactions between individual ideology and privatisation reforms with lags. We include a random slope for individual ideology, to allow the effect to vary across countries. In contrast to the findings on government partisanship, we find a significant interaction results only in the fifth lag, that is, five years after the introduction of the reform, which provides only weak support for our expectation that ideology would moderate reactions to privatisation (*H4*). Figure 4 shows this result (full model available in Appendix Table A3), with ideology displayed on the x-axis, standardised, and the effect of the fifth lag of privatisation on the y-axis. We see that the negative effect of privatisation on evaluations of the health system is concentrated among right-wing oriented individuals. However, this effect is not consistent across time.

Next, we look at the moderation effect of proximity to policy using age and health status as measure for being vulnerable and therefore in need of healthcare. First, we look at the effect of age and find relatively limited effect as there are significant interaction results only in the fourth lag, that

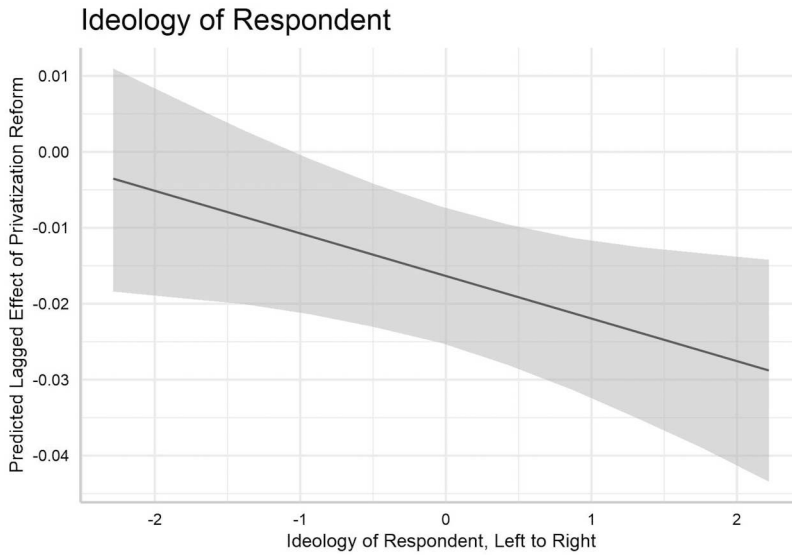

Figure 4. Interaction of privatization and ideology of respondent, lag 5.

is, four years after the introduction of the reform (results available in the Appendix Figure A3).[15] This can be explained by age being a relatively imperfect measure of proximity to policy, as it is related but not fully determinative of one's likelihood of using the health system. We further test the moderating effect of proximity by interacting the individuals' subjective health status with our privatisation indicator and its lags, as health status can be seen as a more proximate determinant of the need for healthcare. As shown in Figure 5 (displaying the contemporaneous effect and effects for the first 3 lags), we can see that the effects of health appear sooner compared to age. Supporting our expectation on the moderating role of proximity (*H5*), the results show that there are both immediate and extended effects of health status on evaluations. In the year of passing a privatisation reform, those in worse health (higher values on the x-axis) are more likely to increase their evaluations of the health system. This effect turns negative already in the first year after a reform passes and continues to decrease in the second year. It then flattens out in the third and subsequent years.

What can also be seen in Figure 5 is that the effect is in fact driven by individuals who report good health (lower values on the x-axis) as with the passing of time they get more negative in their evaluations and reach the level of those in bad health. This suggests that individuals in bad health utilise health services earlier and thus have their evaluations impacted by the reforms earlier compared to those in good health. Those in good health follow later. Three years after the passing of a privatisation reform, both individuals with good and bad health status have more negative views of the health system.

