Exit, Choice – and what about Voice?

Public Involvement in Health Insurance Funds in Corporatist Welfare States


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Abstract

The corporatist welfare states have been put under pressure by growing financial constraints since the 1970s. The new challenges led to reforms which also concern the governance arrangements of the systems. Linking public administration and social policy research, the article sheds light on the transformations of welfare governance in the three corporatist welfare states Germany, France and the Netherlands. The article concentrates on stakeholder participation via boards in the era of the post-golden age. The findings are assessed using an analytical framework based on the trichotomy exit, choice, and voice, which is a further development of the work of Albert O. Hirschman (1970). The article shows that the management of health insurance funds has been considerably professionalised. In contrast, the dimension of public involvement has been neglected in the reforms – especially in Germany and France.

1 Introduction

Improving public sector efficiency was one of the key goals of public sector reforms in the last two decades and still is today. In this context, agencification and autonomisation as a means of modernising public administration played an important role. The creation of autonomous bodies should set the stage for a more flexible and efficient delivery of public services, but led to new problems at the same time: How could the responsiveness of the autonomous administrative bodies to the insured be assured?

The introduction of stakeholder participation via boards is considered one potential strategy to reconcile efficiency and participation in the governance of public institutions and seen as a possibility to counterbalance the autonomy of the professional management (Wilks 2007; Cornforth 2005). Their principal function is, in terms of the theory of Albert O. Hirschman, ‘voice’, i.e. interest articulation in order to alert the management to shortcomings or to make managerial action more responsive to the stakeholders’ needs and demands (Hirschman 1970: 30 et seq.).

Taking a look at continental Europe, however, allows us to see that the idea of stakeholder boards is not entirely new: Countries classified as ‘conservative’ (Esping-Andersen 1990) or ‘corporatist health care states’ (Moran 2000) in comparative welfare-state research have implemented such an organisational arrangement since the very beginning of social policy.
From the perspective of public administration theory, the so-called self-administration model has the potential to reconcile autonomy and accountability through public involvement. Nevertheless, self-administration is highly disputed. Critics see functional as well as democratic deficits. The article aims to immerse in these questions by linking the academic discussions in public administration and social policy research. Recent reforms on the governance level of sickness funds will be analysed here with regard to changing ideas of public involvement. Chapters 2 and 3 describe the analytical framework and introduce ‘voice’, ‘exit’, and ‘choice’ as three different modes of public involvement with self-administration relying mainly on ‘voice’. Chapter 4 examines the challenges to this administration model in the era of the post-golden age. Chapter 5 presents the results of three case studies, analysing the variation between the cases as well as over time. It shows how three corporatist welfare states try to tackle the existing problems especially with respect to their governance arrangements. Our concluding remarks in chapter 6 assess the findings from the perspective of participatory public governance.

2 ‘Voice’, ‘Exit’ and ‘Choice’ as Different Modes of Public Involvement in Welfare Administration

The classifications of different types or regimes of welfare states have been further developed since the early works of Esping-Andersen (1990) and adapted to the domain of healthcare (cf. Moran 2000). They refer to various dimensions: To funding as well as to the organisation of healthcare provision, the stance towards (new) technology, and to governance (for an informative overview see Wendt/Frisinia/Rothgang 2009).

This paper focuses on what is classified in the comparative literature as ‘conservative welfare states’ (Esping-Andersen 1990), ‘corporate-governed’ (Giaimo/Manow 1999) or ‘corporatist healthcare states’ (Moran 2000). One of the main features of this type of healthcare states is its ‘social-based’ mode of governance (Wendt/Frisina/Rothgang 2008). The state is “insignificant as a third-party payer and is relegated to the role of provider of a regulatory framework (...)” (Moran 2000: 152). The state decides who is regulating the healthcare system, but delegates a considerable part of responsibility to societal, non-governmental actors.

While the major part of the literature discussing the governance of healthcare systems is interested in the interplay between the state, market and networks, and, in doing so, focussing on the macro level of healthcare systems, this paper takes its point of departure with the insured of social insurances and deals with participation in healthcare systems.

How can we conceptualise public involvement in sickness funds? Taking the beneficiary’s perspective, the approach of ‘choice’ and ‘exit’ – which has entered mainly the Anglo-Saxon literature recently – seems fruitful (Clarke/Newmann/Westmarland 2007; LeGrand 2007). The discussion seizes on Albert O. Hirschman’s (1970) concept of ‘exit’ and ‘voice’, which is based on the assumption that a client can be regarded as the ultimate resource of control for organisational performance. Exit and voice can be considered as two basic options for consumers to show their dissatisfaction with the quality of products: They can either exit, i.e. choose a product from another producer, or they can use voice, which attempts to repair or improve the relationship through means of communication, initiated by a complaint or proposal for change. The term ‘producer’ can be understood in a broad sense, and easily be applied to any provider of services (e.g. insurances, hospitals etc.).

