

Voice and Choice by Delegation

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Abstract In many Western countries, options for citizens to influence public services are increased to improve the quality of services and democratize decision making. Possibilities to influence are often cast into Albert Hirschman's taxonomy of exit (choice), voice, and loyalty. In this article we identify delegation as an important addition to this framework. Delegation gives individuals the chance to practice exit/choice or voice without all the hard work that is usually involved in these options. Empirical research shows that not many people use their individual options of exit and voice, which could lead to inequality between users and nonusers. We identify delegation as a possible solution to this problem, using Dutch health care as a case study to explore this option. Notwithstanding various advantages, we show that voice and choice by delegation also entail problems of inequality and representativeness.

Many Western countries offer citizens ever more options to shape public services. They can influence decisions about their own or their children's education, their municipality, their police force, and also their health care (Clarke et al. 2007). These options to influence public services are often cast into Hirschman's taxonomy of exit, voice, and loyalty (Collantes 2010; Dowding and John 2008; Dowding et al. 2000; Forster and Gabe 2008; Pickard, Sheaff, and Dowling 2006; Rodwin 2001; Stevens 1974; Young 1974). In this taxonomy, people have two options to influence decision-making exit and voice. According to Hirschman, voice and exit are incentives for states or organizations to improve the quality of their goods or services. Exit and voice opportunities not only help to make service delivery more attuned to individuals' preferences but also improve quality in

general. Partly inspired by neoliberalism, Western countries have used market-oriented reforms of the (semi-)public sector, which included more exit or choice options in health care, for this particular reason since the 1980s (Clarke et al. 2007; Morone 2000).¹ As a result, health providers were expected to become more responsive to health consumers' needs, which would make health care more efficient and cost effective. Individual choices would also best serve citizens' rights and interests.

Policies that stimulate voice and choice do not only have the instrumental aim of improving quality; they also have the intrinsic aim of democratizing decision making. Partly inspired by theorists of participative democracy, Western countries created more opportunities for voice in the public sector. According to these theorists, active citizen participation in public decision-making processes in public organizations of every kind has a number of beneficial effects: it can lead to better decisions based on extensive deliberation, improve the civic skills and virtues of citizens, and give citizens a say in decision making (Michels 2011: 279; Held 2006). Following this line of argument, governments in many countries have opened up a wide variety of opportunities for citizens to express their voice on topics such as local politics, environmental planning, genetic technology, transportation and infrastructure, and health care decision making (Michels 2011, 2012), in a process aptly characterized as democratization from above (Akkerman, Hajer, and Grin 2004).

The goals of increased quality and of democratization prove hard to meet with individual exit and voice, however. It is not only large-scale use of exit and voice options that would be problematic, as it could destabilize a state or organization, but also their limited use. Despite high expectations, empirical evidence from a variety of cases indicates that thus far not many people use their exit and voice options (Dowding and John 2009; Fotaki 2007; Pickard, Sheaff, and Dowling 2006; Tai-Seale 2004; Morone and Kilbreth 2003; Rodwin 2001; Baggott 1997; Lyons, Lowery, and DeHoog 1992). Moreover, people who can and do voice and exit may not resemble people who cannot and do not. As a result, states or organizations might change their service delivery to the will of active individuals only, thereby neglecting the preferences of the bulk of citizens or consumers. It is also likely that people who are able and willing to exit will receive better quality services than those who are left behind (Morone 2000). In addition, reliance on market mechanisms such as choice may undermine the focus

1. In health care, exit is often replaced in the analysis by the concept of choice, since patients are given different options among which to choose that do not necessarily require them to exit a certain organization or product. We discuss this further in the next section.

on the general interest of the entire democratic community, as has been argued in the US case (Grob and Schlesinger 2011). Market mechanisms call on people as consumers. Citizen-consumers therefore pursue their self-interests, largely maintaining existing inequalities in health conditions and health care among citizens. Voice options have been advocated to refocus on the public good in the US health care system (Grob and Schlesinger 2011). However, problems due to a limited uptake can be seen in the case of voice as well. Michels (2011) studied a large number of cases in a variety of countries to assess the effects of these new forms of participatory democracy. She concludes that the presumed beneficial effects do indeed occur (although not everywhere, and not always to the same extent) but that the beneficial effects do not reach beyond the citizens who participate. Hence as long as large groups of citizens do not participate, one can have doubts about the benefits to democracy as a whole.

This is where delegation enters the picture. In some political systems and policy sectors there is a third possibility beside exit/choice and voice. Individuals can delegate their exit and voice options to collectives that exercise voice and choice on their behalf. Without being active themselves, individuals can express their interests through these collective delegates. In this way inequalities raised by differentiated use of individual voice and choice may be overcome, while a certain measure of democratization is still achieved through representative arrangements outside the electoral arena. In this article we focus on delegation of exit and voice, discuss how it functions, and assess its advantages but also its disadvantages, since the principal-agent relationship can be rather complicated.

The Dutch health care system is an excellent case to study the mechanism of delegation. The Netherlands can be considered one of the front-runners in introducing a combination of voice and choice in health care. Within its system of regulated competition, patients have more opportunities to influence decision making through individual exit and voice options. In addition, Dutch citizens have many opportunities to delegate their voice and choice. The Dutch government has recognized that individual patients cannot perform all the activities themselves and has created opportunities to delegate to collectives — for instance, to insurers, trade unions, client councils, and patient organizations that participate and negotiate on their behalf. This may enable those who do not want to or cannot become active themselves to have their interests represented and lead to quality improvement as envisioned by Hirschman.

This article discusses to what extent voice and choice by delegation differs from individual voice and choice and makes a preliminary analy-

sis of whether delegation works better in terms of quality improvement and democratization in practice. In the first section, we elaborate on Hirschman's framework and work out how delegation may differ from individual voice and choice. In the second section we see how voice and choice in Dutch health care play out at the individual level. We continue in the third section with a description of the possibilities and experiences with delegated voice and choice. In the final section we discuss whether delegation constitutes a solution to the problems identified at the individual level.

