Exit and Voice in Dutch Social Health Insurance

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Introduction

According to Hirschmann's concept of exit and voice, people have two options to make sure that firms or organisations realise what they (their consumers or members) are interested in (Hirschmann 1970). Exit is the dominant option in the realm of the economy. It is easy to use for members or consumers and the effects are quite clear for the firm or the organisation: a loss of consumers or a loss of membership. However, specific reasons why exactly consumers or members have used exit is not clear to the management of firms or organisations. Voice is the dominant option in the realm of politics and public services where choice is often practically impossible. Voice is more difficult to use: the use of voice implies lengthy discussions and arguments. However, management gets to know more clearly what is wrong within a firm or organisation. Although it is possible – according to Hirschmann it is even desirable – to combine exit and voice in order achieve optimal results, it can also be argued that the introduction of the exit option reduces the influence of voice. Moreover, the information conveyed by exit may be based on different groups of consumers or members with different preferences than the information conveyed by voice.

In the Dutch public health insurance system voice existed for a long time, but exit was only introduced in the 1990s. In this paper we examine the introduction of exit in the Dutch health insurance system and discuss the combination of exit and voice. Until the early 1990s consumers in Dutch compulsory social health insurance did not have the exit option. There was no consumer choice between sickness funds. However, sickness funds were the focal point of Dutch health system reforms in the early 1990s. Giving the insured free choice between sickness funds was supposed to bring about competition that would at the same time favour quality through selective contracting by sickness funds and curb costs through incentives for efficiency (Greß 2002) . The possibility to use voice – for example, through the 'Council of Insured' or by filing a complaint – remained unchanged throughout the reforms.

Exit in Dutch Social Health Insurance

Comprehensive social health insurance is mandatory for people with an income below a legally specified level in the Netherlands. Social health insurance is administered by sickness funds, which are not-for-profit organizations. The benefits package is uniform, and insurance funds are not allowed to select good risks. Benefits not covered by social health insurance (e.g. dental health care for adults) are covered by voluntary, supplementary health insurance. Here, the selection of good risks is allowed. The market for supplementary health insurance is not differently regulated by government than other damage insurance. Insurers are free to determine benefits, premium rates, and underwriting practices. Although sickness funds are not allowed to offer supplementary health insurance, they do so via private subsidiaries. In their external communication they present themselves as one organisation.

People with income above the threshold are not entitled to social health insurance, so they can only buy private health insurance. This is a major reason why the proportion of the population with private health insurance is quite high (roughly 38 percent). There is also social health insurance for long term care which is compulsory for the whole population in the Netherlands but is not subject to competition. Table 1 summarises briefly the main characteristics of social health insurance in the Netherlands.

Reform attempts that use the position of sickness funds as their point of departure have focussed on three points. The first is the relation between the insured and their sickness funds. Traditionally in the Netherlands people had no free choice of sickness funds at all. Free choice between funds was made possible in the Netherlands only in 1992. Until 1992, most sickness funds were located in separate regions and people had to enroll in the

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Table 1

Social Health Insurance in the Netherlands 2001

Membership	Obligatory for employees under the income ceiling of about € 30,000 (2001) and their families, some groups of social security dependants, old age pensioners (income ceiling € 18,879), self-employed (income ceiling € 18,970); no voluntary membership possible.
Market Share of Sickness Funds	62 percent (37 percent private insurance, 1 percent others or uninsured)
Services insured by obligatory sickness funds insurance	Medical care, pharmaceutical prescriptions, hospital care, dental care <18 years. Supplementary, voluntary insurance possible (e.g. for dental care >18 years and parts of physiotherapy). Only private health insurers may offer supplementary health insurance.
Premium	Income dependent part is uniform, paid by employees and employers to the central fund, distributed to the individual funds. Prospective risk adjustment according to capitation formula based on age, gender, region, employment status and pharmaceutical cost groups. Flat-rate part of premium determined by the individual sickness funds.
Financial responsibility of the sickness funds	Individual sickness funds responsible for increasing share of expenses, currently 41 percent. Minimum level of financial reserves.
Instruments of competition	Selective contracting; supplementary health insurance; flat-rate premium; collective contracts with employers

sickness fund located in their region of residence. In 1992, legally protected regional monopolies were abolished and sickness funds were required to have open enrollment periods, during which subscribers were free to switch sickness funds. At the beginning, the insured could switch every two years, but since 1996 they can switch during the last two months of each year and during two months after a premium increase. All former regional sickness funds expanded their market to the national level and thus began offering social health insurance nationwide, though a few sickness funds explicitly limit their activities to their regions of origin and still present themselves as regional sickness funds. In addition, the legal entry barriers to the sickness fund market were largely removed and several new sickness funds entered the market. Most of these new funds were started by a private health insurer. In 2001 there were 24 competing sickness funds left, 19 former regional funds and 5 new funds (Schut et al. 2003).

