Paying Attention to Politics: Public Responsiveness and Welfare Policy Change

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Abstract

The thermostatic model departs from the assumption that the public respond to policy change in relation to their preferred level of policy. In the paper, this model is tested on public opinion reactions following market-oriented reforms of the welfare service sector in Sweden. The general question in the paper concerns if and how this policy change provides an impact on public attitudes towards privatisation: does the public react at all and in that case, do they adjust their preferences in relation to the level of privatisation in accordance with the thermostatic model? Market-oriented welfare reforms are by some citizens seen as a (positive) re-organisation, and by others as a (negative) retrenchment. A contribution in relation to previous research is that this study also includes individual level factors concerning ideological orientation and proximity that is assumed to condition public responsiveness. The argument is that it’s important to consider opinion cleavages when forming hypotheses about the strength and direction of public responsiveness since the effects on preferences may be quite different depending on point of departure. The design of the empirical study is a natural experiment where public preferences of privatisation of health care is measured before and after the implementation of consumer’s choice in primary health care in 2009/2010. The results show that there seem to be a thermostatic reaction in relation to the increase in private health care providers: preferences for further privatisation decreases in general after the reform although there are also some variations between groups. An important conclusion is that thermostatic reactions varies according to ideological orientation, where right-oriented react thermostatically and left-oriented do not. The paper contributes to a further understanding of the relation between policy making and public opinion. Also, it expands on thermostatic theory by testing its initial propositions on a new empirical case.

Introduction

A crucial prerequisite for representative democracy to work is that the public sends signals to the elected politicians, telling them what they want. This is certainly done in elections, but such signals can also be transmitted between elections in shape of public reactions to particular policy decisions and it’s effects. Citizens’ reactions on policy is a necessary part of democratic responsiveness, which can be considered as a dynamic relationship including also that decision makers respond to citizens’ preferences as they are expressed (c.f. Downs 1957). Good quality of representation presupposes that citizens actually notices and responds to policy changes since if this is not the case, politicians have poor reasons to represent what the public wants (Wlezien 1995, Johnson et al 2005). As has been shown in previous research, public reactions on public policy can come in different shapes and directions and also be expressed more or less strongly in different policy domains (c.f. Pierson 1993; Soroka and Wlezien 2010, Soss & Schram 2007, Campbell 2003).

This paper focuses on the nature and direction of public responsiveness in the domain of welfare policy. The general question in this paper concerns if and in that case how the public responds to particular changes in welfare policy. Also, this paper seeks to qualify and further hypotheses about public responsiveness by exploring how certain factors conditions responses and reactions. The theoretical quest is to investigate whether, and in that case under what circumstances, the public responds like a thermostat on welfare policy change. The thermostatic model of policy feedback suggests that people respond to policy changes in relation to their preferred level of policy. A public reacting like a thermostat
will send signals to the decision-makers telling them if the policy is getting closer to their preferred level by decreasing their preferences for “more” policy. As a consequence, decision makers will know in which direction to go in order to achieve a high degree of policy representation (Wlezien 1995; Soroka and Wlezien 2004; 2010, Jennings 2009; Johnson et al 2005).

Thermostatic theory has mainly been tested empirically on responses to government spending (budget decisions), like for example decisions on how much to spend on defence or welfare. An argument in this article is that the assumptions of the thermostatic model could also be applied to reactions on other kinds of policy, which can be connected to preferences on levels of policy. There is quite a lot of policy that is not clearly related to budget, and that is still very important to citizens and the quality of political representation (see also Barabas 2011, Thomas 2010). This study differs from previous research on thermostatic responses by focusing on one particular reform, using a natural experiment consisting of the implementation of a welfare policy reform that occurred on a specific time. This makes it possible to address some case-specific issues that are also of general interest (see below) and that may condition how the public responds. Additionally, the empirical study concerns policy outcome instead of political decisions, which will hopefully contribute to the knowledge about the role outcomes have in the process of dynamic representation. Since government activity might not be enough to satisfy the desire of voters from policy interventions, the results of those interventions should matter as well (see Johnson et al 2005). By testing the assumptions of the thermostatic model on a new case and also by including analyses of some factors that may condition the thermostatic effect, the paper aims to contribute to the expansion of thermostatic theory as well as to the knowledge about the nature and direction of public responsiveness within the welfare policy domain.

In the empirical case in focus in this paper, policy is directed towards restructuring or reorganisation in order to create a more efficient public sector, a policy different in character compared to spending decisions since it is not primarily to do with spending more or less money. Instead, the target of the policy is to regulate which kind of actors that are allowed to provide welfare service while financed by tax money. The case is connected to the current restructuring of the Swedish welfare state, where the dominant model of publicly financed and provided welfare services is replaced with a New Public Management-inspired policy aiming to achieve a more efficient and responsive public service sector by creating competition between different providers of welfare services. As a result, the welfare service sector becomes more market-like and there has been a noticeable increase in private service providers. For the Social Democratic Welfare states and its citizens, this is a significant change since one of the most defining features of this type of regime is that it provided public welfare services on a totally different scale than all other countries outside Scandinavia (Lindbom 2001, Esping-Andersen 1990). Reforms in this direction have been implemented on several areas, such as school, day care for children and elder care. Some of the most significant reforms have taken place within health care. For some, such reforms are considered a retrenchment since one of the main aims is to increase efficiency and cut welfare costs. Also, it means that the public sector is diminished and a part of the traditional welfare is
put out of reach for democratic control. For others, the reforms means increased freedom of choice for individuals and better quality of welfare driven by competition. The reforms thus bring classic ideological conflicts to the surface which means that parties and people disagree on a value-based level.

The specific case in this paper concerns the implementation of a consumer’s choice model in Swedish primary health care in 2009/2010. The outcome of this reform is, as intended by the decision makers, an increase in the number of private health care centres. The increase of private welfare providers is an outcome that is here assumed to shape and change public opinion of (more) privatisation of health care. The specific question in the paper concerns how the policy change in Swedish health care affects public attitudes towards further privatisation: does the public adjust their preferences concerning privatisation of health care in relation to the actual level of privatisation?