Hirschman's Exit, Voice, and Loyalty

According to Hirschman (1970), people have different options to influence organizations or governments. First, when people are dissatisfied with a certain product or service they can leave (exit) and go to another provider. This will enable them to receive better services elsewhere and will be a signal to providers that they need to improve their service. Exit expects people to behave as critical consumers in the market. In addition to this economic mechanism, people can also use the more political mechanism of voice. They can voice their dissatisfaction, for instance by filing complaints, writing letters, and consulting decision makers. Voice is therefore another way to show discontent to providers. While exit is a relatively straightforward concept, voice is a far messier one. It includes all attempts to change rather than escape from a certain situation. Compared with exit, voice has the advantage of offering information about why people are not satisfied. Loyalty, the third key concept of the framework, influences the use of the other two options. Hirschman argues that loyalty to an organization may lead to the use of voice rather than exit. It can also explain why people remain passive. Loyalty differs from exit and voice, since it is not an active mechanism but a psychological factor that affects decisions on whether and how to become active.

Hirschman's framework is applied often and has been amended in different ways (Dowding et al. 2000; Vollaard 2009), and so has broadened as a result. One amendment was the introduction of the concept of choice to broaden the concept of exit. Choice includes the selection of something. In health care this can be the choice of a treatment or health care provider, "from scratch," without precedence of dissatisfaction. Although choice is a broader concept than exit, it also stems from an economic expectation that it will improve the quality of services through a market-based mechanism. Like exit, critical choice would send a message to providers and give

consumers more control. The concept shows that this behavior does not stem from dissatisfaction alone. The same can be said for voice. People can and are often asked to express their opinion when they themselves are not dissatisfied. This has been identified as an important modification and broadening of Hirschman's framework (Dowding et al. 2000).

Policy makers in many Western countries have adopted these ideas of exit/choice and voice in a variety of policies and have increased opportunities to use them. They see them as an important steering mechanism of public services. The expectations of this type of policy are twofold. First, following the Hirschman framework, it is expected to lead to quality improvements in services rendered. Second, it gives people a way to influence public services as well as a chance to make important decisions concerning their lives, and it raises people to become active responsible citizens, which is valued from a democratic perspective (Sørensen 1997; Held 2006). A combination of exit and voice opportunities may be necessary to reach the goals of quality improvement and democratic empowerment of citizens (Hirschman 1970; Sørensen 1997). While exit alone may undermine general solidarity, particularly when middle classes would escape the public system (Morone 2000), voice would be a necessary corrective, calling on people as citizens to defend the public good (Morone 2000; Grob and Schlesinger 2011).

Hirschman argues that both alert and inert consumers are necessary to give organizations time to respond and improve their services. Alert users could cause an improvement effect that all users might benefit from, whereas inert customers (passive consumers who do not exit or voice) give organizations some leeway to pause, reflect, and improve their services. It is also important that both exit and voice are used and that a balance is found between them. This balance is different for different types of organization. For instance, according to Hirschman, the British National Health Service would weaken if more vocal users opted for private health care providers (Hirschman 1974). The input of voice in health care is necessary for quality improvement to take effect. The fact that more vocal users might be the ones to opt for the private sector in health care means it is likely that there are differences between people who will and can use certain options of exit/choice and voice. This raises the question of whether their activities would lead to improvements for all. Critical and vocal health users may face different health issues than less active health users. Indeed, in his later work Hirschman acknowledged that ideas about satisfactory performance differ among users. Improvement based on the actions of some users may therefore not be an improvement for all.

Hirschman claims it is possible that the changes achieved through voice are primarily in the interest of the “articulate few” (Hirschman 1981). An important question, therefore, is which customers and citizens actually use the options of exit/choice and voice. As noted in the introduction, empirical research has shown that not many people use their opportunity for exit/choice and voice (Baggott 1997; Dowding and John 2009; Fotaki 2007; Pickard et al. 2006; Rodwin 2001). With policy makers’ increased focus on introducing exit/choice and voice options as a steering mechanism for public services, this has become a very relevant issue, as it poses the danger of increasing inequalities between the quality of services provided to different groups of citizens and being represented in decision making (Morone 2000; Glendinning 2008; Fotaki 2011; Grob and Schlesinger 2011).

Collective voice and choice may provide a partial solution to this problem of inequality, since the transaction costs to raise one’s voice or to choose become lower. By acting collectively, patients’ power in health decision making would be enhanced (Rodwin 2001). Although Hirschman mentions the possibility of collective voice, he does not systematically address the existence of different levels of voice and choice. Several authors argue that it is important to differentiate between individual and collective voice (and to a lesser extent between individual and collective exit) (Dowding and John 2008; Dowding et al. 2000; Forster and Gabe 2008). An example of individual voice is filing complaints. Regarding collective voice, one may think of signing a petition or becoming active in a pressure group. This further distinction in the framework is necessary, since the two options have different dynamics. For instance, citizens may have different reasons for becoming active. Collective voice is shown to be used much more often to protect the status quo and does not necessarily stem from dissatisfaction, whereas individual voice is usually said to stem from dissatisfaction (although when people are asked to voice their opinion they may also express their satisfaction) (Dowding and John 2008). The focus of Hirschman-inspired literature is on why and which individuals will use their possibilities of collective voice. However, voice and choice may be organized at the collective level without individuals being active. Collectives can also act as advocates or representatives of individuals when individuals cannot or do not want to perform these activities themselves (Grob and Schlesinger 2011). Individuals can thus implicitly or explicitly delegate their choice and voice options to the collective level. Although this representative role of delegated “voicers” and “choicers” is recognized in the literature (Rodwin 2001; Schlesinger, Mitchell, and

Elbel 2002), it has not been reflected in Hirschman's framework. In this article we try to fill this gap.