Whereas exit can be described as an economic option, voice is, following Hirschman, “political action par excellence” (Hirschman 1970: 16). Voice has been considered the more important in cases of large organizations, insufficient or absent competition, since the option of exit is too costly or not available (cf. Young, 1974: 56). Another assumption is that voice is exercised espe-
cially in cases where people believe that the shortcomings experienced are of a rather coincidental nature and that their organisation could do better (Hirschman 1970: 38). Voice can be expressed in manifold ways; it may constitute a complaint with the aim to individually gain an advantage, but it may also be an act to achieve better quality for the collective consumership (Dowding 2000: 473; Young 1974: 50; Barry 1974: 92-93).

Compared to Hirschman’s original concept, the newer Anglo-Saxon welfare-state literature uses slightly different terms: Here the term ‘choice’ is used interchangeably with ‘exit’ (e.g. LeGrand 2006: 698). The UK being a national healthcare system, there are no options of exit with regard to the NHS as a whole, whilst the possibility to choose between providers was introduced in the 1970s for GPs and in the 1990s for hospitals. Since then, the term of ‘choice’ with its reference to market-like interactions draw a lot of attention in the UK.

In corporatist healthcare states, by way of contrast, choice with regard to service provision is nothing new, as patients have been able – to different extents over time – to choose and change their doctors since the very beginning of the public health insurance system. In corporatist healthcare states with their insurance system, their purchaser-provider-split and their semi-autonomous institutions the relationship between the insured, the purchasers and providers is very fragmented compared to NHS-Systems and requires close examination. This is especially true as over the last years the insured in several corporatist healthcare states have obtained the right to decide about what insurance they want to be member of and the right to change. Moreover, the choice between different policies of the same insurance is an option gaining increasing importance in corporatist healthcare states.

As this paper is mainly interested in the relationship between health insurance funds and the insured (and not in the relationship between patient and provider), the term ‘exit’ is in the following used to describe the possibility to change one’s sickness fund (Greß/Rothgang 2008). The term ‘choice’, which is not coined by Hirschman himself, is used to increase the analytical distinctiveness of the concept. It is applied to describe the possibility to select between different tariffs of a certain insurance.

Modes of public involvement in health insurance administration in corporatist welfare states

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<tr>
<th>Modes of involvement</th>
<th>Scope of action of the insured</th>
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<tr>
<td>Choice (+)</td>
<td>Possibility to select between different tariffs of a certain insurance</td>
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<tr>
<td>Exit (+)</td>
<td>Right to decide about what insurance the insured want to be member of</td>
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<tr>
<td>Individual Voice (+)</td>
<td>Individual and direct voice, expressed via customer surveys or the establishment and monitoring of consumer friendly service standards</td>
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<tr>
<td>Collective Voice (+)</td>
<td>Collective and representative voice, expressed via boards consisting of the stakeholders of the organisations</td>
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The three described mechanisms of involvement might be combined with each other. The conceivable range stretches from countries relying on a single mechanism (exit, but no choice, choice without exit etc.) to healthcare systems which incorporate all possible mechanisms (collective voice is completed with individual voice, whilst the beneficiaries can exit their sickness fund and choose a certain policy within this fund). All three mechanisms of involvement can be
found in corporatist healthcare states. This, however, has not always been the case, as the following chapters show.

3 Self-Administration as a Mechanism of ‘Voice’

Given these differentiations, self-administration can analytically be classified as a participative administration model based mainly on the mechanism of collective ‘voice’. Directly involved in the organisational decision making process, the insured can for instance shape the coverage and quality of the services provided via the boards of the funds.

Health insurance funds are (semi-)autonomous bodies with their own legal form, they have their own scope of action with corresponding responsibilities. Nevertheless, statutory sickness funds are under the regulatory supervision of the respective ministry. In contrast to the control of other administrative units, though, the supervision of the ministry concentrates basically on the legality of the actions and the statutes. Boards consisting of stakeholders are the alternative place of accountability compensating for the low degree of ministerial control, and acting as a countervailing power to the executive boards.

With regard to collective voice, the composition of the board, the mode of selection and the competences of the board members are decisive: Who has the right to select whom as representatives and which mechanism is applied hereto? In the context of public institutions three different modes are known: Election, appointment, and delegation (Klenk 2008: 35, see also Braun et al. 2008).