Soss and Schram (2007) points out welfare reform as a promising case to advance the policy feedback research field since welfare reform can be seen as a "most likely"-case for feedback effects: “In short, welfare reform offers a case in which predictions of mass feedback seem both plausible and amenable to testing” (p 114). The reason is that welfare policies is important to many people and also that many have experience from one or several welfare programs during their lifetime, even though this varies greatly across countries. In Sweden, it is hard for citizens not to have quite a lot of experiences of the welfare state because of its size and scope. This fact can be argued to make Sweden one of the most interesting cases among welfare states if one wants to investigate the effects of welfare policy in general. In that respect, Welfare policy in Sweden is a likely case for public responsiveness. From another aspect, it is rather a case that is a hard test for theories of public responsiveness. Welfare state politics is comparatively conflict-oriented and an ideological issue where people have preferences based on more or less strong values (see further below). This means that welfare policy preferences tend to be quite stable over time. It is thus an open question if changes of welfare policy are strong and significant enough to generate changes in public opinion or not.

**Theoretical outline**

A point of departure is that public policy matter for the vitality and function of democracy by affecting how people think and act as members of a community. Thus, policy is not only output of political decisions, but also inputs that create frames and structures that not only affect costs and benefits associated with future political decisions but also peoples’ incentives and perceptions which in turn influence political action (Pierson 1993).

The process of dynamic responsiveness is sometimes referred to as the policy feedback loop by researchers that seek to establish and analyse the link between policy and opinion. Policy can be expected to “bounce back” since feedback effects in terms of public opinion and the political behaviour
that follows is again transferred as an input in the policy process. A basic assumption in policy feedback literature is that policy have consequences other than outcomes like the number of patients treated by hospitals, the quality of education or how many senior citizens get help from home service. Policies also have consequences for mass opinion such as perceptions of the government, political action, and trust (see e.g Kumlin 2002 and 2010). Thus, the shape and direction of policy make people respond in different ways. Theories within the policy feedback tradition captures the relationship between policy (or institutional design) and mass opinion by seeking to clarify how policies are likely to affect political thought and action in the citizenry. Research on policy feedback-processes thus clarifies how public policy matter for the vitality and function of democratic politics (Mettler & Soss 2004).

The theoretical discussion in policy feedback-based research concerns among other things the nature, strength and direction of public opinion on specific policies. First, it must obviously be assessed that people react at all and in that case what the causal mechanisms look like. Second, the direction and nature of reactions is not self-evident. Some research shows that people's experience with different institutions shape and changes their preferences and also transfer into political actions, in the short or longer run (cf Svallfors 2010). Earlier research have also shown that personal experiences is important for how people respond to policy in studies of how welfare state experiences affect issues like trust and political activity (Kumlin 2002; Solevid 2009).

The public as a thermostat

"When policy increases (decreases), the preference for more policy will decrease (increase), other things being equal." (Soroka and Wlezien 2010, p 23).

The quote above expresses the point of departure for the thermostatic model. People's preferences are assumed to be shaped by policy in such a way that they react with "negative" feedback if policy increases, on the condition that policy moves closer to their preferred level of policy. Public responsiveness refers to reactions following a policy change; do citizens pay attention to policy and in that case also respond? A responsive public will according to this theory behave like a thermostat and adjust preferences for more or less policy in relation to the undertaken policy in various domains. The preferences referred to here is relative preferences, which is defined as the difference between current policy and the public's preferred level of policy. If the public's preferred level of policy is below the current level and the decision makers respond to this wish and increases the level of policy, the public will respond by expressing a decrease in their preferences for more policy: net public support for a certain policy will decrease. That the direction of feedback is negative is important in the model: it means that the public is effective in sending signals to the decision makers about when the level of policy is close to what the public prefers. If the policymakers then respond accordingly, policy representation is satisfactory (Wlezien 1995; Soroka and Wlezien 2004; 2010, Jennings 2009; Johnson et al 2005).
Empirically, the theory is with few exceptions applied on budgetary spending. Soroka and Wlezien measure the public’s net preferences when it comes to the level of spending on such as defense and welfare and show that over time, the public responds to levels of spending thermostatically as predicted: when spending increases, the public responds with a decrease in relative preferences (Soroka and Wlezien 2004; 2010; see also Ellis and Faricy 2011). Some studies have tested the theory on other kinds of policy. For example, Johnson et al (2005) investigates the influence of environmental policy intervention on opinion, and find that public opinion responds thermostatically, but only when policy actually has some effect in terms of decreased emissions (output). The empirical evidence shows that thermostatic theory works as expected in general, also across countries (Jennings 2009) and across policy domains (Wlezien 2000). Additionally, the public seems to react thermostatically also on sub-national government levels (Johnson et al 2005, Pachebo 2009).

Institutional settings as well as salience of policy have in empirical analyses been proven to matter for the strength of public responsiveness. Feedback is assumed to be weaker in countries and domains where policy is decided on many different levels (federalism). Policy that is considered as salient by the public is more likely to generate attention and response. Salience is assumed to be a necessary condition for feedback effects, although not sufficient since it is also necessary that the institutional setting allow for a “clear signal” from policy to public and the other way around. An important conclusion is that for democracy, policy representation is shown to be better when the domain or policy is considered salient by the public since they pay more attention and thus signals clear preferences back to policy makers (Soroka and Wlezien 2010).

The model of thermostatic theory requires that three components can be measured. First, the policy itself, either in terms of political decisions or – as in this case - the results of decisions. The outcome of marketization policy decisions in the Swedish welfare service sector is a marked increase in the level of private welfare service providers. In the particular case of consumer’s choice in primary health care, the result (as was also the intention) is a significant increase in private health care centres. In this paper, this increase serves as the measure of policy outcome. Compared to before the implementation of the reform, the number of private health care centres has increased from 288 to 486, an increase with 69 per cent. The establishment of health care centres is not evenly spread across the country, but ranges from 44 % to 0 % among counties (mean increase 40 %). In general, the new health care centres have established in more densely populated areas (cities and larger towns).