We see voice and choice by delegation as shifting individual voice and choice activities toward a collective party that acts on behalf of individuals, allowing the latter to remain largely passive. In this respect it clearly differs from both individual and collective voice and choice, which require action of all individuals involved. Delegation goes partly against the ideals of participatory democracy, which emphasizes the importance of activating citizens to influence decision making directly wherever authority is exercised. It is unlikely that people who do not participate themselves will develop democratic virtues by designating others to represent them and their interests. Moreover, the diversity of individuals and their preferences will be blurred in the process of representation (Pitkin 1967). In health care in particular, the principal-agent relationship is rather complicated, since it often concerns people who are simply too sick to express their preferences properly (principal) or to act as a representative (agent). Even with explicit, formal procedures for delegation, the formulation and presentation of the interests of (future) patients through collectives could thus be problematic.

However, voice and choice by delegation can also structure the input of citizens or consumers, offering health providers the necessary clarity on health demands compared with the fragmented nature of individual voice and choice, thereby facilitating quality improvement. Even though the ideal of direct participation is lost, voice and choice by delegation may still serve the goal of democratization outside the electoral arena. Even if the collective delegates may act without an explicit and clear mandate from their constituents, they give the largely silent citizen-consumers and their preferences a presence in the (semi-)public sector. Delegation is therefore another democratic way for people to influence decision making, although in this case individuals remain largely passive. An overview of the different options can be found in table 1. In the remainder of this article we explore the option of delegation further by looking at Dutch health care to examine the differences in individual choice and voice and what the advantages and disadvantages can be in practice.

Individual Choice and Voice

First we describe the history of individual choice and voice in Dutch health care. The introduction of these mechanisms was part of an incremental reform process that started in the late 1980s and culminated in the

Table 1 Examples of Influencing Health Decision Making: Choice, Voice, Loyalty, and Delegation

Choice/Exit	Choice of/Exit from Service Provider
Voice	Write letter, file complaint
Loyalty	Not an active mechanism: influences if and how to become active
Delegation	Delegation of choice: insurer chooses provider for the individual of voice: patient organization represents the interests of individual patients in formal decision making

introduction of the Health Insurance Act in 2006. This act completed a system of regulated competition. Health care providers and insurers have to compete for patients/insured on the market. In this article we use the concept of choice instead of exit, since it best describes the opportunities given to patients and the insured in Dutch health care. We identify a variety of activities as individual choice and voice, such as choosing health care providers, insurers, and treatment options, complaining, filling in questionnaires, and participating in focus groups. We classify these activities as individual choice and voice as patients act or are asked to contribute as individuals. Although options such as questionnaires and focus groups collect the experiences of a number of patients, they rely on the experiences of patients as individuals. As we illustrate later, this is different in the case of delegation, where patients are represented as a collective.

Choice

Currently Dutch patients have many options from which to choose in health care. They can choose their insurer, their health care provider, and their course of treatment. However, although people say they find choice in health care very important (Friele, Albada, and Sluijs 2006; Van Reijen 2003) and experimental studies show that people can and do study quality information (Grit, Van de Bovenkamp, and Bal 2008; Groenewoud 2008), in practice not many people use their choice options (Dorgelo, Hekkink, and Bakx 2008; Friele, Albada, and Sluijs 2006; Grit, Van de Bovenkamp, and Bal 2008). Around a third of Dutch patient-consumers annually look for information about insurers, mostly price information and coverage (Boonen, Laske-Aldershof, and Schut 2009). Only 4 or 5 percent of people use their annual opportunity to change their health care insurer. Younger and more highly educated people switch more often than those

who are older and less educated. Moreover, chronically ill people who are handicapped and in bad physical health experience particular difficulty in changing insurers (Reitsma-van Rooijen, de Jong, and Rijken 2011).

It is difficult to establish how many people make a critical choice when selecting their provider (Grit, Van de Bovenkamp, and Bal 2008). In experimental settings people use quality information, and in practice they bypass the nearest hospital on a regular basis (Groenewoud 2008; Varkevisser 2010). A recent study also indicates that almost everyone (96 percent) is aware of significant quality differences among hospitals. However, only 7 percent search for quality information in order to make a choice. More people (48 percent) ask for advice from their general practitioner (GP) or friends and family (Van der Geest and Varkevisser 2012). People find it difficult to correctly assess quality information on providers (Damman 2010). And even though people say that they want a lot of information, they actually use a very limited amount and mostly use it to check the choice they were already considering. Groenewoud (2008) concludes in a literature review that most care users do not rely on quality information when making their choice. They instead tend to use criteria such as proximity, brand loyalty, word of mouth, and trust in the knowledge and skills of professionals.

Research also casts doubt on the image of the critical health consumer being an equal partner to his or her physician. In their study on GP-patient communication in the Netherlands between 1986 and 2002, Bensing et al. (2006) conclude that the development of a more equal relationship between patients and GPs, with patients as active and critical consumers, was not seen throughout this period. The situation for people living in health care institutions is no different. They have been given the right to make choices concerning their care—for example, they are asked to cosign a treatment and care plan, tailored to their specific situation. However, many people are not aware of this option and have never been involved in these decisions (Friele, Albada, and Sluijs 2006). After reviewing the literature, Friele, Albada, and Sluijs (2006) conclude that people almost always say that they want to make decisions about their care, but at the same time they seem to feel that the final decisions should be made by physicians. Individual choice has remained fairly limited in this respect.

Voice

Individual patients can also use their voice to influence health care. On the basis of the 1995 Clients' Right of Complaint Act, patients have the

right to file complaints against a health care professional or health care provider to the complaint committee of the health care provider in question. There are no exact figures on how many complaints are filed. However, the Complaint Act does not appear to be used very often, primarily because not many people are aware of their right to complain (Friele et al. 1999; Friele, Albada, and Sluijs 2006). It is reported that complaint procedures are too abstract and formal for people to use and understand (Van de Bovenkamp, Grit, and Bal 2008b). In addition, research shows that complaints are rarely used by health care institutions in their quality policy, although this was one of the goals of the Complaint Act (Friele et al. 1999). Patients in the Netherlands can also file complaints before a dispute committee about the care they received in a health care institution, which is a less intensive procedure. The dispute committee procedure has not been evaluated yet (Grit, Van de Bovenkamp, and Bal 2008). But in this case, despite the lower threshold, the procedure is not used very often; in 2010 thirty-seven complaints were filed (Stichting Geschillencommissies voor Consumentenzaken 2011). When we look at the possibility of filing complaints against health care insurers, we see the same situation (NZa 2007).