Different aspects of collective voice

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<th>Feature of the board</th>
<th>Possible characteristics</th>
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<td>Composition of the board</td>
<td>Direct participation of insured</td>
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<td>Pre-defined associations representing the interests of the insured</td>
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<td>Mode of selection of the board members</td>
<td>Election, appointment, or delegation</td>
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<td>Competences of the board members</td>
<td>Advisary boards with counselling rights, governing boards with</td>
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<td>encompassing decision rights, or controlling supervisory boards</td>
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In the case of statutory sickness funds, the right to participate in the administration of the insurance funds is most often devolved to the social partners, constituting a corporatist management of autonomous bodies (Ebbinghaus 2006; Süllow 1982). The members of the board of representatives are either elected by the insured or delegated by the social partners. The role of the board of representatives and their competences vary over time and among different countries. Options range from mere advisory boards to governing boards controlling the actions of the executive boards. In addition, there are heavily varying opinions on what their main role actually can and should be, ranging from giving advice to managing.

4 Shortcomings of the Self-administration Model

Self-administration has been a core feature of the corporatist welfare state since its very beginning, but it is nevertheless contested. The weaknesses of this organisational arrangement concern mainly three aspects:
a) **Whose interests are represented?**

The results of empirical research show that the relationship between the actors of self-administration and those being represented is only weak (see the case studies below and Braun et al. 2007). The reasons for this are manifold: First, a general loss of confidence in corporatism can be observed. In most corporatist welfare states a serious decline of membership figures can be recognised over the last two decades (Ebbinghaus 2002). Social-structural changes, the process of deindustrialisation as well as the process of pluralisation or individualisation are multifactorial causes which have led to a weakening of ‘old’ forms of corporate interest representation.

Second, this process of pluralisation has led to the emergence of new groups and associations who are now claiming participative rights in welfare administration (Trampusch 2006).

Third, the corporatist design of the governance of sickness funds has been challenged by the increased coverage rate of statutory sickness funds, the conversion from an originally strictly work-related protection to a scheme including all citizens.

Due to these reasons it can be doubted whether the corporatist design of the self-administration model still is an adequate and effective way to organise public involvement today. Can the board, though representing only a small part of stakeholders, be regarded as an alternative place of accountability?

b) **Individual Action Instead of Collective Voice?**

Moreover, the individual insured and his/her individual action is gaining in importance. In fact, the insured are increasingly considered and treated as consumers. They are given new rights of exit and choice and are addressed by new customer-oriented instruments, e.g. costumer surveys and service standards. Nonetheless, it is not clear yet how these three mechanisms interact and what will be the effect on existing modes of involvement. In the long term, these changes might result in a decline of the importance of collective voice and make the boards dispensable as instruments of public involvement in sickness funds.

c) **Who Governs the Funds? Tensions Between Board and Management**

In the self-administration model, the board with its lay members is formally the highest administrative organ, since the contribution payers are considered the ‘owners’ of the funds. While the management is responsible for the everyday administration, it is the task of the board to define the strategy. However, it might be easier for the board members to decide about questions of everyday business (and therefore to intervene in the competences of the management) than to make strategic contributions (Cornforth 2005). Shortcomings also emerge as the core tasks of the board of representatives require a detailed knowledge of the organisational workflow and close involvement in the organisation, which, however, is hard to acquire due to their part-time and lay status.

Consequently, the board is only to a certain extent capable of exerting influence on the decision making processes and to control the management in an effective way, thus it fails when it comes to the representation of stakeholders’ interests and to effective internal control. The professional management can act more or less independently from the board. Boards in insurance funds are – at the present time - neither an alternative place for accountability, nor do they avoid mere managerialism.
5 The Case Studies: The Current Stage and Emerging Developments of Self-Administration in Health Insurance Funds

How the corporatist welfare states try to tackle the tensions and paradoxes of the self-administration model is discussed in the following sub-chapters.¹

5.1 The German Case

In the German welfare state, the governance of social insurance funds is, beside wage agreements, one sphere of activity within industrial relations. Public involvement in sickness funds has therefore a strong corporatist bias: The CEOs of the funds are appointed by a board, one half of which comprises representatives of the employers and one half of the insured. In line with the idea of ‘social partnership’, which shapes industrial relations in Germany, the insured and the employers – as a general rule – shoulder equal contribution shares. Competitive elections can be replaced by so-called ‘Friedenswahlen’ (non-competitive elections), if the associations of the insured and the employers agree about the composition of the board.

