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Low institutional trust in health insurers in Dutch health care

Hans Maarse[a,*], Patrick Jeurissen[b]

[a] Maastricht University, Department of Health Services Research, Maastricht, Netherlands
[b] Radboud University, Faculty of Medicine, Nijmegen, Netherlands

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ABSTRACT

A central element of the 2006 health insurance reform in the Netherlands is strategic purchasing by health insurers. After a brief elaboration of the concept of trust this article discusses the trust of insured in the new purchasing role of health insurers. There are various indications of a trust problem or credible commitment problem in Dutch health care. Insured say to trust their own health insurer (specific trust) but also say to have little trust in the behaviour of health insurers in general(institutional trust). The article briefly explores four models to explain the trust problem: the lack-of information model, the anticompetition model, the pro-profession model and the political communication model. A critical analysis demonstrates that the 'objective ground' for low institutional trust is rather questionable. Low trust seems to be based more on perceptions than on the insurers' objective purchasing behaviour. The article ends with a discussion on some potential strategies to address the trust problem. Low institutional trust may be something insurers have to live with.

1. Introduction

A central element of the 2006 reform in Dutch health care is strategic (or active) purchasing [1] by health insurers. In the newly introduced system, based upon the principles of regulated competition, they are expected to act as the trustworthy agent of their clients (principal) in negotiating contracts with providers on the costs and quality of medical care [2]. The 2006 Health Insurance Act encourages insurers to take up their upgraded role of active purchaser by the provision that once a year subscribers have the right to switch to another insurer which they believe offers them a better deal, for example a lower premium or access to all providers including non-contracted providers. Another instrument to stimulate strategic purchasing is the regulation that insurers must draw upon their financial reserves or raise their premium (or a combination of both) to cover a deficit. The pre-existing arrangements for ex-post risk equalization have been largely phased out. To reinforce market power the new health insurance regime allows insurers to selectively contract providers and offer health plans with preferred providers restricting patient choice for planned care [3,4].

The model of regulated (or managed) competition assumes that customers trust health insurers. However, this assumption is not always well recognized. For instance, Van de Ven and his colleagues [5] do not mention trust in their list of ten preconditions for successful regulated competition. They implicitly assume that trust will be 'automatic' if these preconditions are fulfilled.

Even though the structure of health care in the Netherlands reasonably meets the preconditions of successful regulated competition [5], the Dutch experience with active purchasing shows that trust in health insurers is not self-evident. After a brief discussion of the concept of trust and an overwiew of data suggesting a trust problem, we present some explanatory models for this problem. The final part of the article includes a critical analysis of the trust problem and discusses some strategies to tackle it.

2. The concept of trust

Trust is an important concept in health care. The Nobel prize Laureate Arrow conceptualized patient trust as a substitute for imperfect information; the information asymmetry in the patient-doctor relationship forces patients to trust their doctor. He also considered the nonprofit status of healthcare providers an important indicator of trust [6]. Freidson [7] defined trust as a key element of the logic of professionalism: patients can trust their doctor because doctors are inspired by 'an ideology that asserts greater commitment to doing good work than to economic gain and to quality rather than the economic efficiency of work'(p. 127). In a similar way Starr [8] stressed the importance of trust in the patient-doctor relationship: patients have to trust their physician, because that is the best way to conceive hope and reduce fear.

* Corresponding author.
E-mail address: h.maarse@maastrichtuniversity.nl (H. Maarse).

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The concept of trust and its dimensions have received much attention in the literature [9–11]. We conceptualize trust here as the expectation of the insured that insurers will avoid strategy options attractive to themselves that would seriously hurt the interests of the insured [12].

Trust is a meaningless concept without specifying the object of trust. Who or what is trusted or not? In this respect it is important to make a distinction between trust in one's own insurer (*specific* trust) and trust in health insurers or health insurance in general (*institutional* trust). Specific trust may differ from institutional trust.