On the level of health care institutions, other options of voice have been created for individual patients in order to improve the quality of care. One example is the use of questionnaires on patient experiences. Dutch health care institutions usually use their own questionnaires, but a national instrument, the Consumer Quality index, has been developed. This index has been validated as a reliable instrument that should be able to assess quality differences. It is not clear whether this will actually lead to quality improvement (Damman, Hendriks, and Sixma 2009; Van de Bovenkamp, Grit, and Bal 2008b). There are also qualitative methods of voice such as instant feedback, focus groups, and mirror meetings, where patients are asked to talk about their experiences. These are used to gain insight into patients' experiences and to identify points to improve care. Although these methods have not been properly studied—there is only anecdotal evidence of their success—the first indications are positive. Patients are indeed activated, and one of the hospitals using these methods reports improvements in opening hours and information material (De Wit, Mul, and Bal 2008; Van Hooff and Bocharde 2007). Mirror meetings were evaluated positively both by patients and health care workers (De Wit, Mul, and Bal 2008). However, in general it is still largely unclear whether these participation methods actually result in the improvement of health care (Van de Bovenkamp, Grit, and Bal 2008a).

Explanations for Little Use of Voice and Choice

Although the government claims that patients want choice and voice (see Ministry of Health, Welfare and Sport 2000–2001, 2007–2008), Dutch patients do not make use of many such opportunities. Different arguments have been put forward to explain this apparent lack of interest.

One complicating factor is that there are shortages in health care. Under those circumstances, investing time and energy to select the best provider may seem pointless (Friele, Albada, and Sluijs 2006; Groenewoud 2008). It is also possible that the health care market has so far not led to diversity among providers, which means they are simply too much alike to make choosing a worthwhile activity (Groenewoud 2008). Furthermore, many people may not be aware of their rights (Friele, Albada, and Sluijs 2006). It may be that the information being offered is not of the right type, which could be why people do not use it (Grit, Van de Bovenkamp, and Bal 2008; Groenewoud 2008). An additional reason for not using the choice option or the right to file complaints is that people in the Netherlands simply seem to be satisfied with what is offered, and also feel loyal toward health care providers and insurers (Bijl, Boelhouwer, and Pommer 2007; De Jong and Loermans 2008; Loos and Mante-Meijer 2007).

Another possibility is that exercising choice and voice is quite difficult, and not everyone seems able to use these options. The sheer quantity of options is also problematic, especially considering that patients are also busy trying to get better or coping with their health condition. In order to use one's voice and choice options one has to search for and process a lot of information, sometimes in a state of emotional or physical distress. According to survey research, only 22 percent of the Dutch population fits the critical consumer profile of an independent, rational individual searching for information on health care quality, which figures prominently in policy documents (Brethouwer and Van Oord 2006). Moreover, the majority of these critical consumers are healthy citizens who tend to use health care only incidentally. The ability and willingness to choose also depend on the condition the patient is suffering from. In acute and life-threatening situations, being a critical consumer is simply not an option. Being a critical consumer is easier with routine operations that can be planned or with chronic illnesses. Other characteristics also determine whether people will become critical consumers, such as being relatively young, highly educated, male, and nonmigrant (Brethouwer and Van Oord 2006; Dorgelo, Hekkink, and Bakx 2008; Loos and Mante-Meijer 2007). Furthermore, complaining is notoriously difficult for certain groups. For instance,

people in nursing homes may fear retaliation, which prevents them from filing complaints (Friele, Albada, and Sluijs 2006).

Delegation of Choice and Voice

Not many individuals are able or willing to use their choice and voice options. A certain level of inertia may be necessary to prevent destabilizing the entire health care system with large-scale voicing and choosing. However, limited voice and choice may result in improved health care for only active critical consumers and may subsequently decrease the amount of time and energy spent on loyal, compliant patients. Thus inactive patients may end up in the hands of less capable professionals. The reality of individual choice and voice does not meet the ideals of participatory democracy and may even foster inequality (Trappenburg 2008). Voice and choice by delegation may partly solve these problems. Health professionals have often subsumed the role of patients' representatives, particularly in seeking the right treatment. However, the focus here is on explicit or implicit delegation to collectives rather than individual professionals who take care of individual patients.

In the Dutch health care system, voice and choice can be delegated to a variety of collectivities. Patient organizations, health insurers, and client councils are of particular relevance here, but other collectives (such as employers and trade unions) can also act on behalf of patients (Enthoven and Kronick 1989; Van der Grinten 2000; Van de Bovenkamp, Grit, and Bal 2008b).

Patient organizations are abundant in the Netherlands. There are hundreds of disease-specific patient organizations (for breast cancer, diabetes, renal failure, etc.). About half a million people have joined such organizations (Oudenampsen et al. 2008). Members are on average older, have higher income, and have been diagnosed with the disease longer than nonmembers (Newcome Research and Consulting 2006). Many of these disease-specific organizations belong to umbrella organizations such as the Dutch Federation of Cancer Patient Organizations. These umbrella organizations in turn often cooperate in regional and national umbrella organizations, such as the National Patient and Consumer Federation. Most of the work of disease-specific patient organizations is done by volunteers. Professionals support the work of less than half of the disease-specific organizations and umbrella groups (Oudenampsen et al. 2008). Most (70 percent) patient organizations are associations in which the governing board can be held accountable by the members in the general

assembly. Other patient groups are foundations, which have only contributors who lack a formal way to have a say in the governing board's policies and composition. Dutch patient organizations rely on membership contributions, government subsidies, and in some instances funding from the pharmaceutical industry (Van de Bovenkamp and Trappenburg 2011).