The self-administration model is highly contested due to the unsatisfying performance of the board with regard to its two main tasks, i.e. representing the interests of the insured and controlling the management of the organisations. These problems have been critically discussed throughout the post-war history of self-administration in Germany (Bogs/Ferber 1977). It was, however, not before the transition to the post-golden age of welfare state policy that the governance of sickness funds was put under scrutiny and structural reforms were implemented.

5.1.1 Introducing Competition by Means of Exit and Choice

The so-called ‘Gesundheitsstrukturgesetz’ (GSG, 1993) represents a significant step in German health policy as it departs from the previous strategy of ‘corporatisation’, i.e. to sustain and strengthen the corporatist self-administration system (Döhler/Manow-Borgwardt 1992). In search of more efficiency and pessimistic with regard to the disposition of the actors engaged in self-administration to contribute to cost containment competition was introduced by giving the insured the option of ‘exit’. Previously, the occupation of a person had determined the membership in one of the sickness funds. As the scope of services is essentially fixed by law, the contribution rate was – besides service quality – the main parameter for competition. The ensuing reform laws, however, pushed forward the transformation of sickness funds into competing market players by giving them more discretionary power with regard to both the service providers and the insured. From the perspective of the insured this means an increase of individual choice. The ‘Health Modernisation Act’ (‘Gesundheitsmodernisierungsgesetz’, GMG, 2004)

¹ The case studies presented in this paper are three out of eight of a larger research project. The project conducts a systematic comparison with regard to the development of self-administration of three insurance-branches (old age, sickness and unemployment) in conservative welfare states. Apart from Germany seven additional European countries, which employ – or at least once employed – self-administration as an instrument of participation are included in the study (Austria, Belgium, the Czech Republic, France, Hungary, Luxemburg, the Netherlands). The methodical approach of the case studies in these eight countries is based on qualitative tools involving policy analysis, expert interviews and secondary as well as documentary analyses. The interviews for the three case studies presented were conducted in 2008.
allowed sickness funds to contract selectively with service providers and gave them at the same time the possibility to offer multi-optional tariffs to their insured.

5.1.2 The Board and the Management as Countervailing Powers?

The introduction of competition in the health insurance system came along with reforms of the internal governance structure of the sickness funds. To ensure that funds are able to compete like private companies, their internal governance structures should likewise be adapted to those of private companies: The executive board was therefore professionalised and strengthened by enhancing its autonomy from the board. Together with the professionalisation of the CEOs of the funds, the number of lay members of the board was reduced, and their main tasks – controlling and advising the executive board – were specified (Felix 2001). The idea was to organise the internal governance of funds as a countervailing system of managers and stakeholders. This idea, however, failed. Although the necessity of clear competences and further training for the lay members of the board has been considerably stressed in reform discussions, there have so far been no serious efforts to improve the working conditions of the lay board members. The actors of self-administration self-critically admit that participation requires special qualifications: “The associations involved in self-administration offer trainings – but there are neither enough courses for all board members nor are they mandatory”, explains one of the interviewees (see also Paquet 2006). With the executive board becoming increasingly professionalised, the maladjustment between management and board grew: The lay members of the board are in most cases not able to exert effective control.

5.1.3 And Voice?

Board failure is not only clearly recognisable with regard to the interplay between the management and board of representatives. Moreover, empirical research has shown that there is no effective linkage between the insured and the representatives of the insured on the boards. In most cases the insured know nothing or only little about their representatives on the boards; often the insured are not even aware that the possibility to participate in the administration of sickness funds exists. Finally, the greater part of those interviewees with some knowledge of the self-administration model is not satisfied with the outcome of the boards (Braun et al. 2007). One reason for the ‘distance’ between representatives on the boards and those being represented by them might be that the social elections are abandoned in most cases. The insured have therefore no influence on who is representing their interests. For traditional actors of self-administration, however, the option of ‘Friedenswahlen’ provides the advantage of safeguarding their monopoly of power. The dominance of organised interests in self-administration and the necessity of adjustments to the modes of appointment have been discussed a lot in public media as well as in academic research (see most recently Braun/Klenk/Kluth/Nullmeier/Welti 2008). Moreover, to increase the responsiveness of self-administration an opening of the self-administration model towards new actors, for instance self-help groups, has been proposed (cf. ibid.). The traditional actors of social self-administration, however, are defeating reforms arguing, firstly, that ‘Friedenswahlen’ were an effective mode for selecting board members and, secondly, that an opening towards new actors fostered the political machine: “Self-help groups have only the interests of a part of the solidarity community in mind. The labour unions, however, represent the whole community of insured”, the interviewees state (not taking the argument of only partial representation due to a decline in union membership figures seriously). As the responsible ministry avoids severe conflicts with social partners in this field, no reform measures were undertaken up to the present day.
5.1.4 Sickness Funds between Competition and Solidarity