Before the reform, all sickness funds charged uniform income dependent contributions. Income-related contributions are not determined by individual sickness funds but are uniformly set by the government. Contributions are deducted from payroll and paid to a General Fund. From the General Fund the money is redistributed among sickness funds. Prior to the reforms, sickness funds' expenses were fully covered by payments from the General Fund, and sickness funds were not allowed to charge any direct contribution for mandatory insurance.

In order to establish price competition between sickness funds and to increase incentives for choice for consumers, a flat-rate contribution (additionally to the uniform income dependent part) was introduced. The need to charge a flat rate contribution was created by setting the risk-adjusted capitation payments to the sickness funds below expected costs. Sickness funds have to recover the remaining costs via charging the flat-rate contribution directly to their insured. On average, sickness funds recover 10 to 15 percent of their costs by these out-of-pocket contributions. It was and is expected that differences in flat-rate contributions induce the insured to choose the cheaper insurance with the best service and that sickness funds are induced to increase their efficiency and service orientation in order to lower their costs and increase their attractiveness to the insured (Schut et al. 2003).

A second relationship also changed in the Netherlands: that between sickness funds and health care providers. The sickness funds used to be obliged to contract with every provider in their area. Abandoning obligatory contracting was an important change in the Netherlands, because it gave way to the possibility of selective contracting

based on quality and costs of the services provided. Sickness funds are able to contract selectively with providers of ambulatory care, e.g. general practitioners, specialists and physiotherapists. They still are obliged to offer contracts to all hospitals and other health care facilities. Price competition between providers is limited. The maximum tariffs for ambulatory care services are fixed by the Central Tariff Authority within the boundaries of global budgets determined by the Health Ministry. Insurers and providers may contract at prices below those maximum tariffs, but not above them. Also, hospital budgets are fixed by the Tariff Authority (Greß 2002).

A third reform for sickness funds to work efficiently is the extent to which they are actually responsible for their financial results. Before the reforms, sickness funds were not responsible at all for their financial results. If sickness funds had higher costs than what they received as premiums, the difference was compensated by a central fund. The absence of appropriate incentives for sickness funds was perceived as a major problem. Therefore, in 1993 the retrospective reimbursement system was replaced by a system of prospective risk-adjusted capitation payments. Initially, the risk-adjustment methodology was very crude (only age and gender were used as risk adjusters), Therefore, 97 percent of surpluses or deficits were still equalized retrospectively among sickness funds or compensated by the General Fund. Since 1995, however, the financial risk for sickness funds has been raised gradually from 3 percent to 41 percent in 2002, alongside a refinement of the risk adjustment methodology. Consequently, individual sickness funds faced increasing incentives to act as a prudent buyer of health services. For administrative expenses sickness funds receive a separate budget from the General Fund. Sickness funds bear the full risk of exceeding the budget for administrative expenses .

Effects of Exit in Dutch Social Health Insurance

Implicitly, the hoped-for success of the health care reforms in the Netherlands was based on three assumptions. First, consumers have free choice between insurers and exercise their right to choose – or at least threaten to use Exit. Second, sickness funds compete with each other via price and quality of services without having permanent monopoly power. Third, non-effective and/or non-efficient providers are induced by insurers to work more effectively and efficiently and provide good quality (Greß et al. 2001).

A crucial precondition for the success of social health insurance reforms in the Netherlands is that consumers to some degree search for lower-priced sickness funds. So far, this has not been the case. From 1995 to 1999 only one sickness fund gained a considerable amount of members – almost 100,000 since 1995. But it did so, not because of its low premium or excellent service, but because it took over another sickness fund. Four others gained more than 20,000. Three sickness funds experienced a relatively large loss of more than 20,000 members. The majority of funds gained only a little. In total, gains were larger than losses, indicating a growing market (Greß et al. 2002). A more recent survey of membership gains and losses has shown that between 2002 and 2003 the total number of publicly insured has slightly decreased. Overall, there were more losses than gains. Losses were experienced particularly by the funds with the highest premiums. The five sickness funds with lowest premiums saw an increase in their number of members. However, the number of insured actually changing funds was relatively low, suggesting that the effect of premium differences is limited (College voor Zorgverzekeringen 2003). Premium differences between the funds with the highest premium and the funds with the lowest premium increased from 3 percent in 1995 to 63 percent in 2003. Thus, relative price differences between insurers increased quite significantly. However, in absolute terms potential savings for individual insured are rather limited. Compared to other countries, price sensitivity of Dutch consumers is rather low (Schut et al. 2003, Schut and Hassink 2002).