Client councils have been established by law in health care institutions to ensure patient participation in decision making. The councils consist of patients or clients of these institutions but also family members and, especially in hospitals, representatives of patient organizations (Hoogerwerf, Nievers, and Scholten 2004). The law stipulates that the client council should be reasonably representative for clients without stating specifically what that implies. Client councils often receive financial and administrative support from health care institutions, albeit in varying degrees (Van Gelder et al 2000; Hoogerwerf, Nievers, and Scholten 2004). Survey research shows that about three-fourths of client councils maintain contacts with their constituencies, with marked differences in how often these contacts take place (Hoogerwerf, Nievers, and Scholten 2004).

Private health insurance companies have also been given a role to represent their clients. Dutch citizens have to take out a health insurance, while insurers are obliged to accept everyone applying for basic health insurance. Clients may opt for reimbursement to a certain level of the health care they obtained themselves or to receive benefits in kind from health providers contracted by their health insurers. Insurers may act on behalf of their clients when they select health providers based on price and quality (Ministry of Health, Welfare and Sport 2006). Insurers are also obliged by law to ensure clients a reasonable level of influence in their organizations. They have often done so by creating councils for the insured.

Delegation of Choice

The clearest example of delegation of choice is the collective insurance contract. The Health Insurance Act explicitly states that organizations may close contracts for their members. They may negotiate with insurers about the content and price of insurance packages for their members and strike deals with insurers. Organizations may negotiate collective discounts up to 10 percent, which makes them attractive for people to join. Many collective contracts are available, ranging from contracts via employers, trade unions, or municipalities (for people on welfare) to patient organizations, sports associations, banks, or lotteries (De Jong 2008). People

readily use their chance to delegate their choice: 65 percent of the insured had joined a collective in 2008 (*ibid.*). Moreover, there are signs that differences between the more and less educated in changing insurers have become smaller as a consequence of the collective contracts (De Jong and Groenewegen 2007).

The collective contracts that patient organizations try to close for their members are of a special kind that is worth mentioning here. Patient organizations try to negotiate not only the price but also the quality of care. Delegation to patient organizations might therefore be a way for a relatively weak party in society, people with a certain disease or condition, to strengthen its position. Forty percent of patient organizations have closed or are trying to close a collective contract for their members (Berk, Van der Steeg, and Schrijvers 2008). However, research shows that negotiating collective contracts is not an option for all patient organizations. Patient representatives need certain skills to be able to negotiate with insurers, and large patient organizations are more attractive for insurers than smaller ones (Bartholoméé and Maarse 2007; Nederland, Oudenampsen, and Ter Woerds 2007).

Choice of care provider (doctor, hospital) can be delegated as well, again to different actors, the insurer being one example. One of the leading ideas in the Health Insurance Act is that insurers should purchase care selectively, taking the quality of care into account (Ministry of Health, Welfare and Sport 2006). As yet insurers are not doing selective contracting very often, but there have been some attempts to do so. For instance, one insurer offers a policy that encourages people to go to a small number of providers (with the exception of acute care). This insurer has mainly tried to lower the premiums it charges, not to improve the quality of care (Grit, Van de Bovenkamp, and Bal 2008). Another insurer is trying to buy care selectively on the basis of quality, using quality indicators to decide which providers to contract with. It started with breast cancer care last year, and care for a small number of other conditions has followed (Van de Bovenkamp et al. 2011). Other insurers use selective care purchasing only minimally. Insurers can also channel patients to a certain health care provider through financial incentives. Yet experiments show that few people respond to such incentives, since they tend to trust their insurer less than their health care provider. People have a strong preference for the status quo even when they could get better quality care elsewhere (Boonen 2009). It remains to be seen whether in the future insurers will increasingly buy their care from health care providers selectively and try to channel their insured more. By doing so they could take over some of

the choice options of their insured. Interestingly, the delegate role of insurers could even limit the choice options of individuals.

Patient organizations can also play a role in helping people choose among health care providers. They can be seen as delegates, since they take over parts of the choice activities that are expected from individuals. They do so in different ways. Some patient organizations award quality marks to hospitals or other care providers that abide by the criteria they have formulated (Van de Bovenkamp, Trappenburg, and Grit 2010). Patient organizations put information on their websites, hand out information leaflets, serve people by means of telephone help desks, and organize peer support groups (Berk, Van der Steeg, and Schrijvers 2008; Oudenampsen et al. 2008). These services not only provide individual patients with information to choose their health care provider, they also help make decisions about treatment options. Patients and health care providers believe that these activities help patients deal with their situations, increase their knowledge, and improve communication with health care professionals (Berk, Van der Steeg, and Schrijvers 2008). However, the precise effects of these activities have not yet been properly researched (Oudenampsen et al. 2007).

Of course, even within the mechanism of delegation, individual patients still have an individual choice to make; to join a collective or not, to follow the insurer's or patient organization's recommendation for a certain provider or not. Some activity of the individual is still necessary. What is important here though is that the complicated choice process is delegated to the collective level which allows individual patients to leave the brunt of voicing and choosing to others.

Delegation of Voice

The delegation of voice is a common phenomenon in Dutch health care. As described above, health care institutions and many health insurance companies have client councils. This can be considered delegation to a collective, since the task of client councils is to represent the interests of all insured and patients of a certain insurer/provider. The law gives client councils the right to advise the board of directors on many different issues. The institution may not act against the council's advice without consulting with it first.