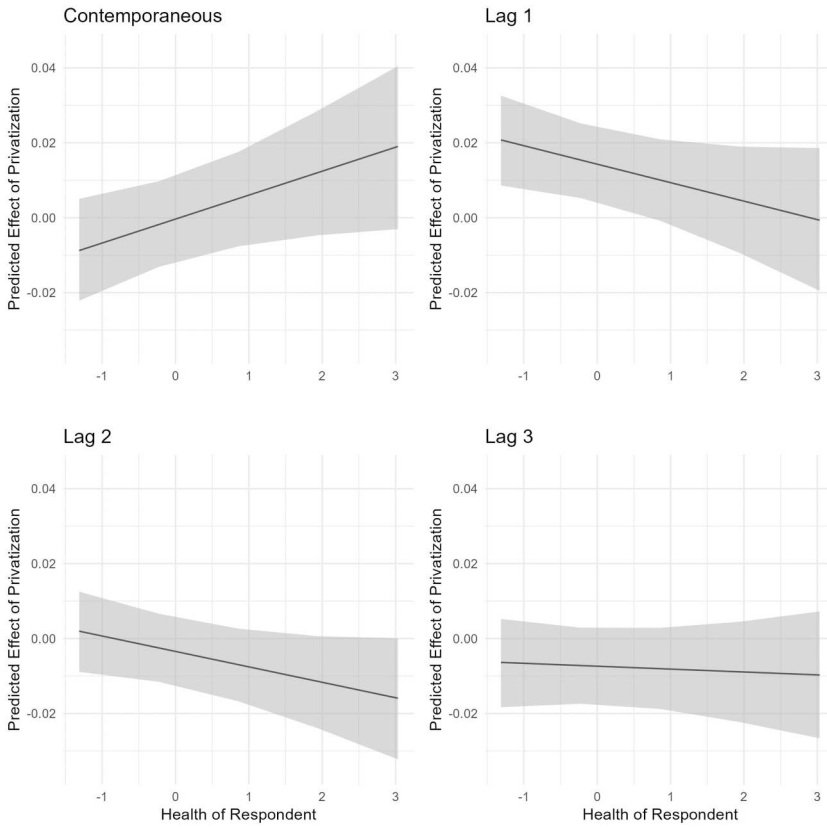

Figure 5. Interaction of privatization and health status of respondent.

Finally, we combine our expectations on the effects of the proximity of different types of individuals to policy with those related to the proximity of different types of policies to individuals. If both expectations hold, we should see those more proximate to policy, i.e., vulnerable individuals who are more likely to come into contact with the health system, to be especially sensitive to policies with more direct effects on users. We therefore expect the more vulnerable to have stronger negative effects for out-of-pocket payments, cuts in benefits, and mandatory private insurance. Indeed, this is what we see when we interact with both age and subjective health with all six policy types (results available in Appendix Tables A6 and A7).

Discussion

The test of our first hypothesis shows no immediate effect of privatisation on evaluations in the year passing the reform, which then becomes positive, but four, five and six years after the reform was introduced, we find a negative effect. The initial positive effect is due to a specific type of reform, voluntary

private insurance, and to a lesser degree to reforms privatising hospitals. This could be interpreted by the individual and optional character of the voluntary private health insurance which is often linked to choice and can also be seen as relieving the burden from the public system. With respect to privatisation of inpatient care, the positive reaction could be interpreted by the perception of privatisation as a solution to common problems of public hospital debts and as a measure contributing to a more efficient use of resources. However, the long-term negative effect of hospital privatisation can be explained by experiences patients get over time. Even though reforms that turn hospitals into, for example, joint-stock companies, may leave general access to inpatient services initially intact, over time due to the availability of 'extra' services such as private hospital rooms which can be afforded only by the better of, these reforms can generate resentment reflected in evaluations. Other reform types, which are more immediate and directly linked to wider user experiences, such as out-of-pocket payments and cuts in benefits, have consistent and strong negative effects. This suggests that the reality of the new user experiences with the health system ultimately worsens evaluations (see Hacker, 2004; Larsen, 2020).

This temporal dynamic could be interpreted by the difference between the substantive and instrumental rationality frameworks (see Burlacu *et al.*, 2018). The introduction of privatisation reforms does not immediately affect the utilisation of medical services as it takes time for most citizens to experience them in practice. From the point of view of instrumental rationality, there is no reason to expect citizens' immediate reactions to reforms. Indeed, we find that there was no change in public opinion in the year in which the reform was passed and this suggests a lack of 'symbolic' effect of privatisation reform on evaluations. However, our results show that citizens reacted positively to privatisation reforms the year after (i.e., one year after the reform) by improving their evaluations, but became more negative in the years that followed, suggesting that once the new privatisation measures were implemented, citizens relied on their instrumental rationality to form their attitudes. This is also supported by our analysis of disaggregated effects, where results show that policies that affect users' experience by reducing access to and availability of services, were drivers of negative evaluations.

More generally, these findings suggest that citizens attitudes towards the health system are not stable but are updated based on experience along with the implementation of the reforms. Yet, this interpretation is limited due to the lack of knowledge on the effective use of medical services of the ESS survey respondents, which is one of the limitations of our study. However, as we utilise proxy measures for service utilisation, our measures provide support for the interpretation that the impact of privatisation reforms is moderated by proximity. Those with bad health status and therefore most likely to

need and experience healthcare services see the most pronounced negative effects in the years after the implementation of policy.