The second component in the model is the public’s relative preferences for the level of policy, that is the difference between preferred level and the level of policy. Here, relative preferences are measured by opinions on more or less privatisation of health care (in relation to the present situation). In a country where welfare services traditionally have been provided by the public sector, it is likely that the public have a preference about how much privatisation there should be, on a range from none at all (only
publicly provided) to all (only provided by private actors). This could obviously also be a dichotomous opinion: either you want privately provided health care or not. But the question of private health care centres is connected to personal freedom of choice: the argument for letting also private actors provide health care is, apart from increasing quality of health care by competition, to give people the opportunity to choose the health care centre which suits them best. The former system with practically only public health care centres gave very limited possibilities to make such a choice. This means that people probably at least partly relate privatisation of health care to more or less freedom of choice. Opinions on increasing or decreasing privatisation of health care may reflect a perception of when the number of health care centres is enough to create a good range of choices. Another reason that privatisation of health care should be a range rather than either/or is that people might have a perception of how much privatisation that is possible without losing democratic control over the health care sector.

The third component of the thermostatic model, citizens’ preferred level of policy, is not normally something that can be measured but needs to be estimated indirectly. Soroka and Wlezien (2010) uses some control variables to capture changes in absolute preferences over time, for example perceived security threats when measuring opinion on budgetary spending on defence. Johnson et al (2005) uses environmental conditions to capture probable causes for changes in preferences over time. In the analysis of this paper, the measurement over time is not as extended as in former analyses. This means that it is more unlikely that absolute preferences change during this time period. Also, there has been no particular external change that is likely to have had an impact on absolute preferences during the time period. For these reasons, absolute preferences are not included in the model of analysis.

**An extended frame of analysis**

In a general framework for analysis of mass feedback processes suggested by Soss and Schramm (2007), one of the dimensions – visibility- refers to the degree to which a policy is salient to mass publics. The second dimension is proximity, which refers to the direct versus distant form in which a policy is encountered. High proximity means that people have individual experience of a policy or program. The proposition of this framework is that the relationship between public policy and mass opinion will proceed according to different logics depending on a policy’s location on the dimensions. A policy with low proximity and low visibility will not very likely influence mass opinion, while a policy that has high proximity and visibility will have the greatest potential for public responsiveness effects. Following Soss and Schramm an additional reason, apart from saliency, to expect reactions from a policy change is that many people actually have experiences from the policy in question (see for example Kumlin 2002). This framework is in this paper used to further develop the assumptions of thermostatic theory: under what circumstances can we expect public responses to policy change?

In Sweden, health care has been one of the most salient issues for party choice during the elections in the 90’s and 00’s, and the most important one in the 2010 election (Holmberg & Oscarsson 2011). Also,
health care is pointed out as one of the most important issues for society in various surveys. Although opinions on the saliency of health care may vary some between groups, it is an opinion that is embraced in general, not only by some segments of the society. In this respect, opinions on the saliency of health care are not something that varies significantly among the population. In this paper, it is therefore considered as a policy where changes should generate reactions among the public in general.

Health care is characterized by proximity in a general sense, since most people in Sweden uses a health care centre more or less often in their lives. Recent figures from a regional survey\(^1\) show that about 90% of the Swedes have been in contact with a health care centre, either themselves or a close relative. But it is also a fact that older people are more frequent users than younger (about 82% of those aged 65-85 compared to about 57% of those aged 15-29), which means that the older part of the population in general more often have personal experiences from health care centres and thus also should react more on the reform than younger people. Concerning the primary health care reform in focus here, proximity also has a geographical connotation. The health care reform was decided on the national level, but implemented on the local level (counties). The outcome of the reform differ greatly across the country, where some areas got a noticeable increase in the number of private health care centres some parts of the country did not get any or very few. This means that the citizens have very different experiences from the reform: for some people it will be a “close” matter, since they have personal experience from being able to choose from several health care centres while for others, the reform will be more “distant” since it does not have any practical consequences for them. This means that personal experiences of the reform will differ and because of this it is reasonable to expect variations in responses to the policy change: people living in areas where there has been a significant increase in private health care centres is more likely to react on the health care reform than those living in areas with no increase.

In accordance with this line of reasoning, health care will be perceived as more or less proximate depending on individual experience and thus varies between distant and proximate. The older among the population should perceive health care as more proximate, and thus be more attentive to the health care reform than the younger. In accordance with the thermostatic model, the older should also react with decreased net preferences over time as a reaction to the increase in private health care centres. Also, those living in areas where there has been an increase in private health care centres should respond with decreased net preferences more clearly than those who live in areas where there has not been any increase.

Apart from a good case for contributing to the discussion of the general nature of policy responsiveness in terms of saliency and proximity, the particular characteristics of the case makes it possible to explore a specific question of interest for understanding under which circumstances the public can be expected to react thermostatically. A defining feature of the Swedish debate on privatisation is its ideological character. A left-right cleavage is present both among parties and the public, and there is a strong and

\(^1\) West Sweden SOM-survey, 2010
independent correlation between ideology and public opinion on privatisation (Bendz 2012, Nilsson 2012). The argument here is that the left-right conflict in welfare policy can be used to investigate how individual value structures condition public responses to policy change.

Ideological orientation is in this case connected to a normative value structure that refers to what values should govern the welfare state. The value of equality is (or maybe has been) a core value of the Social Democratic welfare model (Esping-Andersen 1990). As a consequence of the embrace of equality as a primary value, the public welfare sector is traditionally extensive and the private sector has been given limited space, in order to give citizens equal access to welfare services. The restructuring of the welfare sector, of which the reform in this paper is a part, challenges this traditional value structure and instead emphasizes values like individual freedom of choice (Blomqvist and Rothstein 2000). The underlying values expressed as an ideological left and right have consequences for opinions on for example how much the market should be allowed to provide welfare services. Those oriented to the left are in general significantly more negative towards privatisation and significantly more positive towards public provision of services (Bendz 2012). The other way around goes for those who are oriented towards the right. This is valid for public opinion as well as for the political parties although there have been some changes of policy position during the last decades. The during many years so politically dominating Social Democratic Party has initiated and supported market-oriented reforms to some extent, but on the other hand still advocates a strong public sector and shows an ambivalent stance towards private actors in the welfare state (Stolt and Winblad 2009, Green Pedersen 2002).