Institutional trust may be an indicator of the consumers' appreciation of the organization of health care. Following this reasoning, lack of trust in health insurance can be interpreted as lack of trust in the organisation of health care which reflects upon health insurers in particular. In this respect it is interesting to refer to research in the United States which found that trust in health insurers correlates with trust in physicians and satisfaction of care and with an item assessing overall worry about health insurance [13].

Trust is a matter of interpretation or perception. It may not only rest on personal experience (and thus be 'real') but also be influenced by other factors, for example the framing of the insurers' role in political communication by politicians, media, opinion leaders and, last but least, health care providers.

3. Indications of low institutional trust in Dutch health insurance

An early indication of a potential trust problem was the finding of Boonen and Schut that the percentage of respondents willing to follow their insurer's recommendation on preferred providers had declined from 50% in 2005 to 25% in 2007. Health insurers faced what they called a 'credible commitment problem' [14]. Based upon an on-line panel survey among the insured of a big insurer in the Netherlands, Bes et al found another signal of this problem: 55% of the respondents said to have no interest in receiving advice of their insurer in choosing a caregiver [15].

A more recent indication of low trust was that in a survey with panel data from 2012 only 31% of the respondents stated to trust health insurers, compared to 87% and 73% for general practitioners and hospitals respectively [16]). These percentages remained more or less the same in a survey with panel data from 2016. However, the percentage of respondents in the latter survey who said to trust health insurers had slightly declined to 27 percent [17]. Another survey-study found that in health insurers scored a 6.4 on a 10-points trust scale compared to 7.4 for doctors and other health care providers [18].

Asked for the reasons of low trust, respondents gave as their opinion that insurers continued to raise their premiums, even though they had made a significant surplus in previous years. They also told that insurers could restrict the patients' freedom of choice and that they did not always reimburse the full costs of medical treatment (e.g. the costs of consulting a non-contracted provider). In other words, respondents believed that insurers did not act in the interest of their subscribers [16].

The Consumer and Market Authority (Autoriteit Consument en Markt) published somewhat less dramatic results. Asked whether they trust that health insurers are keen to serve the interest of their customers, 38% of the respondents in a survey (held in 2017) expressed low trust, whereas 17% said to have much trust; the remaining 45% declared themselves neutral. Another finding was that 39% of the respondents who had switched to another health insurer in 2017 said to have little trust in health insurers. The ACM also reported that the percentage of 'low-trust' respondents had slightly increased from 32% in 2014 to 38% in 2017 [19].

The aforementioned findings suggest a low level of *institutional* trust. They tell us something about how respondents assess the role of health insurers after the health insurance reform. Low institutional trust suggests that many insured do not consider health insurers as a trustworthy agent in negotiating contracts with providers. Interestingly, *specific* trust scores significantly higher. One study found that trust in one's own insurer averaged at 7.3 compared to 5.9 for trust in health insurers [18]. In another study 58% of the respondents said to trust their own insurer, whereas only 28% said to trust health insurance [16]. The difference between specific and institutional trust suggests that low institutional trust is based more on global impressions than upon personal experience with one's own insurer. In this respect it is worth mentioning that satisfaction with one's own insurer has always been an important argument for non-switching to another insurer (63% of all subscribers had never switched in the period 2006–2017) [20].

Although the findings point into the same direction, critical questions can be raised about their validity. How were the questions formulated? How did they influence the respondents' answer? What about the representativeness of the samples? More research is certainly needed to get a profound understanding of consumer trust in Dutch health insurance and how it has developed over time. Nevertheless, there is good reason to conclude that there are signals of an institutional trust problem in current Dutch health insurance.

There are more indications for this conclusion. In the 2017 national election the Socialist Party launched the proposal to implement a fundamental overhaul of the health care system by the introduction of a single payer system dubbed 'national care fund'. Health insurers had to be abolished: their expenses for marketing and rewarding intermediaries could better be spent on health care. Although the political feasibility of this proposal was nihil, it nevertheless received a remarkable broad public support.