With respect to our findings on government partisanship, we show that evaluations are negative when left-wing government passes the reform and positive when right-wing governments do this. These findings provide support for our expectation of the symbolic effect of politics on health system evaluations, based on citizens' expectations of government's reform behaviour given its ideology (see Langsæther *et al.*, 2022). Another mechanism at work may be the justifications of the governments themselves. Right-wing governments are likely to pass privatisation out of ideological commitments, arguing in favour of the positive impact that such reforms could have on the efficiency of health systems (like the previously mentioned example of justification for hospital privatisation). Left-wing governments, on the other hand, more rarely privatise healthcare but when they do so usually consider reforms as a practical solution to budgetary problems or as constraints from international pressures, which is seen as rather confusing by the voters (Raess, 2023). The justification of privatisation reforms by left-wing governments might therefore be seen as less convincing to the public, who take a more negative view of the health system both initially, and later as these reforms get implemented.

Our results also show that this differential effect of left and right wing governments is a short-term effect. This suggests that when evaluating policies citizens as voters pay attention to how governments justify these policies at the moment of their introduction. They may (or may not) be persuaded by the arguments of political parties. However, it is the citizens' direct experience with the reforms that more decidedly determine their impact, suggesting the distinctive temporal dynamic of the feedback effect. This is supported by our different findings on the role of proximity to policy and individual ideology since it is ones' health and not ideology that shows stronger, both immediate and extended moderating effects on the link between privatisation reforms and evaluations.

Conclusion

Are citizens responsive to health reform? Do changes in health policy influence citizens' evaluation of the health system? Is the relationship between evaluations and policy change stable or does it change over time? Lastly, which factors moderate this relationship? We set out to answer these questions by looking at health system evaluations in the context of reforms privatising the provision of medical care in 30 European countries over 20 years.

Our results show that citizens initially increase their evaluations of the health system after governments pass a privatisation reform, which is

explained by reforms that enhance choice (introduction of voluntary private insurance) and the fact that these reforms are passed by right-wing governments. However, from a longer temporal perspective, privatisation reforms decrease evaluations of the health system. This effect is driven not by the partisanship of the government that passed the reforms, but by the type of privatisation reforms that more directly affect users experience by decreasing access and availability of services (reforms introducing out-of-pocket payments and cutting healthcare benefits). Individual proximity to health policy is also relevant as our results show that those with worse health status, and thus in higher need of medical care, in the context of privatisation evaluate healthcare more negatively. Overall, our results demonstrate that citizens are responsive to policy change and that these responses are dynamic as they change over time. Short term, citizens respond to privatisation by being positive due to the indirect character of reforms and their political context (see Burlacu *et al.*, 2018; Rönnerstrand & Oskarson, 2020), but from a long-term perspective it is the direct effect of these reforms on users and individuals' need for healthcare that worsens their response to privatisation (see Larsen, 2018, 2020).

Based on our findings, we suggest several further avenues for research in the field. One promising direction of future studies is analysing how personal experiences matter for the public evaluations of healthcare and other welfare services in the context of social policy reforms (see Larsen, 2020). The data used in this article have limitations as they do not account for utilisation of healthcare services, making us rely on proxies such as subjective health status and age. As our findings show an effect of these proxies on evaluations, this calls for further research which would be able to track a more precise link between individual experiences with medical care and views of the health system.

Another possible avenue of research is exploring the effects of the more complex political dynamic of policy reforms on public opinion on health or other welfare reforms. Previous research shows that policymakers often introduce reforms as part of larger negotiated packages (Häusermann, 2010), but we were not able to test for the role of reform packages due to our data limitations. We do account for the number of privatisation reforms, and our results suggest that it is contact with the health system following the reform, and not the way in which the reform is passed, that makes the differences. Further research could test this by constructing data on reform packages more broadly.

Lastly, an area of research that could contribute to our understanding of factors shaping the link between policy and opinion is related to the discursive dimension of politics. In this article, we looked at government's partisanship, but the ideological profiles of the governments do not tell us about specific justifications governments of different profiles use when they

introduce reforms changing the public-private mix (see Tarkiainen, 2023). Further research on this discursive aspect of welfare or health politics and its potential to influence public views could refine our understanding of policy-opinion link and add to theory development in the field.