Soroka and Wlezien (2010) shows in their analyses of thermostatic responses to policy, that although there are some differences in how people respond depending on education, income and party affiliation, the direction of responsiveness is the same across groups: an increase in policy leads to a decrease in relative preferences. In the case of privatisation of health care, there are deep and value-based differences between groups when it comes to preferences of policy level. This makes it reasonable to expect differences in how groups respond to policy changes. That left-oriented and right-oriented people have significantly different preferences about the level of privatisation means that they have different “starting points” when privatisation reforms are implemented. Those oriented to the left can be assumed to range from preference of no privately provided health care at all, to low or moderate levels. Possibly, for some of the most left-oriented among the public the question about privatisation is indeed dichotomous: any privatisation of publicly financed welfare at all is considered to be against their values. For others, it might be the case that some privatisation is acceptable, for example in some kind of health care or under some specific conditions. For those oriented to the left, the health care reform most likely bring health care policy further away from their preferred level of privatisation because of the significant increase in private health care providers. The hypothesised change in relative preferences is either a decrease in relative preferences for more privatisation (if possible), or the same level as before. But among leftists, a decrease in relative preferences can hardly be interpreted as that the policy moves closer to their preferred level, rather that increase in privatisation have moved policy even further from it.
Those oriented to the right probably range from preferring moderate to high levels of privately provided health care (although it might be the case that also right-oriented can have a dichotomous view on privatisation). For people who position themselves on the right on the scale, a decrease in relative preferences is to be expected as an increase of privatisation would mean that policy moves closer to their preferred level. In this case, the interpretation is more unambiguous in relation to thermostatic theory.

Questions and expectations

Basically, the thermostatic model makes two assumptions about policy responsiveness:

1) The public is expected to react on (salient) policy change
2) The public is expected to react thermostatically on policy change, meaning that their net preferences will decrease when policy increases.

The analysis departs from these two assumptions, and tries them empirically. This means that it is a theoretical possibility that the public (in general or in certain groups) do not react at all, and it is also possible that they react in another direction than predicted (positive rather than negative). That the policy in question is salient should increase the likeliness that people react.

In the analysis, three specific questions will be answered:
To what extent does the public respond thermostatically to increases in private health care centres?
To what extent does proximity make a difference for the strength of public responsiveness?
To what extent does ideological orientation matter for the strength and direction of responses to policy?

The expectations, following the theoretical discussion above, is that the public will react on the increase of private health care centres with a negative feedback, that is a decrease in net preferences for further privatisation of health care. As regards proximity, the expectation is that people who have experiences from health care react stronger than those that are more distant. We should find that right-oriented people respond thermostatically to an increase in private health care centres since the policy moves closer to their preferred level of privatisation of health care. Left-oriented people may either respond with the same (negative) net preferences for more privatisation of health care, or an even more negative opinion since the policy moves away from their preferred level of privatisation.

The Restructuring of the Swedish Welfare State

The restructuring of the Swedish welfare state has been going on since the beginning of the 1990's. The right wing government started to open up for competition and models of consumers’ choice in their period in government 1991-1994. This development was slowed down somewhat when the Social Democrats regained power 1994-2006, but still went on. When the right wing government coalition
came to power in 2006, the reforms aiming towards competition and increase of private actors in welfare services was again implemented at a faster pace (Hartmann 2011). This development implies that values like consumerism, individual rights, economic efficiency and private initiative are stronger today than a couple of decades ago. A policy re-orientation – or perhaps even an institutional change - has taken place in the Swedish welfare state since the public sector is today to a larger extent seen as mainly a service producer instead of an instrument of social transformation (and promoter of social equality). This changes the role of the citizen from a passive service recipient to an actively choosing service consumer. The citizens are thus expected to take responsibility over their welfare in an active way by making good and informed (rational) choices according to their preferences.

The welfare program that is analysed in this paper, the primary health care system, builds on The Act on System of Choice in the Public Sector ("Lagen om Valfrihet", LOV) which was implemented by the centre-right government in 2009 (government’s proposition 2008/09:29). The Act opens the opportunity for the local municipalities to let private companies compete on equal terms with the public sector organisations for the providing of welfare services within health care and social services. The local authorities set the economic compensation given to the suppliers. The service is financed publicly, through tax money. The Act on System of Choice in the Public Sector can be characterised as a form of consumer’s choice, which is defined by that there are at least two providers for citizens to choose between in a certain service area (Edebalk and Svensson 2005). Since 2009/2010 The Act on System of Choice in the Public Sector is applied in primary health care, meaning that private and public providers of primary health care are allowed to establish in the counties, which is the local level that is responsible for health care in Sweden. The county politicians decide the terms and conditions that the health care providers are to fulfil, and every provider that fulfils these conditions is allowed to compete with other providers for the patients. The citizens then get the possibility to choose between the public and private providers available in the county (proposition 2008/09:74).

**Design and method**

This is a single case study that is designed as a natural experiment, with measures before and after a “stimuli” in shape of a welfare reform that was implemented at almost the same time across the country. As mentioned above, the reform resulted in an immediate increase of private health care centres: 223 new private health care centres started, mostly in 2009 or 2010 (an increase with 23 per cent units). This makes it possible to measure opinions on privatisation of health care before and after the reform to answer the question if the public responds thermostatically in relation to the increase in privatisation of health care. A similar design was used by Johnson et al (2005), who measured opinion before and after environmental policy intervention in the American states.

For the “before” measures, the years 2007 and 2008 is used. The exact starting point of the health care
reform varies between counties. The start ranges from 2007/2008 (two counties) to 2010, but the majority of counties implemented the reform either autumn 2009 or during the first six months of 2010. This means that measuring public opinion on privatisation in 2007 and 2008 as “before” and 2010 and 2011 as “after” is not a perfect measure, but as a picture of the whole country it is reasonably adequate. It can obviously be discussed when it is reasonable to expect reactions on policy, is it possible that people react immediately after the effects are seen? In this case, I argue that a rather swift reaction is realistic, since people in general got a concrete reminder of the reform. Everyone got a letter from the county authorities, where they were asked to choose a health care centre from a list. In this list, every approved health care centre was included. Also, the media coverage was quite extensive.