Various conclusions may be drawn from this assessment of the impacts of governance reforms in German health insurance funds. To be sure, the professionalisation and managerialisation of sickness funds has had positive impacts with respect to customer satisfaction and service quality. However, only a fraction of the insured can benefit from these organisational changes of public insurance funds: Those able to behave like responsible market participants, i.e. people who are able to choose between health insurance funds, to assess the various tariffs, and to make use of their right of complaint. Elderly, needy and handicapped persons, however, did not benefit from these developments to the same extent (Gerlinger et al. 2007). The impact of both marketisation and managerialisation was a functional organisational change of health insurance funds: They developed from ‘payers to players’ (Bode 2002), which in their self-conception no longer ‘administer sickness’, but ‘organise health’ (Marstedt 1998: 196) and orientate their corporate strategy towards an improved market position.

5.2 The French Case

5.2.1 No Exit, no Choice – and What About Voice?

The French social security system constitutes a mixture of Beveridgan and Bismarckian elements. Despite its initial claim of universality, the system created in 1945 reproduces main characteristics of the Bismarckian welfare state: Most benefits are earnings-related, funding is traditionally provided by social contributions, and the system is administered by semi-autonomous funds. Health coverage is divided into a basic, compulsory sector that pays for the major part of health services, and a complementary sector administered by mutual insurance associations (Hollmann/Schulz-Weidner 1997: 278). Options of ‘exit’ and ‘choice’ are non-existent in the compulsory sector, they only exist in the domain of complementary coverage.

The social security system was considered one of the main achievements of the forces of the Résistance after the end of the Second World War. The active participation of these forces in the administration of the new system was therefore an important demand (Catrice-Lorey 2000: 11), the social partners, and especially the labour unions, being considered as the legitimate collective and corporatist ‘voice’ of the insured.

The French sickness funds have traditionally a board of representatives (conseil d’administration) and an executive director originally elected by and responsible to the board. In contrast to the German case, where contributions and representational rights were linked, the composition of the French self-administration boards was characterised by a disequilibrium between employer and worker representatives to the advantage of the labour unions (Catrice-Lorey 1997: 86). Even if ‘voice’ was seen as an important mechanism, its organisation was contested from the very beginning. Modes of appointment changed several times throughout history. The members of the boards are nowadays delegated by the trade unions as the last social elections took place in 1983.

The National Sickness Fund of Employees (CNAMTS) has a public legal form, whereas the subordinated local funds are private organisations. The funds have managerial autonomy, with regard, for example, to negotiations with care providers, especially in the ambulatory sector, whilst the hospital sector is mainly regulated by the state.
5.2.2  In Search for a New Governance Model – Reforming the French Health Administration

During the ‘Post-Golden Age’, the strong increase of deficits made efficiency in administration an important reform issue on the French political agenda.

The French Government introduced two main health insurance reforms in 1996 and in 2004, which were marked by the search for a new model of governance. Discussions concerned mainly the scope of autonomy given to the funds, respectively the role of the state, whereas questions of public involvement were virtually absent from the reform agenda.

a) Limiting autonomy: Towards a state-centered model of self-administration

“In the sector of health insurance, (…) the state has always delegated power with an elastic band.” (A former lay-member of the CNAMTS).

The scope of autonomy given to the funds has been highly debated in the context of increasing deficits of the social security system since the 1970s. In 1996 the Juppé Government tried to resolve the problems of cost-containment by limiting the financial autonomy of the funds. Since then, the parliament determines the objectives of national health expenditure (ONDAM) once a year in the social security bill (PLFSS). After this financial bill has been passed by parliament, the funds negotiate and sign a special convention (COG) with the state, fixing management goals within the given health budget.

Another innovation strengthening the state’s influence comprises the introduction of a new supervisory board for the National Sickness Fund including representatives of the state, mainly members of parliament. It controls compliance with the national health expenditure objectives (Hassenteufel 1997: 182).

In 2004, the rising social-security deficit led to a new reform-attempt, marked by the intention of centralising the health insurance sector and its governance structure. For this purpose, a new umbrella organisation (UNCAM) was created, unifying the health insurance schemes for salaried workers, the self-employed and for farmers. The general director of the National Sickness Fund became at the same time the general director of this new umbrella organisation. This federation obtained the competencies to negotiate and sign the conventions with care providers, within the objectives fixed by the convention with the state.