Finally, it is not only subscribers (and left-wing politicians) showing lack of trust in health insurance. Many providers are critical too. A sign of this is the manifesto '*Het roer moet om*' [Need for Radical Change of Direction] of general practitioners. In this manifesto, published in 2015, they urged less bureaucratic control of insurers and an equal level playing field between GPs and insurers in contracting. In essence, the manifesto called for trust in the GP as professional. Patients should no longer be viewed as a loss-making item. The manifesto drew much public attention.

3.1. Implications of low institutional trust in health insurance

There are several arguments to consider the low extent of institutional trust in Dutch health insurance [21] a problem. First of all, low trust increases uncertainty in social interaction and, as a consequence, transaction costs to minimize this uncertainty [22]. A second problem is that low institutional trust negatively affects the efficiency of the health insurance market, if fear of not being accepted by another insurer motivates persons to abstain from switching to a better or equivalent but cheaper health plan (Dutch legislation on basic health insurance gives all insured to right to switch to another insurer or health plan by the end of each calendar year and obligates insurers to accept every new client; a similar regulation does not exist in complementary health insurance). Third, low institutional trust indicates a legitimacy problem, which may ultimately develop as a serious political problem and undermine the stabililty of health insurance. Fourth, and perhaps most important, low institutional trust may gradually weaken solidarity in health insurance [23].

3.2. A brief international outlook

How do the indications of low instutional trust in the Netherlands compare to the experience in other countries practicing regulated or managed competition?

A brief outlook suggests a mixed picture. As for the United States, much has been written about the 'backlash against managed care' in the 1990s. Both consumers and providers were critical about the practice of selective contracting, utilization reviews, patient channeling and financial incentives to reward providers for efficiency gains [24,25]. This situation has not changed. A recent survey indicated that on a scale of 100 points trust in US health insurers hit an all-time low for provider executives (52) and physicians (558). Consumers had a somewhat higher trust in health insurers (69) but trusted their physicians most (793) [26]. Of course, one should be cautious in comparing these findings with those in the Netherlands, because of many fundamental differences in the structure of health insurance between the Netherlands and the United States.

Interestingly, signs of discontent with health insurance in other countries practicing active purchasing seem (much) less pronounced than in the Netherlands. For instance, in Switzerland 81% of the population said to favor the health insurance system in place (data of 2014) [27] and in a referendum in September 2014, 62% of the voters rejected a popular initiative to switch from the existing health insurance system with 61 competing insurers to a system of a single public insurer [28]. In Germany 86% of the population said to trust their sick fund or insurance company (data of 2017) [29]. Both results raise interesting questions on the low score of the Netherlands. Answering these questions requires detailed research which is beyond the scope of this article.

4. How to explain institutional low trust in health insurance?

There is no single explanation for the institutional trust problem. We briefly suggest four models which in our view are not exclusive but complementary.

The *lack-of information model* conceptualizes low trust as the result of lack of health insurance literacy [30]. Given the complexity of health insurance and the detailed structure of health insurance plans, people may not well understand health insurance and the role of health insurers. Insured may wrongly believe that they may not be accepted by an alternative health insurer and therefor abstain from their right to switch to another insurer in basic health insurance. A small percentage of insured (less than 5%) gave this fear as argument for non-switching [31]. Misperception may also be due to failing information of insurers to their customers. There is some evidence for this explanation. Hoefman et al [16] reported that many people misunderstand the tasks and responsibilities of health insurers. Institutional trust appears to be higher among customers who are competent to understand health insurance and able to make an informed choice in purchasing a health insurance plan. Another finding is that trust tends to increase if people are well and timely informed by their insurer. In this lack-of-information model trust is basically a matter of information that can be solved by more transparency.

The *anti-competition* model reflects a critical attitude to competition in health care. Health insurers are perceived as profit-driven organisations with an interest in increasing premiums, restricting the patients' freedom of choice (selective contracting, preferred providers), denying pre-authorisation of necessary medical care, not reimbursing the full costs of medical care rendered by non-contracted providers, and so on. For instance, Hoefman et al [16] found that two-thirds of the respondents believed that health insurers are more interested in low prices for health care than in value-based health care. In their view insurers may also contract less volume of care than needed to serve their subscribers timely.