A possible difficulty is that 2010 was an election year which means that public opinion may be influenced by the election and the parties’ campaigns and thus behave differently than in “normal” years. This possible effect will be discussed in the result section.

The datasets that are used in the paper is the SOM-surveys, which are sent out as a postal survey in the autumn every year to a random selection of Swedes in the whole nation as well as in some regions. In the empirical analysis, a merged dataset consisting of National SOM-surveys from 1986-2011 is used (N=73757). The National SOM Survey was sent out to about 6000 persons in 2007-2008 and to about 9000 years 2009-2011. In 2007-2008, the survey was divided into two sub-surveys and in 2009-2011 into three, with partly different sets of questions. In total, 21 347 respondents answered the surveys 2007-2011.

The question concerning privatisation of health care (see more below) was answered by approximately 1500 persons in 2007-2008 and approximately 3000 persons in 2009-2011. In total, the question was answered by 12 379 respondents during 2007-2011.

The variables

The question used for measuring the dependent variable, preferences about more privatisation of health care, is a part of a survey question where the respondents are asked to give their opinion on a number of policy suggestions (Below is a number of suggestions that have been present in the political debate. What is your opinion on each of them?). The item used here is “letting more of health care be provided by private actors” (the five response alternatives ranging from very good to very bad suggestion, with “neither good or bad” as a middle alternative). This question is similar to the ones used in other thermostatic theoretical analyses and should thus serve it’s purpose here as well.

A note of caution is that the question refers to all health care, not just primary health care. It is therefore

\[1\] The SOM-institute is an independent survey organisation at University of Gothenburg. For further information, see www.som.gu.se.
possible that the respondents refer to for example hospitals when answering the question. But since the
debate has been focused on primary health care and also that this is the type of health care that most
people have experience from, it is probably a good enough measure.\(^3\)

The measure used for assessing the opinion on privatisation in the descriptive analyses is net
preferences, that is share of positive responses minus share of negative responses. This is the measure
used by earlier empirical studies that tests thermostatic theory, which facilitates comparisons.

The first variable measuring proximity is age. The questions used from the survey are both year of birth
and a categorized variable, which capture different age groups. Geographical proximity is measured by
using a question where respondents were asked about which kind of residential area they live in. The
variable is then categorized as follow: countryside, villages/small towns, larger towns or one of the three
largest cities (Stockholm, Gothenburg, Malmo). This categorization captures the differences across the
country when it comes to the establishment of new private health care centres: very few established in
the countryside or in small towns, some more in the larger towns but the majority in the three larger
cities. It is important to keep in mind that there are differences within those regions. For this reason, it
would have been better to use the smaller geographical units (local communities) in the analysis although
there is unfortunately not sufficient available data.

People’s ideological orientation is measured by a question asking where the respondents place
themselves on a left-right ideological scale: to the right, somewhat to the right, neither left nor right,
somewhat to the left or to the left. This variable is used both in full and in a categorized version.

Methodologically, the analysis consists of two steps. First, a description of net preferences of more
privatisation of health care over time is presented both for all and within proximity and ideological
groups. Second, OLS regressions are used in order to capture effects of each variable for separate years
and all years taken together.

**Results**

In this section, the first question to be addressed is whether the public reacts on an increase in
privatisation of primary health care. The second question concerns the direction of reactions: do the
public react thermostatically? The third question is if public responsiveness seems to be conditioned by
proximity and ideological orientation.

The first figure shows the net preferences concerning the level of privatisation of health care between

\[^3\] In the same survey question, another item concerns the privatisation of hospitals. This increases the likeliness that
the respondents refer to other parts of health care than hospitals.
2007 and 2011. Net preferences refer to the share of respondents that have answered that they want more privatisation, minus those who answered that they do not want more privatisation. Consumer’s choice in primary health care was introduced between 2009 and 2010 in the counties, the major group of counties introduced in 2010 or late 2009. This means that the measure is a bit shaky but it is reasonable to expect a general decrease in relative preferences in 2010 or at least 2011 if the assumptions of thermostatic theory are correct.

Figure 1: Net preferences, privatisation of health care. 2007-2011.

As can be seen in the figure, net preferences are stable between 2007 and 2009, increases a bit in 2010 and decreases to a lower level than before in 2011. For every year, the share of respondents that are negative towards privatising more health care exceeds the share that are positive to this suggestion which is indicated by the negative values. Given that it takes a while for public opinion to react to changes in policy and that the implementation varies over counties, the 2011 result indicates that there is a thermostatic effect. Although to be certain it would have been preferable to see an effect also in 2010, it is perhaps not very surprising that figures deviates from the expected since this was an election year. Also, there was a general “right-wing upsurge” in this year. This means that results for 2010 may be considered as an exception to the general development and thus harder to interpret.

Since the decrease in net preferences is quite small, the conclusion must necessarily be drawn with some caution. The change between the years 2009 and 2010 is statistically significant as is the change between 2010 and 2011 (95 % confidence intervals). The change between 2009 and 2011 is at a slight risk to overlap (2009: 14,1+/−1,4: -16 to -13. 2011: 17,4+/−1,6: -19 to -16).

The next part of the analysis consists of similar descriptions of the changes in net preferences for different groups. The first indicator on proximity is geographical and refers to in what kind of area the respondents live. In this case, geographical areas coincide with variation in increase of private health care centres.
The assumption was that people living in the countryside and in small towns should not react with a decrease in net preferences since they do not have as much personal experience of the increase in private health care centres as others. This turns out to not be the case: People living in the countryside show a significant decrease of net preferences in 2011 as compared to before the implementation of the reform. Those living in the three largest cities or in larger towns show almost the same net preferences in 2011 as in 2008 and 2009. (Concerning the larger cities, people were significantly more positive towards privatisation in 2007 than other years. This may be explained by that Stockholm was one of the counties where the health care reform was implemented first.) The most negative towards privatisation of health care lives in the smaller towns, and their net preferences rather goes up slightly after the implementation of the reform. It is tricky to interpret the tendencies, but the conclusion is that geographical proximity hardly matters for if people react thermostatically or not. This result has also been checked with data from regional surveys and also with other geographical variables, with the same conclusions. Also to note in the diagram, is that the differences between geographical units have decreased in 2011 compared to the earlier years: where people live mattered more before the reform and after for privatisation opinion.