A survey of Dutch consumers conducted in 2000 showed that they perceived differences between sickness funds as being quite small. This survey has recently been repeated (Delnoij/E. van der Schee 2003). In Table 2 the results of both surveys are presented. In the 2000 survey, the added result of the two answer categories “very large differences” and large “differences” was never bigger than 30 percent for any item. The highest percentage was for the extent of the supplementary coverage package and its premium (both 30 percent), Only 19 percent perceived large or very large differences of the flat rate premium. 14 percent perceived large or very large differences between the basic benefits packages of

Table 2
Perception of differences between sickness funds by Dutch consumers in 2000 and 2003

	Very large or large differences (%)		Small or no differences (%)	
	2000	2003	2000	2003
Supplementary coverage package	30	39	70	61
Supplementary coverage premium	30	43	70	57
Arrangements regarding complaints or objections	26	26	74	74
Efforts to cut down waiting lists	25	30	75	70
Speed in which bills are remunerated	24	27	76	73
Accessibility by telephone	23	26	77	74
Consumer orientation	22	22	78	78
Flat rate premium	19	32	81	67
Basic benefit package	14	14	86	86

Source 2000 data: Kerssens et al. 2002.
Source 2003 data: Delnoij/E. van der Schee 2003.
Sample size: 2000: (n = 846); 2003: (n = 976).

individual sickness funds although the basic benefits package in fact is uniform. In 2003 this overall picture has remained the same, though compared to 2000 somewhat more consumers perceive differences between sickness funds when it comes to the supplementary coverage package and premium, and the flat rate premium.

All in all, from 2002 to 2003, after the largest increase of flat premium rates ever, 3.1 percent of the publicly insured switched to another sickness fund. Those who did were younger and higher educated than the insured who did not switch. In response to the question as to why they are insured with their current sickness fund, most people state that they have been with this sickness fund ever since they were young (37 percent of the respondents), that it is the most well-established sickness fund in the region (28 percent of the respondents), and that family and friends are also insured with this particular fund (16 percent of the respondents), These top three reasons for being insured with a particular fund reveals that the Dutch insured do not yet act as rationally calculating consumers, but base their choice on affective reasons (e.g. reputation of the sickness fund) rather than cognitive ones such as the premium level or benefits package (Delnoij and van der Schee 2003). Differences in flat rate premiums are probably not large enough to overrule these other considerations and the (psychological) costs of collecting information, getting at a decision and actually implementing the decision.

However, after the abolishment of regional monopolies and the introduction of competition between sickness funds, the health insurance landscape changed significantly. A process of formal mergers between sickness funds and informal cooperation between sickness funds and private insurers sharply reduced the number of insurers (de Roo 1995; Groenewegen 1994). Sickness funds were intent on defending their regional market shares by merging with their competitors. Thus, formally regional monopolies are abolished but in fact they are still in place (only the regions have become larger or multiple).

There has been little change in the contractual relations between providers and sickness funds. So far, sickness funds have hardly used their power to contract selectively with providers. Until recently, sickness funds and providers still negotiated collectively on a national and regional level. This has been heavily criticized by the Dutch Competition Authority, which has issued new regulation demanding individual bargaining and contracting of ambulatory providers (Nederlandse Mededing-ingsautoriteit 2002). Yet, there is hardly a culture of bargaining on the micro-level. Sickness funds, which traditionally focused on equity and solidarity, might have difficulties adapting to a culture where they are supposed to bargain for the best possible health care arrangement exclusively for their own insured (e.g. in terms of waiting times or quality of care), but deny those advantages to customers of other sickness funds. It is also not clear whether or not health care providers are prepared to differentiate between patients who are insured with different insurance carriers – although until the 1970s they used to differentiate between privately and publicly insured patients. Individual contracting also introduces higher transaction costs (Groenewegen/Greß 2000, Terstegge 2003). Furthermore, there is no price competition between providers, since there are no contracts with prices below maximum tariffs. As a result of manpower shortages in health care, it is the providers rather than the sickness funds who can afford to display selective behavior. In a recent survey, about 10 percent of Dutch general practitioners stated that they ask patients to choose

between only a limited number of sickness funds (with high local market shares) in order to cut down the administrative burden of contracting (Kerssens/Delnoij 2003).