Patient organizations play an important role in the delegation of voice. The government has assigned them an official third-party role, after health care insurers and providers, which gives them access to various decision-

making processes (Van de Bovenkamp, Trappenburg, and Grit 2010). Patient organizations are expected to speak on behalf of patients. They perform many activities to contribute the patient's perspective. Over 60 percent perform lobbying activities directed at government (Berk, Van der Steeg, and Schrijvers 2008). However, most of their voice activities concern participation in formal decision-making procedures. Patient organizations are active in government policy making, medical guideline development, and health care indicator creation; they work together with providers and insurers on quality improvement projects, train professionals, provide insurers with information on health care purchasing, and are active in health research (Van de Bovenkamp, Trappenburg, and Grit 2010). Moreover, the Quality of Health Institutions Act (*Kwaliteitswet zorginstellingen*) states that care providers should consult with patient organizations. Patient organizations and other actors in the health care field express the wish to intensify their contacts and the participation possibilities (Van de Bovenkamp, Trappenburg, and Grit 2010). So at first sight both client councils and patient organizations have a strong position that enables them to represent the interests of individual patients.

Patient organizations point out that participation can indeed lead to positive results in terms of quality improvement (Van de Bovenkamp, Trappenburg, and Grit 2010). However, several difficulties have been identified in studies on the functioning of client councils and patient organizations in practice. First, it is often questionable whether they can really influence decision making (Van Gelder et al. 2000; Van de Bovenkamp, Trappenburg, and Grit 2010). Patient organizations participate in decision-making processes along with well-organized parties, such as health care professionals, insurers, and the Ministry of Health, that have a long-established position in health care decision making. Representatives of patient organizations or client councils have difficulty getting their points across and do not know how to influence the decision-making agenda. Moreover, topics on the agenda and decisions made reflect the interests of the other parties rather than the priorities of patients (Trappenburg 2008). Patient organizations and client councils also find themselves in a dependent position, because they have little power to back up their voices in case of disagreements (Van de Bovenkamp, Trappenburg, and Grit 2010; Hoogerwerf, Nievers, and Scholten 2004).

A second problem is finding people willing and able to do the work for patients who want to remain passive (Trappenburg 2008; Van der Kraan et al. 2008; Van Gelder et al. 2000; Hoogerwerf, Nievers, and Scholten

2004; Van de Bovenkamp, Trappenburg, and Grit 2010; Berk, Van der Steeg, and Schrijvers 2008; Oudenampsen et al. 2008). Moreover, patient organizations are asked to participate so often that they cannot comply with all requests. This is more problematic for some groups than others. For instance, larger patient organizations are usually more active than smaller ones (Berk, Van der Steeg, and Schrijvers 2008; Oudenampsen et al. 2008).

Third, there have been problems concerning delegates' representativeness. It is challenging for volunteers in patient organizations to properly represent the diversity of patients' preferences, while patients, struggling with their own conditions, often cannot effectively hold the groups accountable. In addition, client councils often have difficulty involving certain groups (e.g., people with immigrant backgrounds) who might have different health care preferences (Van Gelder et al. 2000). Furthermore, participation in formal decision-making processes requires skilled people. Patient organizations and client councils are therefore often advised to professionalize (Hoogerwerf, Nievers, and Scholten 2004; Van der Kraan, Meurs, and Adams 2008; Van Gelder et al. 2000; Oudenampsen et al. 2008). Patient organizations are trying to follow this advice by training volunteers and hiring professional employees (Berk, Van der Steeg, and Schrijvers 2008; Oudenampsen et al. 2008; Van de Bovenkamp, Trappenburg, and Grit 2010). Although professionalization can help them participate in discussions and decision making, it weakens the descriptive representation of patient organizations. Delegates no longer literally *stand for* their patients and their families. The professional agents can still *act for* patients to defend their preferences, but since they are no longer selected based on common health experiences, they may be less able to understand their constituents' health problems (see Pitkin 1967). In other words, even though delegation of voice through client councils and patient organizations may offer individual patients the chance to remain passive and focus on their individual conditions, it may also raise a number of problems related to effectiveness and representation.

Discussion

In this section we look at whether delegation is a good supplement to or substitute for individual voice and choice, using our case study to illustrate some advantages and disadvantages that relate to the two goals of this policy: increasing quality and democratization. The overview in the pre-

vious section shows that like individual voice and choice, delegation may take on different forms; for instance, different actors act as delegates, and delegation may happen implicitly as well as explicitly.

Our first analysis of the concept of delegation has taught us a few lessons, which we discuss below. We argue that the results of this case study have practical and theoretical implications: theoretical, because the results show that it is important to differentiate between individual choice and voice on the one hand and delegation on the other, since there are different underlying mechanisms with potentially different effects; and practical, since our case study shows that delegation can create advantages and disadvantages, which are summarized in table 2. As we noted in our introduction, choice and voice options are introduced in many countries and in many policy fields. Our results may therefore also be informative for other policy areas and countries in Europe and elsewhere. For instance, the experiences in the Dutch case may shed light on the problems of market-induced inequalities in the US health care system. Both individual and collective voice of patients have been advocated to counteract the emphasis on individual interests and to empower patients (Grob and Schlesinger 2011).

As table 2 shows, individual choice and voice have several potential advantages, such as quality improvement in general and for the individual and democratization of health care. In spite of the positive effects of some of these opportunities, their limited use makes it questionable that the goals are reached in practice. The narrow use of individual choice and voice in Dutch health care confirms findings in other countries (Schlesinger 2011). Becoming active is difficult; hence not everyone is able to or wants to participate, which could lead to uneven redistribution effects. Responses to this phenomenon in Dutch health care have focused on improving information, heightening awareness (Groenewoud 2008), and trying to further secure the patient's position through legislation (Ministry of Health, Welfare and Sport. 2007–2008). However, it is questionable whether this will solve the problems attached to individual choice and voice. There may be limits to the level of choice that is desirable (Coulter 2005; Schwartz 2004). Schwartz (2004) argues that choice is good but only up to a point; more choice is not always better for people's well-being. The process of choice should not become too complicated or time-consuming. There is also a limit to the amount of voice options people desire (Hibbing and Theiss-Morse 2002). Hibbing and Theiss-Morse argue that people appreciate that others make political decisions for them; very few people dream of participating in myriad decision-making pro-