Moving on to the next proximity variable, which is age: since the older part of the population uses health care centres more frequently than young people, they should react more clearly on a policy change.
As can be seen in the diagram, there are differences in reactions between the age groups. While the youngest group does change their net preferences after the reform, they do not react as predicted by the thermostatic model: their net preferences increase. In contrast, those aged 50 and above show a predicted decrease in net preferences after the reform. For those aged 64 and above, the decrease in net preferences goes from -12 in 2007-2009 to -22 in 2011, which is the largest drop among the age groups. The changes between the years before the reform and 2011 is statistically significant (95 % confidence interval) for all groups except 30-49 years, where the change is also comparatively smaller than for the older groups. The conclusion from this result is that proximity in terms of personal experiences seems to condition public responsiveness. The assumption of the thermostatic model is valid among the group that in general has personal experiences from health care, but not among those that in general has no or limited experience.

In the next diagram, the changes in net preferences on privatisation of health care is showed for ideological groups, ranging from left to right.
As is seen in the diagram, ideological groups arrange themselves neatly from left to right when it comes to preferences about more privatisation of health care, with people on the far left as the most negative to the suggestion and people the right as the most positive. The analysis over time shows some interesting patterns. While respondents who orient themselves to the left do not change their net preferences significantly after the consumer’s choice reform was implemented, right-oriented seem to do. Looking at the figures for each group, the net preferences for the left-oriented varies between 72 and 77 over the investigated years (not statistically significant changes at 95 % level). For the people defining themselves to the right, net preferences goes down from 57 in 2009 to 51 in 2010 and 46 in 2011 (changes significant at 95 % -level). The same pattern goes for the group defining themselves as somewhat to the right even though they are not as positive to the suggestion to privatise more health care (also these changes are statistically significant on the 95 % -level, for years 2009-2011). In other words, right-oriented people react thermostatically but left-oriented do not.

As discussed above, the result can be interpreted as that people to the ideological left are not very affected by an increase in private health care centres, they were negative before and are just as negative after the reform: they thus keep giving the same signals to the decision makers over the years. For the right-oriented, the signal can be interpreted as that the level of privatisation of health care gets closer to their preferred level. Ideology seem to be an interaction variable, where an increase in privatisation have different effects depending on ideological orientation.
Regressions

The purpose with the regressions is first to check the effects of ideological orientation and age on preferences by analysing correlations within each group: do preferences for more privatisation of health care change significantly over time within different groups? Secondly, the analysis shows effects of variables under control for each other for each year, and for all years taken together.

In the analyses including all years, a time variable is used to investigate the effect of the including years on privatisation opinion. This variable compares the years 2007/2008 to 2011 to capture the before-after effect as well as possible. (The year 2010 is excluded from the after-measure because of its “outlier” character as an election year). The dependent variable used in the analyses below is a dichotomous variable, which differs between those who are positive to privatise more health care and those who are negative towards this suggestion. The share of positive follows the same pattern over time as net preferences.

The first step is to further investigate if a move from before the reform (2007/2008) to after the reform (2011) has an effect on opinion on more privatisation of health care. This is done for people in general and also within groups by running OLS regressions for each group with time as an independent variable. In which groups do preferences for more privatisation of health care change significantly after the reform?

In this part of the analysis, only ideological orientation and age is included (geographical proximity is analysed, but as before show no significant effects).

Table 1: Bivariate OLS-regressions within age groups and ideological groups, 2007-2011.

<table>
<thead>
<tr>
<th>Groups</th>
<th>B</th>
<th>Sig</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>-.03**</td>
<td>.07</td>
<td>12576</td>
</tr>
<tr>
<td>Left</td>
<td>-.01</td>
<td>.78</td>
<td>1081</td>
</tr>
<tr>
<td>Somewhat left</td>
<td>.01</td>
<td>.76</td>
<td>2056</td>
</tr>
<tr>
<td>Neither left nor right</td>
<td>-.04</td>
<td>.17</td>
<td>2181</td>
</tr>
<tr>
<td>Somewhat right</td>
<td>-.11***</td>
<td>.00</td>
<td>2198</td>
</tr>
<tr>
<td>Right</td>
<td>-.023</td>
<td>.52</td>
<td>1067</td>
</tr>
<tr>
<td>15-29</td>
<td>.65*</td>
<td>.98</td>
<td>1307</td>
</tr>
<tr>
<td>30-49</td>
<td>-.01</td>
<td>.77</td>
<td>2815</td>
</tr>
<tr>
<td>50-64</td>
<td>-.06***</td>
<td>.02</td>
<td>2487</td>
</tr>
<tr>
<td>64-85</td>
<td>-.07***</td>
<td>.02</td>
<td>2096</td>
</tr>
</tbody>
</table>
What this table shows is which groups that actually reacts on the policy change in focus here, and in that case in what direction. Of the ideological groups, only those defining themselves as somewhat to the right show a significant reaction. The b-value is negative, which means that their preferences for more privatisation decrease between 2007/08 and 2011. From the descriptive analyses, we would have expected also those to the right to react in a negative direction. Part of the explanation for this mystery is probably that for this group, preferences differ in 2007 and in 2008, which means that when these two years are merged, the jump in preferences to 2011 is probably to small to be significant. Using a dichotomous ideological variable (left-right), the analysis shows a significant decrease of preferences for right-oriented. Still, the result is interesting: it seems like those defining themselves as far to the right is not as sensitive to this policy change as those somewhat to the right. It is possible that those defining themselves as definitely to the right does not as readily change their preferences on privatisation as a consequence of policy change: instead they continue to signal that they prefer more privatisation. The same line of reasoning goes for those oriented to the left: their preferences are not affected by the policy change, they are as negative to privatisation as before the reform. Those somewhat to the right is perhaps the most likely among the groups to have a preference for a “middle” level of privatisation and thus more likely to have a limit to how much privatisation they want, which makes them more sensitive to policy change in this case.

