

Voice and choice in health politics

The establishment of healthcare systems in the Western world since the WWII led to a wide variety in decision-making infrastructures regarding the production and consumption of health goods and services. Whereas states used to command and control national health systems such as in Sweden and the UK, suppliers of health products and health insurance dominated in market-oriented systems such as in the USA, and social partners played a significant role in corporatist healthcare systems such as in Germany and Belgium (Moran, 1998). In most systems, however, the medical professional held a rather prominent position, particularly regarding patients, because of a hierarchy of knowledge. In addition, healthcare has become understood as part of citizenship in most systems, the right of health laid down in national or international law (Freeman, 1999).

Healthcare systems have experienced quite a few reforms since the 1970s to enhance efficiency and contain costs. States often gained more control through a more regulatory role in the re-organized systems (Saltman, 2002). They also issued democratising reforms expected to change citizens-patients from passive consumers into active participants in Western healthcare systems. Citizens-patients have received more opportunities to express their desires, grievances, or concerns at macro level (in decision-making of healthcare systems), meso level (in hospitals or health insurance organizations), and micro level (*e.g.*, individual treatment plans) (Wildner, et al. 2004). Regarding health products and health insurance, citizens-patients have also often gained more options to choose between public providers, between public and private providers, or between domestic and foreign providers.

The focus of the workshop is on citizens-patients. The workshop does not just seek an update of the various voice and choice reforms in Western healthcare systems. Since the reforms have been into force in several countries for some years now, it has become possible to examine the interaction and impact of the various voice and choice options on citizens-patients across a number of systems. Such an examination requires a comprehensive and comparative framework to explore interaction and impact of the various voice and choice options at various levels in various systems. Health studies often cursorily refer to Albert Hirschman's "exit, voice and loyalty" to describe citizens-patients' choice, influence, and solidarity in healthcare systems (Hirschman, 1970). An advantage of Hirschman's taxonomy of the behaviour of citizens-consumers is the linkage between sociological, economic

and political factors. However, Hirschman's taxonomy is still relatively untested, also outside the health sector (Dowding & John, 2008). Nevertheless, recent, more elaborated applications of Hirschman have demonstrated its potential to analyse the interaction and impact of voice and choice reforms in healthcare systems (see Freeman, 1999: chapter 7; Ferrera, 2005). One of the purposes of the workshop is to refine and test the Hirschmanian framework, also by inviting papers-givers challenging Hirschman, offering competing understandings. Empirically, various questions deserve special attention in a workshop on voice and choice in health politics:

- Why did health authorities introduce voice and choice reforms in the first place? How have they motivated, legitimated or justified the reforms? Have health authorities sought legitimization of decision-making by involving citizens-patients in health decision-making at micro, meso and macro level? Have they felt forced to do so, bowing for the growing assertiveness of emancipating citizens-patients? Or have health authorities attempted to limit the prominence of health professionals by giving more say to citizens-patients? And have citizens-patients actually asked for more choice, or did health authorities offer more choice to splinter a potential collective expression of dissatisfaction on healthcare provision?
- A second question is about the forms and shapes of voice and choice. Who do for example speak on behalf of citizens-patients? Do they it themselves, or do patients' organisations, lawyers, trade unions, health insurance funds, consumer associations, and political parties represent the interests of citizens-patients? Do patients-citizens have a decisive or advisory role in policy-making on hospital management, health research policy, and priority-setting and rationing of public services at micro, meso, or macro level (sub-national, national or supranational)? And which choices have been offered to citizens-patients in the various healthcare systems? Can they choose among health insurance funds, health providers, health products, or healthcare systems?
- The third question is how the various voice and choice arrangements interact. Do citizens-patients express their desires less (voice), if they are offered more choice (exit)? And do more voice options at micro and meso level limit voice at macro level? Do well-educated and affluent citizens-

patients use more choice and voice options than others, which may lead to a two-tier welfare system putting solidarity under pressure? Or do all citizens-patients remain silent as long as they feel satisfied with, or have strong loyalty towards their healthcare systems, health providers, or insurance funds? Are citizens-patients up to the job to choose and voice, or do they still lack the information to make health decisions and remain therefore rather inactive and non-participatory? And which choice or voice options have enhanced the legitimacy of states, governments, and other health actors among citizens-patients? Do they consider healthcare part of citizenship as well as the freedom to choose and participate in decision-making?

- Will the power relationship among citizens-patients, health providers, and health purchasers change due the voice and choice reforms? And has the corporatist, market-oriented, or statist background of a healthcare system left its mark on the changing power relationships, differentiating the impact of voice and choice policies across different systems?
- Most actors in Western healthcare systems subscribe to the principles of universality, solidarity, equity, quality, accessibility, and affordability. A comparative assessment of Western healthcare systems would indicate whether and which voice and choice reforms have met those principles, as well as the immediate purposes of the reforms, such as efficiency, patient satisfaction, and responsiveness.

Empirical and historical papers examining the introduction, interaction and impact of voice and choice reforms in Western healthcare systems, if possible of comparative nature, are welcome. Expertise on North-America and Eastern Europe will also be appreciated considering the political sensitivity and drastic reforms respectively. As one the aims of the workshop is to develop a comparative and comprehensive framework analysing voice and choice in health politics, paper-givers are emphatically invited to follow or challenge the Hirschmanian framework. The reforms of healthcare systems are part of larger processes of redefinition or reconstruction of citizenship, democracy, legitimacy, and market-state relations. Specialists on those issues are therefore also welcome in the workshop.

References

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