Notes

1. We define privatization not only as changes in ownership of healthcare facilities, but as process that refers to a wider range of measures that are associated with an increase in private elements in financing and delivery of healthcare (André et al., 2016; see also André & Hermann, 2009).
2. In most European countries, privatization of primary (GP) and hospital care does not imply changes in the universal accessibility of care as from a perspective of users as services remain available on equal terms. These types of reforms also contribute to freedom of healthcare provider choice (see Immergut et al., 2021).
3. In Figure A1 in the Appendix, we plot the dichotomous indicator for each country over the study period to show the number of years with privatization reforms per country in our sample.
4. Reforms that introduced mandatory private insurance occurred in two countries, Germany and the Netherlands. In terms of the results, even though the uncertainty is captured in our wider confidence intervals, due to the small sample size for these reforms we interpret results with caution. Our main results remain the same even when excluding this reform type from the aggregated privatization measure.
5. Given that individuals are nested in survey waves and countries, we consider three-level multilevel models to be the most appropriate modelling strategy. For robustness, we run our main models including survey wave and country fixed effects. The results are in Table A4 in the Appendix and show stronger and more significant coefficients than in our original analysis. We maintain the mixed effects models for their flexibility, including the possibility to model cross-level interactions.
6. Each individual in a given country and wave is matched with the reform history for that country for the previous six years from the year they completed the survey. For example, Italian respondents from ESS9 were surveyed in 2018 and 2019. Those surveyed in 2018 are match with a 2-year lag for the 2016 reform, and a 6-year lag for the 2012 reform. Respondents from 2019 are matched with a 3-year lag for the 2016 reform only.
7. For left: market regulation [403], economic planning [404], protectionism positive [406], controlled economy [412], nationalization [413], welfare state expansion [504], education expansion [506], labor groups positive [701]; for right: free enterprise [401], incentives [402], protectionism negative [407], economic orthodoxy [414], welfare state limitation [505].
8. For robustness, we also run an alternative specification of government ideology, by using the party family categorization of ParlGov (Döring & Manow, 2021). Results are in Table A5 in the Appendix. They support our findings using the Manifesto Project coding.
9. While a more direct measure of utilization or experience with healthcare services would be ideal, the ESS unfortunately does not have such a question

across survey waves. Nonetheless, we think that age and subjective health status are valid proxies. Older individuals, as well as those reporting a lower overall health status, are much more likely to utilize health services more often than young and healthy individuals. Thus, the former group should feel the actual practical impact of privatization policies more quickly than the latter.

10. Similarly, other scholars such as Busemeyer et al. (2021) use 5 lags.
11. We also account for the sequencing of reforms in three ways. First, we include a control for the overall level of private expenditure in the health system, which accounts, albeit imperfectly, for a 'status quo' of the system's public-private mix. We also run an interaction model between our privatization measure and existing levels of privatization in the system, which shows that reforms are perceived in the same way irrespective of the existing level of privatization (Table A8 in the Appendix). Second, our fixed effects models (Table A4 in the Appendix) account for all country differences, including any health system differences. Third, we include a cumulative measure of privatization reforms to account for any within-country differences related to sequencing of reforms. Our results remain the same. The interaction with the cumulative measure shows that respondents do not evaluate reforms differently depending on the number of previous reforms (Table A9 in the Appendix).
12. Results of our analysis are shown in figures with coefficient plots, showing only the effects of the main variables of interest. Table A1 in the Appendix includes all controls and model fit. The table also includes a model that replaces privatization reforms with patient rights, showing no effect. Thus, the effect of reforms is specific to privatization.
13. Long-term, privatization of inpatient care also contributes to the negative effect on evaluations. We elaborate on this point in the Discussion section.
14. In our alternative specification, using the party family categorization of ParlGov (Döring & Manow, 2021) in Table A5 in the Appendix, we find the same pattern, that privatization reforms by right-wing governments, in particular Christian-Democrats, have a more positive effect on public evaluations compared to those by left-wing governments.
15. Figure A3 in the Appendix shows the effect of privatization reforms 4 years after their passing, across the range of the age variable. What we see is that older respondents decrease their evaluations of the health system, while the youngest cohort shows no effect. Young people, who have very little contact with the health system, show no change, with the effect becoming increasingly negative as individuals get older.

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Disclosure statement

No potential conflict of interest was reported by the authors.

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Data availability statement

The article uses two publicly available datasets. The HEALTHDOX health politics in Europe data set is available at https://hdl.handle.net/1814/69838, and the European Social Survey, is available at https://www.europeansocialsurvey.org/.

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