For the age groups, the two older groups (over 50) show a significant reaction in 2011. The youngest show a significant reaction, but at a lower level of significance (90 %). The reactions go in the predicted direction, with a small decrease in preferences for more privatisation of health care for the older groups. The younger group (if the significance level is accepted) instead show an increase in preferences for more privatisation after the reform. It is possible that this age group do not react to the reform, and that their changed preferences are explained by other factors. Another possibility is that they react on the policy change, but in another direction than predicted by the thermostatic model. For example, their impressions from increased privatisation might generate a preference for even more privatisation since the reform as such brings a change in the level of privatisation they actually prefer.

The second step of this part of the analysis is to include all variables in a multivariate regression. Here, age, geographical proximity and ideological orientation is treated as independent variables, which mean that we are able to see their effects on privatisation opinion under control for each other. Even though explanation of the variation in privatisation preferences is not a main goal in this paper, it is still interesting to check how the proximity factors and ideological orientation behave when included in the same analysis.

The years before the reform (2007 + 2008) and 2009, 2010 and 2011 are analysed separately as well as
together. In the analysis of all years, the time variable measuring the step from before (2007/2008) to after (2011) the reform is included.

Table 2: Multivariate OLS regressions, separate years and 2007-2011.
Dependent variable: Share of positive towards the suggestion to privatise more health care.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>0.00</td>
<td>0.00</td>
<td>0.01</td>
<td>.002***</td>
<td>.001***</td>
</tr>
<tr>
<td>Geographical area</td>
<td>0.03</td>
<td>-0.02</td>
<td>-0.01</td>
<td>0.06</td>
<td>0.02</td>
</tr>
<tr>
<td>Left-oriented</td>
<td>-0.27***</td>
<td>-0.25***</td>
<td>-0.29***</td>
<td>-0.22***</td>
<td>-0.25***</td>
</tr>
<tr>
<td>Right-oriented</td>
<td>0.36***</td>
<td>0.34***</td>
<td>0.38***</td>
<td>0.32***</td>
<td>0.34***</td>
</tr>
<tr>
<td>Time/year</td>
<td></td>
<td></td>
<td></td>
<td>-0.04***</td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>.05</td>
<td>-.33</td>
<td>-.67</td>
<td>-.42</td>
<td>-1.9***</td>
</tr>
<tr>
<td>Adj R2</td>
<td>.29</td>
<td>.27</td>
<td>.35</td>
<td>.24</td>
<td>.27</td>
</tr>
<tr>
<td>N</td>
<td>3301</td>
<td>3091</td>
<td>3214</td>
<td>2970</td>
<td>12576</td>
</tr>
</tbody>
</table>

p< 0.01 *** p < 0.05 ** p <0.1 *

Comment: Age is year of birth. Geographical area is a binary variable, where 0 = country side/small towns and 1 = larger cities. Ideology is a dummy variable where neither left nor right is the reference category. Left and rather to the left, respectively right and rather to the right is merged. Time/year is a binary variable where 0 = 2007/2008 and 1 = 2011.

First, the before-after measure (time/year) in the last column (all years included) shows that preferences for more privatisation of health care in average decreases significantly even though the effect is very small. The important conclusion here is that this effect exists even though other variables is included (the bivariate effect is -.0.3, sig= 0.067) This means that irrespective of age and ideological orientation, there is a significant before-after effect. When including other variables, age (year of birth) only has a very small significant effect when all years are included: the younger people are, the more positive towards increasing privatisation of health care (the same result appear when using the categorized variable). Also in 2011 the effect is significant, which indicates that age is a bit more important for privatisation opinion after the reform than before. As already noticed in the descriptive analyses, geographical proximity does not have anything to do with opinions on privatisation of health care. For all years, ideological orientation has a strong and significant effect: people oriented towards left are significantly more negative towards the suggestion to privatise more health care than those oriented to the right, and vice versa. Although explanation of the variation in privatisation opinion is not an aim of this paper as such, it is interesting to note that ideological orientation also accounts for the greater part of the explanatory strength of the model, showed in the measure adjusted R2.
Conclusions

Does the public respond to changes in welfare policy and in that case, how? The general conclusion is that people do seem to pay attention to welfare politics and also that there is a negative effect over time in accordance with the assumptions of the thermostatic model. But there are some issues to discuss in relation to this general conclusion. Even though the effect is significant and visible in the analyses, it is not very impressive – especially when other variables are included in the analysis. As mentioned in the introduction, the implementation of consumer’s choice in Swedish primary health care can be considered as a most likely case for public responsiveness since health care is a salient and visible policy area. Considering this, we should expect the effect to be stronger and the signal from the public clearer than has been proven to be the case. From another perspective, the empirical case is a hard test for theories of public responsiveness since privatisation is strongly connected to ideological values meaning that preferences may be less volatile than otherwise. As is discussed below, considering variations in both strength and direction according to left-right dimension helps to unfold and understand the general result.

An argument in the paper is that analyses of public responsiveness should not settle with conclusions only about the public in general, as such approach risks missing important variations hiding behind the accumulated results. The results show that the assumptions of the thermostatic model are, in some respects, conditioned by proximity and ideology in a systematic way. This means that conclusions about the nature and directions of public responsiveness can be further qualified than is currently the case in the thermostatic model since people are not equally likely to react thermostatically to policy change. The results point in the direction that public responsiveness seems to depend not only on the nature of the policy (salient or not) but also on personal experiences and value structures.