The reform clearly cut back participation in the healthcare system. Indeed, nowadays the state not only decides on financial issues but also appoints quasi unilaterally the general director (cf. Bancarel 1996; Bras 2004: 969), who has been given the main and quasi unique administrative power. In the new centralised and hierarchised system the social partners have lost a great deal of influence: “Nowadays and especially since 2004, we can nearly call it a state-administration” (Lay-Member, CNAMTS).

b) Representing the interest of those concerned?

A second trend questioned the traditional mode of corporatist participation. In order to reduce the deficits, the French Government levied a special social security tax that since 1991 has to be paid on all incomes. The extension of health insurance coverage to the whole French population (Palier 2005: 289) in 1999 was a big step towards universalism and challenged the quasi-monopoly of representation of the corporatist actors on the boards of representatives. The legitimacy of the labour unions was furthermore diluted by the immense decline in their membership figures since the 1980s (Chapman et al. 1998: 18), which contributed to the growing tensions between the different labour unions within the boards. Critics diagnosed an internal
blockade resulting in a striking incapacity to contain deficits. “They are in a permanent logic of competition and objection and not of negotiation or administration.” (Lay-member, CNAMTS)

Nevertheless, when it came to discussions concerning the composition of the boards or the widening of the options of public involvement, the solutions were and still are highly disputed.

“I think that the role of the social partners has to be reformed. The representatives on the boards have to become the real advocates of the users and the clients of the system.” (President of a sickness fund)

“I am strictly against the opening of the boards to other forms of representation. The system has to be administered in the aim of the general interest. The social partners remain the only legitimated and responsible administrators.” (Former President of a sickness fund)

c) Internal Organisational Reform: Hierarchisation and professionalisation of the management

Without deeply changing the composition of the boards, the reform in 2004 weakened the traditional corporatist mode of ‘voice’, transforming the boards of representatives (conseils d’administration) into simple advisory boards (‘conseils’). Power shifted from the boards to the director of the funds. Today the boards of representatives only have a limited right of objection to the nomination and limited capacities of control.

The strengthened role of the director can be considered as the realisation of the idea of a more qualified and professional management. Observers qualify this phenomenon as the emergence of a new technocratic welfare elite (Hassenteufel/Palier 2005: 16; Bras 2005: 77), which is, on the one hand, obliged to the government, but has, on the other hand, a strong autonomy of decision-making.

“The social partners have no capacity of action in front of a general director who symbolises a direct influence of the public powers, as he is not even responsible to the board of representatives” (Lay-Member, CNAMTS)

“(…)The former administrative board is nowadays called only “council”. It doesn’t administer anything.” (Former lay-member, CNAMTS)

5.2.3 From Restricted Voice to a State-Centred Form of Welfare Administration

As seen above, the French self-administration model has experienced some profound transformations during the last decade. The social partners lost a great deal of influence within the boards. However, contrary to the cases of Germany and the Netherlands, the traditional mode of self-administration has not been weakened by the introduction of options of ‘choice’ or ‘exit’. It is much more the universalisation of access to healthcare and the decline of corporatism which led to changes with regard to public involvement and the way ‘voice’ has been organised. Changing the competencies of the boards without reforming their composition and leaving the former entities in place by adding new ones, the French government tried to resolve the problem of cost-containment thereby avoiding conflicts about competencies or participation.

The mechanism of ‘voice’ even if weakened remains the corporatist one. Indeed, patients’ associations still play a marginal role in the French health sector. The development of the French governance model in the Health insurance sector went from restricted self-administration via controlled managerialism to technocratic regulation of the health insurance sector. The main question is whether the new ‘elite of the welfare state’ (Hassenteufel 2001) will be able to resolve the growing financial problem of the French health insurance sector and to be at the same time responsive to the insured.
5.3 The Netherlands – Self-administration in a Privatised Health Insurance System

Mainly modelled after German law, “Sickness Fund Decree” of 1941 was the first mandatory healthcare insurance in the Netherlands. The implemented self-administration, however, drew on experiences of public involvement made in the days of voluntary health insurances. Compared to Germany and France there are several differences: One of the most important is that social partners nowadays are only one actor amongst many others in the Netherlands. As a rule, insurances have increasingly chosen to keep out social partners as well as lobby groups over time. They are regarded to rather strive for their own best, whereas the common good of all insured is claimed to be overlooked: “You are sitting here on your own account. We do not work together with interest groups, because the insurer is for all, all people”, as a lay-member of the self-administration put it.