So far, there is quite a gap between the expected results of health care reforms in the Netherlands and the changes that really took place. Actors did not behave according to the three behavioral assumptions outlined above. This discrepancy is mostly due to a conflict between cost control and competition and due to a conflict between competition and cooperation in the health field.

The conflict between cost control and competition ensues from government policy which is rather ambiguous. Certainly, the Dutch government postulates competition and increased responsibility of actors, such as sickness funds, providers and consumers. However, much policy is actually focused on cost control and regulation of supply and prices rather than a shift of responsibilities from government to market actors. Market actors have few incentives and instruments to act according to the behavioral assumptions outlined above. Insurers still face limited financial risk. Moreover, they are not allowed to contract selectively with hospitals. More importantly, capacities of some providers are quite tight. Sickness funds are quite happy to be able to contract with almost any GP, because the supply is extremely short.

The second conflict is caused by a contradiction between the cultural and institutional context of primary care in the Netherlands and competition. Traditionally, ties between patients and general practitioners (GPs) are stronger than ties between sickness funds and insured. Consumers would rather change their sickness fund than their physician. Accordingly, insurers are afraid of losing their insured if they stop contracting individual GPs. Since high market shares are one of the most important strategic targets of all sickness funds, they try to avoid the loss of insured. Moreover, there is strong local and regional cooperation between GPs, which is encouraged by the Ministry of Health. Regional groups of physicians organize night and emergency services; local groups meet to discuss prescription patterns as well as quality assurance issues. In practice, under the new regulation of the Dutch Competition Authority, for sickness funds these local groups of GPs are more or less the biggest unit they are allowed to contract with. Existing groups of GPs may be unwilling to welcome newcomers in their area, and sickness funds are hesitant to contract individual physicians who may not have access to shared arrangement for emergency services. But under the Competition Law, providers (GPs) are not allowed to use their market power to block newcomers' entrance to the market.

Voice: The influence of the insured persons in the governance of sickness funds

Sickness funds are not allowed to make profit from their social health insurance business.[1] Therefore, they can either be a foundation or a mutual guarantee fund (which is the common form), The insured need to have a reasonable amount of influence on the governance of the sickness funds. Formally, the highest power of mutual guarantee funds has to be a council in which the insured are represented. The by-laws of sickness funds specify the recruitment of members of the councils. Recruitment usually is based on co-optation by the existing members of the councils or on nomination of the board of directors or the board of governers. The rank-and-file insured are usually not informed about the possibility to participate in the governance of the sickness funds or about how the councils actually function (van de Schee et al. 2000). Nearly 90 percent of the insured do not know that there is a formal possibility to exert influence.

The following are areas where the councils can formally exert influence: appointing and suspending of directors and governors, changing the by-laws and determining the annual accounts. Determining the budget is only in a few cases the official competence of the "Councils of Insured". The subjects actually being discussed are broader than the formal topics. Examples of subjects are: developments in health insurance, internal organisation and general policy of the sickness funds, external policy, cooperation and mergers, premium, insurance package, sevice, and complaints. However, formally councils have no right to decide on these matters.

According to sickness funds managers, the formal power of the councils is large but the actual influence small. The reason is an alleged lack of professionalism on the side of the members of the councils, while the subjects being discussed are quite complicated. As advantages of the "Councils of

[1] Sickness fund subsidiaries for supplementary health insurance are allowed to make profits – and indeed they are quite profitable.

Insured“ the following were mentioned by managers: public relations function, controlling the board of directors, sounding board for the directors. The disadvantage is that the ‘Councils of Insured’ can delay decsion-making.

According to the perception of council members – nearly half of them old-age pensioners with an average age of 60 years – they are quite well able to understand the topics that are being discussed, with the financial subjects most difficult to understand. Most members feel that they are being taken seriously by the managers of the sickness funds. Nearly half of the members of the councils say that they have much influence; 40 percent state that they have little influence. On the whole the members themselves are more positive about their influence than the managers of the funds. If voice is used at all, it is used by different category of people than Exit. As a rule, the old and sick have a high interest in the benefits package and service, do not switch insurance funds and hence are either satisfied or have only voice as an option – while the young, healthy and higher educated have a higher interest in low premiums and switch more often, using the exit option.