As a way of digging deeper into the micro foundations of public responsiveness, the analysis includes to what extent ideological orientation matter for the strength and direction of responses to policy. The results show that public responses differ significantly depending on ideological preferences. From one perspective this is not very surprising, since the preferred level of privatisation differ according to ideological orientation: a good part of the left-oriented citizens is likely to object to the idea of any privatisation at all since they consider it to be a retrenchment of the welfare state. In contrast, right-oriented are in general more positive to privatisation of welfare services and see it not so much as a retrenchment as a way of increasing freedom of choice and efficiency. But the results also shows that there are differences in relation to the assumptions of the thermostatic model: Respondents defining themselves as left-oriented do in general not react like a thermostat, while right-oriented do. A likely interpretation of this result is that the right-oriented has the “right” starting point for a thermostatic response to occur. They vote for a government that promises to increases privatisation, the government delivers what is expected, and this creates a response from the right wing public (their voters) signalling that privatisation policy gets closer to their preferences.
How is the left-oriented lack of response to be interpreted in relation to the thermostatic model? According to Soroka and Wlezien, the ”crux” of the model is the negative feedback of policy on preferences:

”It is what distinguishes a reasonably informed public – one that knows something about what policymakers actually do – from an uninformed public.” Soroka and Wlezien 2010, p 25).

Thermostatic reactions mean, according to Soroka and Wlezien, that the signal that the public send contains meaningful information and that effective accountability is possible since the public can reward or punish the government for its actions. Does this mean that the left-oriented respondents are not informed and do not send meaningful signals to policy makers in this case (but that right-oriented are and do)? I think that a signal that is persistently negative as in this case, is not necessarily to be interpreted as that left-oriented citizens are more uninformed about policy changes than right-oriented citizens. A more credible explanation is that the policy change does not change their views about privatisation of welfare services: it is still dominantly negative and (even more) far away from their preferred level of privatisation. As their starting point before the reform is different than right-oriented the response is another. The absence of thermostatic response does thus not self evidently indicate ignorance.

A second assumption in the paper is that proximity should matter for the nature of public responses. The idea behind geographical proximity was that people living in areas with no increase in private health care centres should show a slight or no difference in net preferences before and after the reform. The reason for this assumption is that there are considerable differences across the country as to the actual outcome of the health care reform, namely the increase in private health care centres. The results show that there are no such effects. This could mean either that the outcome does not correspond with opinions on privatisation of health care, or that people respond to the general (national) policy and not the situation where they live. According to previous research, the degree of federalism accounts for some of the variation in democratic responsiveness across countries. In countries with several levels of government, the signal between decision makers and public opinion is “blurred” since it is more difficult for people to know which level to hold responsible (Soroka & Wlezien 2010). In this case, two governmental levels are involved in the decision making: consumer’s choice in primary health care was a decision from the national government, but the county councils was allowed to formulate the detailed rules for the health care providers. Also, the organisation of health care is in Sweden is delegated to the counties and thus policy varies across the country. This fact might contribute to that people can either refer to national policy or county policy when answering the question about level of privatisation.

The second indicator of proximity used here is age, departing from the assumption that health care is considered more proximate for older people since they use the health care centres’ services considerably
more often than the younger. The analyses shows that older people respond to the increase in private health care centres with a decrease in net preferences in accordance with the thermostatic model, but that the younger do not: instead, their net preferences for more privatisation increase after the reform. The multivariate regression shows that this tendency still holds when other variables are included – preferences for more privatisation decrease with age. The result should according to thermostatic theory be interpreted as that the policy has moved closer to the older respondents’ preferences for privatisation but not necessarily to the preferences of the younger groups.

A theoretical possibility when studying public reactions on policy is that preferences increase when policy increase, instead of the other way around. Explanations for this kind of result are not included in the thermostatic model. In the case of privatisation of welfare services, it could from another theoretical perspective be reasonable to expect a positive feedback from the citizens rather then a negative, resulting in more positive net preferences after the health care reform. This seems to be the case when it comes to younger people. As mentioned above, increased privatisation means more freedom of choice for the citizens when using welfare services. Although everyone does not necessarily perceive this as a good thing, most people appreciate to be able to choose the service provider that suits them best and also to be able to change service provider if they are not happy. Consumer’s choice is in this respect empowering for the citizens. Empowerment within the welfare state domains has been shown to generate positive feedback effects. For example, experiences of empowering welfare institutions generate positive opinions of welfare state programs as well as trust for the government (Kumlin 2002). In a previous paper, I show that positive experiences in terms of increased empowerment have some effects on peoples’ opinions of privatisation. The results in this study were a bit inconclusive and not entirely consistent with the hypothesis that positive experiences should generate positive opinions (Bendz 2012). But considering that the direction of public responsiveness is not self evident under all circumstances, a future challenge is to specify more closely under which premises the public is likely to respond thermostatically and when it is instead more reasonable to expect an increase in a positive direction.

Public responsiveness and political representation

The relevance of this study ultimately departs from a democratic ideal that is a prerequisite for the thermostatic model. If the public do not send clear signals as a response to political decisions and its outcomes, politicians is assumed to have little or no incentives to represent the electorate’s policy preferences. Politicians should react on public opinion and also represent policy opinions among the electorate. In a party democracy, this is not always so straightforward. In Sweden, members of parliament generally represent their parties before the opinion of their voters (Esaiasson & Holmberg 1996). In relation to the results of this study, this means that if the signals from the voters clash with the governing party’s policy position, policy responsiveness may not happen. Instead, voters have to rely on other ways of signalling, like for example including their opinion on salient policies when choosing what party to vote for in elections.
Since policy representation is not investigated here, the discussion concerning how public opinion feeds back into politics is necessarily hypothetical. Soroka and Wlezien (2010) points out that if only certain segments of the population is paying attention (that is, sending signals back to decision makers), only those will be properly represented. When it comes to privatisation issues in Sweden, the centre-right-wing government represent its right-oriented voters in this case and less so the left-oriented voters that in general vote for the left parties. The results show that although relative preferences for more privatisation of health care have decreased among right-oriented citizens, this group is still more positive than negative to increase the level of privatisation after the reform. The decrease in relative preferences indicates that the level gets closer to right-oriented peoples’ preferred level and thus that the policy goes in the right direction in this respect, but to interpret this as a signal to stop further privatisation is probably not correct if this groups opinion should be represented. For the right-centre government, policy responsiveness would be of some importance in this case: given the salience of the policy domain, if they do not pay attention to signals from their voters they risk losing at least some voters to the left-wing parties since they are more restrictive towards privatisation. For this to happen it is however likely that it would take a similar reaction to privatisation in other areas such as elder care where there has also been an increase in private alternatives.
References


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