5.3.1 Voice gets Company by Exit

Whereas the solution in the 1970s and 1980s had been to restrict the competences of sickness funds, market elements were introduced from the beginning of the 1990s on (Companje 2008). In order to make the system more efficient, sickness funds responsible for certain regions, occupations, or employers were abolished in 1992 (Roebroek/Hertogh 1998). A quasi-market between the statutory sickness funds was introduced (Lieverdink 2001: 1190), which mainly competes on the basis of flat-rate contributions. With regard to public involvement this mainly brought along two relevant changes: Citizens obtained the right to select ‘their’ sickness fund and the internal governance structure of funds were reformed. Until then, self-administration consisted of lay-members of the funds, which composed the executive committee led by the director and vice-director. From 1992 onwards, a professional executive board was introduced, while the lay-members got a sitting on the 'Members' Board” (Ledenraad), the board of representatives. Officially still the highest organ in the organisation, reality looks different, though, as one interviewee summarized: “Thus, in principle, we are the highest organ, but in reality you give away something of the governance. If the executive board comes along with a good proposal, we all only say: Great!” – “Thus, we can exert less influence today.” As in Germany and France, the professionalisation of the executive part of the insurance was not accompanied by a likewise development with regard to the lay-members.

5.3.2 Voice, Exit and Choice in a Privatised Healthcare System

The introduction of the quasi-market was based on a report by the Dekker commission (Commissie Structuur en Financiering Gezondheidszorg 1987). Competition between sickness funds – in order to effect lower costs – being the first step in a row; the process has for now ended with a twofold development: All health insurances were privatised in 2006. At the same time

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2 The Dutch healthcare system rests on three pillars: The ‘Exceptional Medical Expenses Act’ (AWBZ) covers costly and lengthy treatments and care. The second compartment is regulated in the ‘Health Insurance Act’ (ZVW) and mandatory for all citizens. The third pillar, voluntary, supplementary insurance-policies, can cover a variety of services not included in the ‘Base-Package’ of the compulsory health insurance. This paper will deal solely with the second pillar of the system.
the legislation of the 1990s was intended to ensure quality and give patients an extended voice in everyday matters on the level of service provision in order to counterbalance market forces. Though the regulation is piecemeal and has been consecutively reduced, the term “privatisation” should not belie the fact that the Dutch healthcare system is nearly as heavily regulated as e.g. Germany.

Exit from the early 1990s was strengthened by the privatisation when choice was introduced as another instrument of involvement. Health insurances are entitled to selective contracting with service providers and may differentiate their polices to some extent. Seen from the perspective of a responsive insurance, which employs customer surveys, service-lines, etc., it is all about ‘having knowledge about the customer’ and not about a ‘say of insured’ as one representative of an insurance put it.

This is in line with the philosophy intended by politicians: Market is the solution for under-funding, and collective representation of interests is only meaningful on the national policy or service provision level. Hence, the former minister of health concluded: “I would say 80% of the concerns of the insured is connected to the freedom of choice and the competition between insurers. The car driver is absolutely not interested in being able to influence the management of Volkswagen through a consumers’ board whatsoever, as long as she is able to change to Toyota in case Volkswagen ceases to produce good cars. Oh, the Members’ Boards and all that… These are very tiny groups of people. An insurer quickly has two million beneficiaries. Nobody knows who is sitting on the Members’ Board. I do not know how they get in there, either. There are no elections and nothing. I do not have a clue. Thus: What does that represent now?”

In contrast to this rather negative view on collective voice, the new ‘Health Insurance Act’ claims, as did the former ‘Compulsory Sickness Funds Act’, that insurances have to “make guarantees about an appropriate extent of influence for the insured” (ZVW article 28). More detailed rules are left to the statutes of the respective insurance company. Most health insurances continue therefore to have the instrument of a Members’ Board, since the reform insurances are free to choose their legal form as a public corporation or private, entrepreneurial company. It is therefore conceivable that forms of participation and influence might be subject to greater change in the future; but for the time being the following picture applies: For those insurers organised as a ‘friendly society’ the board is formally the highest governing body with a range of competences, since the company is ‘owned’ by its members. The members of the board of representatives are selected in a variety of ways, be it volunteering or advertising for volunteers, who then are most often elected by the Members’ Board.

The majority of those insurances which remained or those sickness funds which resolved to change their legal form to become limited companies have chosen to institutionalise, respectively to keep the Members’ Boards, though their competences often were cut and they formally no longer constitute the highest executive body. A few have chosen to abolish this instrument of participation altogether and to establish ‘Advisory Boards’ or ‘Advice Platforms’, which may serve as communicational instruments, but hardly have the bindingness of Members’ Boards.