On the whole, voice as a social mechanism to convey information from insured people to the management of public insurance funds does not work well. One of the reasons is that it is not clear who the members of councils of insured represent. They lack the backup of a constituency. With the rise of the organized patient movement in the Netherlands, one of the obvious ways to strengthen the voice option would have been for the patient movement to constitute itself as representing patients interests in insurance councils. One other way through which voice and exit may gain strength in their combination is when firms or organisations that hold collective contracts start voicing their preferences. In that case voice is backed up by a credible threat of a large number of insured exiting.

Conclusions

In theory, consumers of social health insurance in the Netherlands are able to use exit as well as voice in order to inform their sickness fund of their dissatisfaction. The use of exit was introduced only in the early 1990s. In theory, this combination could be a very efficient way to signal to the directors of sickness funds the need for readjustment in managing their organisations. Thus, it is worthwhile to examine the results of the combination of both mechanisms. Exit alone only conveys the information that something is wrong but not what is wrong. That is the reason that quality systems, which were originally developed in the market sector, emphasize client or customer surveys.

The introduction of free consumer choice of sickness fund has been a major part of social health insurance reforms in the Netherlands. Their main purpose has been to increase the efficiency in the provision of services by giving market actors such as consumers, sickness funds and providers more instruments and incentives to compete. Consumers can exercise their option to use exit by switching to another sickness fund on a regular annual basis or when their sickness fund is increasing its flat-rate contribution.

So far, the overall success of these reforms has been limited. This is mostly due to strong government regulation of prices and capacities as well as to a strong tradition of cooperation in the Dutch health care system. Accordingly, incentives for consumers to exercise their right to use exit are rather small. Price differences between sickness funds are still small – at least in absolute terms. Moreover, since sickness funds still are reluctant or restricted in their possibilities to contract selectively, consumers do not perceive quality differences in the provision of services between sickness funds – which might be another important reason to switch. There may be a vicious circle at work, where sickness funds do not contract selectively because the limited use of the exit option hardly triggers competition between them, and consumers hardly switch to other sickness funds because they see no differences.

Members of Dutch sickness funds can use voice by becoming member of councils of the insured. The costs of this option are much higher than the costs of exit. The situation would be different if they also could use voice by voting on one of a number of competing candidates for a seat in a council of insured. However, a large majority of the rank-and-file insured have no knowledge about their right of formal representation, let alone that there is something to choose. New members of these councils in fact are mostly nominated by existing members of councils or by the directors of sickness funds. The

topics that the members of these councils and rank-and-file insured are most interested in are discussed at council meetings. However, the councils have no formal right to decide on these topics.

According to Hirschmann, the combination of exit and voice is desirable in order to establish an efficient mechanism to signal to management that something is wrong (Hirschmann 1970). However, thus far consumers have not perceived any benefit in exercising their right to exit. Moreover, most members of sickness funds are not even aware of their right to use voice. The introduction of exit did not strengthen the voice option and current policy ideas tend towards a much weaker representation of insured in the governance of public insurance organizations, as recently proposed by a committee to advise on 'good governance' in health insurance (Glasz 2002). Obviously, both mechanisms need major adjustments in order to work efficiently.

The exit mechanism will probably work most efficiently when consumers have sufficient incentives to switch sickness funds. Experience from German social health insurance shows that consumers are inclined to switch if contributions to sickness funds differ significantly. However, this experience also shows that there needs to be an effective mechanism for risk adjustment in order to avoid risk selection of sickness funds.

The voice mechanism will probably work more efficiently when members are better informed about their right of formal representation. Moreover, members of councils will enjoy a much a higher degree of legitimacy when they are elected by the rank-and-file insured. Another way to 'modernise' voice would be to have a (chosen) commissioner (not necessarily a member) in the governing board of insurance funds and the obligation for the insurance funds to organize yearly surveys of their members, with the chosen commissioner having the special task to see to it that the results of the member surveys are translated into policy.

Government could also design and implement a set of quality criteria for public health insurance organisations, based at least in part on surveys among the insured, and have these published internally and externally. Exit and voice would then be organized on a different level, but it would steer public insurance organisations away from only looking at premiums, as is the danger now.

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