The *pro-profession* model rests on the belief that third-parties like insurers should not interfere in the doctor-patient relationship. The model is closely connected with Friedson's logic of professionalism and the rejection of competition in health care. Health professionals consider the 'logic of the market' antithetical to 'the logic of health care' [32], because it replaces the trust-based relationship between doctor and patient with a contract-based type of relationship [33]. The provision of health care care requires collaboration and trust [34]. This point was also put central in the aforementioned manifesto '*Het roer moet om*'.

The political communication model emphasizes the role of framing of public opinion central. Facts do less matter than the perception of these facts. The media play a central role in this respect and constitute an important channel for stakeholders to influence public opinion [35]. The impact of political communication can hardly be underestimated given the political controversy that has surrounded the market-oriented reform from its very beginning [3]. The media mostly report on what goes wrong in health care. Many providers with private practice complain publicly on insurers' purchasing behavior and, in doing so, shape public opinion.

As said before, these four explanatory models are not exclusive but complementary. Although they overlap each other in some respects (in particular the second and third model), each model highlights a specific light on the institutional trust problem.

5. Is there an 'objective ground' for low institutional trust?

Low institutional trust in health insurance reflects a critical judgment about the introduction of regulated competition in Dutch health care and the performance of health insurers. To what extent is this judgment supported by 'objective facts'? To answer this question we reconsider each explanatory model.

As for the lack-of-information model one may argue that there was indeed reason for criticism. For instance, the Dutch Healthcare Authority (in charge of overseeing the insurers' market behavior) repeatedly concluded that insurers failed to inform their customers properly and timely on their contracting policy. However, in its latest report the Authority said to be satisfied about the insurers' information to its clients, although information on waiting times and the traceability of information still needed further improvement [36]. The key question is of course whether better information will indeed translate in higher institutional trust.

In the anti-competition model health insurers are framed as profit-driven organizations in search of huge profits. In fact, the great majority of health insurers are mutualities or organisations without commercial shareholders. Another assertion is that health insurers make huge 'profits'. It is certainly true that they have built up substantial reserves in recent years, but one should not overlook the raised solvency requirements imposed by European legislation and The Dutch Bank (from 8% of turnover to about 17%). To brush up their reputation and also under political and public pressure insurers have cut into their reserves since 2013 by mitigating the annual increase of their premiums [3]. However, the continuation of this consumer-friendly premium-setting in future seems doubtful.

Furthermore, insurers are framed as powerful market players who can dictate the terms of contracts with providers. Four insurers (the 'big four') have a total market share of almost 90%. Physiotherapists, psychotherapists and other providers with private practice say to have no other option than ticking the box. However, reality is more nuanced. In practice, all general practitioners are contractedMost most of them other providers with private practice are contracted as well, though often with a budget constraint. As regards general practitioners, there is much

doubt on whether health insurers are really capable to play the role of countervailing power [37]. As regards the insurer-hospital relationship, The insurers' negotiating bargaining power vis-à-vis hospitals also seems relatively weak. seems less strong. Mergers and information-asymmetry place hospitals in an advantageous position. The relationship between hospitals and insurers can be best conceived in terms of mutual dependency [38]. Insurers also hardly channel patients. In reality, they are much less capable to do so than assumed in the model of regulated competition [39].

In the pro-profession model insurers are criticized for interfering in the patient-doctor relationship. The evidence for this criticism seems scarce. Health insurers assert to abstain from interference in the doctor-patient relationship. They argue that the requirement of pre-authorization of some specific medical treatments does not alter this. Asking doctors to take medical guidelines seriously and not-contracting providers who fail to meet quality standards is in their view quite different from interfering in the doctor-patient relationship. The same applies to contracts with providers on quality of care and financial incentives for better performance. Nevertheless, there is some circumstantial evidence of doctors complaining on insurers withhoulding pre-authorization. Another complaint is that insurers interfere in prescribing medicines by requiring that doctors only prescribe the lowest priced generic medicines. Unfortunately, systematic research on these complaints is lacking.