In times when many health insurers restructure their insurances to companies with a variety of social services, members want to actively participate, influence and decide what becomes of ‘their’ insurance. This has sometimes led to a different self-perception and a more critical view on the policy of the executive board among those sitting on the board (cf. Nederlandsche Zorgautoriteit 2007: 11). Some Members’ Boards seem to arrive at the conclusion that you can and should become active to overcome the subordinate role of the representatives. This is supported by one member: “The Members’ Board must have the right to say: O.K., we want to include this in the benefit catalogue. Others say: A Members’ Board does not need to bother itself with such things, but I think it should, since it is about access to healthcare! I do not know what we are, yet, but we are an essen-
tial part of the whole to make sure together with the executive board that we are on a good track. And I think that we have come a bit further.”

In sum, it can be concluded that the Netherlands went down a similar road as Germany until the mid 1990s. When it comes to marketisation and the introduction of measures associated with this development, the country was much more consequent in its implementation. Today, a broad variety of self-administration can be witnessed, with instances of boards with rather advisory functions, on the one hand, and instances of very active boards which challenge their management, on the other. In which direction the development is going to head remains to be seen; chances for a renaissance of public involvement, however, are comparatively good in the Netherlands.

6 What Comes beyond Public Involvement in a Corporatist Design?

With the end of the ‘Golden Age’ of the welfare state, the ideas of New Public Management have been discussed in most European countries as means of reforming welfare administration. As described above, the issues of autonomy and public involvement shaped the reform discussion also in corporatist welfare states, which can build on a long tradition of autonomous bodies steered by stakeholders. Changing ideas in social policy and in public administration have altered the organisational demands and provoked new pressures on the self-administration model. Even more, the challenges of the post-golden age have revealed organisational weaknesses of corporatist welfare governance.

Even though Germany, the Netherlands and France belong to the same healthcare regime and face similar problems nowadays, they found different answers to the question of how to deal with financial austerity and how to restructure their administrative arrangements.

These answers can be assessed with regard to our analytical framework.

First, in all countries mechanisms of collective voice have been weakened. The search for efficiency has resulted in a process of managerialisation concerning the internal organisational structures of the sickness funds with a striking similarity: The executive committees of the funds have been professionalized and the autonomy of the CEOs towards the board of representatives has been strengthened. The professionalisation of the management, however, was not accompanied by a concurrent professionalisation of the boards. This resulted in an imbalance between boards and CEOs, which is one of the reasons contributing to the loss of influence of the boards of representatives and their mechanism of collective voice. In the Netherlands, moreover, it depends on the goodwill of the insurances and the commitment of their members to what extent these rights can be used and are used by the boards.

Second, in order to ensure the responsiveness of statutory insurance funds towards their members, the Netherlands as well as Germany rely more on market solutions and on consumer participation and have introduced mechanisms of ‘choice’ and ‘exit’. In the French example in contrast, choice and exit exists only in the sector of complementary health insurance, yet not in the basic sector, in which coverage has been extended to the whole population.

Boards as a room for ‘voice’ nowadays play only a subordinate role. Rather than using the organisational advantage of the self-administration model, the role of boards has been diminished. Indeed, the process of reforms has come to a halt after reforms dealt with managerial issues. This applies particularly to Germany and France. With the reorganisation of self-administration, the first formal step was taken to adapt its structure to the new competitive situation in Germany. In France, the introduction of a professionalised and centralised management was meant to bring the ever-growing deficits to a halt. It may hold true that these
measures help to make decision-making more efficient, but in terms of accountability no answer is given to a range of severe problems, as long as questions about the legitimacy of self-administration, a widening of the circle of people to recruit from, and the relationship between management and self-administration boards remain unsolved.

Interestingly enough, the three countries have in common that the implemented reforms follow a path-dependent trajectory. In fact, all of the observed countries have maintained the core institutions of their original corporatist arrangement. Nonetheless, the reform strategies applied vary as to the mix of elements of voice, choice and exit and their combinations introduced. The ongoing governance reforms have rather resulted in growing divergence within the corporatist welfare states, a finding that requires explanation. Further research should be concerned with the question in which way changes in welfare governance might be connected with and depend on country-specific contextual and historical factors, as there are different traditions of administration as well as general institutional and societal conditions which could impact on the reform-paths (cf. Windhoff-Héritier 1988; van Waarden 1992). The future research on self-administration is to further explore the country-specific factors that seem to be decisive for the understanding of reform-paths of governance arrangements in corporatist welfare states.

The corporatist welfare states have, with their long tradition of self-administration, a trump card when searching for an institutional arrangement which allows for reconciling efficiency and participation. Nonetheless, the opportunity to reconcile managerial goals and public involvement in health insurance funds via strong boards being responsive to the members has been missed – at least until today. The step from a traditional self-administratoin to a managerialised self-administration has been completed. Will the next step help to overcome the managerial bias of the early reforms by strengthening accountability through public involvement?
Reference List


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