Table 2 Advantages and Disadvantages Attributed to Individual Choice/Voice and Choice and Voice by Delegation

	Advantages	Disadvantages
Individual choice and voice	<p>General quality improvement: Offers information for better services</p> <p>Individual quality improvement: Services can be more attuned to individual preferences</p> <p>Advantages attached to participatory democracy: Enhances civic skills and virtues and gives patients the possibility to influence decision making</p>	<p>Little use in practice</p> <p>Redistribution effect/inequality: Not everybody can or wants to participate</p> <p>Too many responsibilities are shifted to individuals</p>
Delegation	<p>Quality improvement: Offers information for quality improvement in a structured way</p> <p>Democratization through representation: A second best ideal if individual choice and voice have failed</p> <p>Individuals have the opportunity to remain passive.</p>	<p>Representativeness and inequality: May cause additional inequalities or increase existing inequalities</p> <p>Tension with individual participation</p> <p>Conflicting interests of delegates: Other interests of delegates may go against interests of groups they represent</p>

cesses. Our results corroborate these conclusions. Moreover, giving voice and choice also means increasing citizens' own responsibility. In the case of health care, if a treatment does not work, a professional does not perform up to standards, or a health insurer offers deficient services, modern health consumers have themselves to blame for choosing incorrectly or failing to speak up (Hurenkamp and Kremer 2005; Stone 2005). Clarke et al. (2007) clearly show that although health care users value opportunities of choice and influence in decision making, they do not appreciate the shift of responsibility from health care workers to themselves.

Collective voice may help make health care systems more focused on patient interests (Rodwin 2011; Grob and Schlesinger 2011). We argued in the Introduction that delegation can potentially be positive for both individuals and service providers. Therefore, we believe, delegation needs more political and scholarly attention. In the following section we discuss

the advantages and the disadvantages of delegation on the basis of our preliminary study.

Advantages

Policies that stimulate voice and choice have the more instrumental aim of quality improvement and the intrinsic aim of democratizing decision making. The largest advantage of delegation is that it gives individuals who are not able or willing to become active the option to remain passive and become critical consumers by proxy. Delegation gives those who are not willing or able to use their voice and choice a chance to shift most of the burdens and responsibilities to a collective. In terms of quality improvement, these delegates can improve the quality of services for a broader group of users. They can represent the interests of all users, which means that they can potentially lessen the uneven redistributive effects of individual voice and choice. Our case study of Dutch health care shows that delegation is used often. However, it also shows that delegation can decrease inequalities, as in the case of collective insurer contracts or peer support and information provided by patient organizations. When delegates offer good information on what patients or citizens want from a certain provider, the provider can use this information to improve quality. For instance, positive effects have resulted from the participation of patient organizations in decision making, such as better information for patients and better availability of medication (Van de Bovenkamp, Trapenburg, and Grit 2010). Compared with individual choice and voice, delegation has the advantage that service providers do not have to respond to all kinds of individual choices and voices but are offered a structured feedback loop instead. The fact that many actors in Dutch health care want a central organization they can talk to in order to learn about patients' preferences shows that they recognize this advantage (*ibid.*).

Delegation might be considered inferior to individual choice and voice. It does not meet the ideal of citizens' direct participation, as propagated by advocates of participatory democracy. However, given that these goals are unattainable for large parts of the population, delegation might be considered an attractive second-best ideal. With the help of collectives, citizens may yet raise their voices and exercise choice in health care, even though their physical or mental condition does not allow them to do so. They may not personally develop civic skills as envisioned by participatory democrats, but their voices are heard by proxy and their interests are taken into account. With the help of collectives, exit and voice can yet

take place, while people barely use these options at the individual level. Delegates can act as representatives for patients' interests, contributing to higher-quality health deliberations. Collective delegates may have to represent their constituents without a clear and explicit mandate, because the skills or organizational resources necessary to obtain information about health consumers' preferences are missing. However, even if they operate mostly independently, they can take care of their constituents and act as a kind of trustee (Pitkin 1967). Many people also seem to appreciate that others represent their interests in decision-making processes (Hibbing and Theiss-Morse 2002). Most patient organizations are associations, which means they must have internal accountability. Although this does not guarantee a proper representation of their constituents' wishes, it may certainly contribute to it. Thus delegation can be a way to make decision making more democratic.

We may conclude that delegation potentially has important advantages compared with individual choice and voice, and there is some evidence that these advantages can also be seen in practice. However, the precise effects of delegation are still difficult to establish. The much desired quality improvement effect has yet to be substantiated; therefore more research into the subject is needed. What we do know on the basis of our results is that next to these possible advantages, delegation also creates new problems or tensions and old problems in a new guise that warrant attention.

Disadvantages

Delegation is not a cure-all for redistribution effects. Although delegation decreases certain inequalities, it may also cause additional inequities. Inequality caused by delegation takes two forms: between different groups and within groups. First, delegation may lead to redistribution effects *among* different groups of people. On some subjects people can choose which actor to delegate to (in our case study, collective insurer contracts). This gives people the opportunity to delegate to an actor that is available to them—for instance, their employer, union, or professional organization. However, this situation also means that not all options are available to all, which could lead to inequalities among groups (housewives, pensioners, and the unemployed may not have access to employers, unions, or professional organizations). The difference in the ability of delegates to play their role may also cause inequities. In our case study, the differences between large, skilled, and capable patient organizations on the one hand and small, amateur patient support groups on the other may

lead to inequality among different types of patient groups. The problem that was identified on the individual level therefore reemerges at the collective level; not all delegates can cope with all the participation possibilities granted to them. In our case study, this might lead to redistribution of care and attention from groups with a serious disease to groups of patients with a minor affliction, represented by an active patient organization consisting of relatively healthy members. This problem may be exacerbated by the fact that the groups that remain silent—for example, people with low socioeconomic status—also have more and different health problems than the vocal, more highly educated population (Van Oers 2002; Morone and Jacobs 2005).