That insurers should refrain from interfering in the patient-doctor relationship was recently confirmed in a lawsuit against an insurer after denial of prior authorization of a rehabilitative treatment of an patient. The court concluded that the professional's opinion should be leading in the choice of treatment. Withholding authorization is only justified if there is clear evidence for a doctor violating the medical guidelines set out by his or her professional society [40].

From our analysis follows the conclusion that the objective ground for low institutional trust is rather questionable. Low trust seems to be based more on perceptions than on the insurers' objective purchasing behavior. The often negative publicity in the media (political communication model) is likely to play a significant role in this respect. However, following Thomas' famous theorema, perceptions are real in their consequences [41] and, by consequence, constitute a reality health insurers have to cope with.

6. What can be done?

A central element of the introduction of regulated competition in Dutch health care was the upgrading of the role of health insurers. Government documents on the reform described their active purchasing role in terms of 'countervailing power'. This point was also underscored by the former minister of Health: 'In every system you need a policeman who looks at what it costs and what it yields and in our system health insurers play this role' [42]. The role of policeman is obviously only one of the insurers' role in health care, but one should not underestimate its influence on institutional trust. Low institutional trust may be an inevitable consequence of purchasing in the Dutch context.

This does not mean that insurers lack instruments to tackle the problem. First, the problem should not be ignored but taken seriously. The national association of insurers did so by launching a publicity campaign in some national newspapers. The purpose of this charm offensive was to explain their role and what customers might expect from them. Another strategy is to be transparent. Nevertheless, one should not make the mistake to see low trust as a mere information problem. It is certainly more complex.

Another strategy is to further improve customer service. A quick and adequate response to customers in search of concrete information (e.g. which provider in my neighbourhood has a short waiting time? Does my provider has a contract with my insurer? What is my co-payment?) may not only have a positive effect on trust in one's own insurer [43], but also enhance institutional trust.

Probably the most effective strategy to increase institutional trust is building a trust relationship with the providers of medical care. This strategy is based on the assumption that doctors' trust in health insurance will positively affect the patients' understanding of the insurers' role in health care.

Institutional trust in health insurance requires an effective supervisory system that rapidly intervenes if health insurers fail to perform their legal tasks properly. In the Dutch health care system the Dutch Healthcare Authority is charged with this task. The oversight of insurers works pretty well in the Netherlands, but there is always room for further improvement.

Interestingly, institutional trust in health insurance raises a political dilemma. Policy measures to expand regulated competition may undermine institutional trust, whereas policy measures to reinforce institutional trust may restrict the room for regulated competition. In 2013 the government chose for the first option by a revision of the Health Insurance Act to give health insurers more room for channeling patients. The revision did not get a majority in the Upper Chamber [3]. The opponents argued that the revision would restrict the patient's freedom of doctor choice. Recently, the Lower Chamber chose for the second option by adopting a formal ban on dividend payment to shareholders of health insurers (the ban is intended to replace a temporary moratorium on dividend payment). One of the arguments for this decision was that the option of paying insurers a dividend would undermine institutional trust. However, it is evident that the ban will further increase the hybridity of Dutch health care [3].

7. Conclusion

There are various signs of low institutional trust in Dutch health insurance. Low institutional trust may cause inefficiency in the health insurance market, undermine the legitimacy of health insurance and eventually decrease solidarity. There is no single explanation for low institutional trust. Several factors including lack of information, the belief that health insurers act as profit-driven organisations and the fear that they interfere in the doctor-patient relationship play a role. Critical public communication on insurers' behavior also plays a role. Insurers face the challenge of building a trust-based relationship with their customers. This is quite a challenge, however, given the traditional strong 'coalition' between doctor and patient. Low institutional trust may be something insurers have to live with.

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