An example of redistribution effects is also found *within* collectives. Existing literature casts doubt on whether patient groups can properly represent larger groups of patients/citizens (Nathanson 2005; Grob 2011; Epstein 2011). These doubts have been strengthened by our case study. Not everyone is equally equipped to be a representative; only people with certain skills can participate effectively. In our example, patient organizations and client councils have been taught to professionalize (Berk, Van der Steeg, and Schrijvers 2008; Goudriaan and Goris 2007; Nederland and Duyvendak 2004; Oudenampsen et al. 2008). But professionalization further increases the importance of the representativeness problem. Professionalization leads to a bias in favor of more vocal, highly educated citizens. Those citizens are listened to most in interactive policy making and are also the ones who run professional interest organizations (Bovens 2006; Hibbing and Theiss-Morse 2002; Skocpol 2003).² The policy belief that participation is bound to lead to better decision making leads to the question “better for whom?” (Bovens 2006; Epstein 2011). In the case of Dutch health care, the people active in client councils and patient organizations seem to be the same empowered, highly educated white people who fit the profile of the individual active health care consumer. Professionalization of collectives not only weakens representation in terms of delegates no longer sharing similar health experiences with their constituents; it may also lead to a shift in the interests represented. The differences between those who can and those who cannot be active health care consumers increase, because collectives are dominated by the same critical consumers. This effect also comes to the fore in other literature on participation processes (Hibbing and Theiss-Morse 2002). Choice

2. Other participation methods that allow individual unorganized patients to participate, such as focus groups and mirror meetings, may be less problematic.

and voice are both especially suited for assertive highly educated, mildly afflicted consumers and citizens. Delegation does not cure and may even strengthen this bias, which Hirschman identified.

The second issue warranting attention is that tensions can be identified between individual and collective levels, which come to the fore when analyzing delegation. Whereas at the individual level a great deal of policy attention is paid to what the individual user wants so as to organize services more responsive to individual needs, at the collective level delegates have to generalize; they have to put forward what *the* average citizen/patient wants. This is difficult, if not impossible, when many authors claim that *the* average citizen/patient does not exist. Although delegation may be a substitute for individual choice and voice, delegation cannot amount to the same effect. We therefore agree with Grob and Schlesinger (2011): we should recognize the diversity in patient preferences to mitigate this problem, at least partly. Nevertheless, it seems plausible that there are some common denominators in what people want from their services. But to find out exactly what these are requires much work. In the Netherlands, patient organizations and client councils do not always have the resources to study the preferences and priorities of their members (Van de Bovenkamp, Grit, and Bal 2008b). Nor have other delegates such as insurers succeeded in this yet (*ibid.*). Hence in practice the input of patient organizations or client councils depends largely on which patient representative is taking part in the decision-making process. He or she may be aware of what other patients want, but it is largely coincidental what he or she does and does not know.

Third, actors to whom responsibilities have been delegated have interests of their own. Organizations to which individuals can delegate want to survive and accomplish additional goals, and although interests may often coincide, that is not always the case. For instance, it is likely that quality of care is not always insurers' highest priority, as they have other interests besides providing the best care to their enrollees; they also have to consider the survival of their organization and sometimes the profits they have to pay to their shareholders. One result is that enrollees are hesitant to trust their insurer to channel them to the best quality care provider. Whereas the first two disadvantages can potentially be partly overcome by building strong links between delegates and those they represent, this third disadvantage might be more difficult to solve, since the possibility of conflicting interests will remain, even when these links are in place.

Conclusion

People have been given many options to influence public service provision in many Western countries. Policy makers expect the use of these options to improve the quality of services and democratize decision making, in line with Hirschman's framework. That framework has been helpful in this respect, since it differentiates between influence possibilities of different backgrounds: the partly economic mechanism of exit and the more political mechanism of voice. Throughout the years Hirschman's framework has been expanded to include more general patterns of consumer and citizen behavior. For instance, the concept of exit has been complemented with choice to denote the possibility of selecting an option from a menu of public services without preceding dissatisfaction. Another modification is the distinction between individual and collective voice and choice. In this article, as a further modification of the framework, we identify the option for individuals to delegate possibilities to exercise influence while allowing them to remain inactive.

In the Netherlands there are several delegation possibilities in the health care system, which makes it an interesting case for studying this option's potential. The Dutch case shows that individual voice and choice options are barely used, so it is questionable whether the goals of quality improvement and democratization of services are being met. In theory, delegation to collective actors such as patient organizations may compensate for the failure of individual choice and voice. Evidence from the Dutch health care indicates that problems of individual voice and choice may be overcome to a limited degree. However, our case study also shows that there are important disadvantages attached to the much used delegation option. Although delegation offers individuals the opportunity to remain passive and shift their responsibility, it can also increase the inequalities attached to individual voice and choice and add others resulting from the distribution of representation skills both between and within organizations representing health users. Certain organizations may be better than others at obtaining information about their constituents' preferences and representing their interests. The potential difference in health preferences between the usually higher educated delegates and their constituents may also lead to an underrepresentation of the latter's interests. Moreover, there is an intrinsic tension between the ideals lying behind individual choice and voice and what delegation to the collective level has to offer. Delegates may also have interests of their own in addition to representing their constituents. For delegation to become a success in terms of qual-

ity improvement and democratization, patient representatives' abilities to know and act in accordance with their constituents' preferences should receive more attention.

Thus far the literature has paid little attention to voice and choice by delegation in health care. With a view to the prominence of this issue and other policy areas, the distinction should receive more attention and empirical research. This is important from a theoretical point of view, as this case underlines the need to distinguish the various forms of voice and choice because of the differences in underlying dynamics, effects, and advantages and disadvantages. From a practical point of view, this case highlights the importance of critically assessing different ways of participation. Delegation might be a promising possibility alongside individual and collective choice and voice, but we should proceed with care to avoid the many familiar and unfamiliar obstacles on the path to quality improvement and democratization.

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