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Managed competition in the Netherlands: Do insurers have incentives to steer on quality?

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ABSTRACT

In health care systems based on managed competition, insurers are expected to negotiate with providers about price, quantity, and quality of care. The Dutch experience shows that this expectation may be justified with regard to price and quantity, but for quality the results are less conclusive. To examine the incentives insurers face for enhancing quality of care, we conducted in-depth interviews with CEOs and organised separate focus groups with purchasers and marketers of five Dutch health insurers. Jointly these insurers account for more than 90 percent of the market. We distinguished three categories of both positive and negative incentives to steer on quality: social, competitive and financial incentives. The overall picture emerging is that insurers are caught in a struggle between positive and negative incentives, with CEOs being more positive about the incentives to steer on quality than purchasers and marketers. At present, the social mission perceived by insurers seems to be their most important driver to invest in quality enhancement. However, whether or not the role of the social mission is sustainable in a competitive market remains unclear. Improving publicly available information on quality therefore seems to be crucially important for reinforcing the positive as well as counteracting the negative incentives insurers face with respect to enhancing quality of care.

1. Introduction

In countries with health care systems based on some form of managed competition (e.g. Germany, Switzerland, the Netherlands, and the US) insurers are expected to act as prudent buyers of care on behalf of their insured. To this end, insurers are incentivized to contract providers that offer good quality care at the lowest possible price. Evidence about whether and how insurers are able and willing fulfilling this role, however, is scarce.

The Netherlands provides an interesting setting for investigating the role of health insurers, because it is widely perceived as a frontrunner in implementing managed competition in health care [1]. The available evidence suggests that in contractual negotiations with health care providers Dutch health insurers put much emphasis on cost containment. They enforced large price reductions for generic drugs [2,3], and effectively negotiated lower prices for e.g. hospital care physiotherapy and mental health care [4]. In the first years after the 2006 reforms, the effect on national spending was limited because price reductions were compensated by increasing utilization. After 2012, however, insurers shifted their focus to negotiating expenditure caps and the growth of healthcare expenditure started to decline. Although this shift was also motivated by mounting pressure from the government to contain cost, the conclusion that health insurers so far have been increasingly successful in cost containment seems justified [5–7].

When it comes to improving healthcare quality, however, the role of insurers as purchasing agents is much less convincing. There is ample evidence that quality so far has only played a limited role in insurer-provider negotiations [4–6,8]. One of the explanations is the lack of a clear, transparent and broadly accepted take on quality of care. There is limited consensus on appropriate quality indicators and measurement methods and the required data are often not publicly available [9]. But it is not clear if this lack of consensus and transparency can fully explain the limited role of quality in contractual negotiations between insurers and providers. A key question thus is whether insurers experience sufficient incentives to steer on quality.

To find an answer to this question, we investigated how Dutch health insurers perceive their incentives to steer on quality of care. However, rather than taking the insurer as unit of observa-

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tion, we distinguish three main groups of internal stakeholders within insurers that are directly or indirectly involved in insurers' decisions about purchasing strategies: executives, purchasers and marketers. Specifically, we examined whether these different groups of stakeholders within insurers share the same view and experience the same incentives with regard to steering on quality. We investigated this by (i) conducting in-depth interviews with the CEOs of insurance companies, and (ii) organizing focus group discussions with employees of these companies that are primarily responsible for purchasing and marketing.

This paper contributes to the literature by deepening the understanding of the role of insurers in a system of managed competition. Our study provides direct insight in insurers' motives rather than deriving this from system outcomes or theoretical reasoning. It also improves our understanding of the dynamics within an insurer by disentangling the motives of different groups of internal stakeholders within the insurer that are directly or indirectly involved in strategic purchasing decisions. To the best of our knowledge, this is the first study of insurer motives based on interviews and focus group discussions with key representatives from health insurers. The results may be relevant for countries in which third party purchasers are expected to act as prudent buyers of care on behalf of a defined population.

In Section 2 we briefly describe the background and context of the Dutch healthcare system. Section 3 discusses the methods we used and data we analysed. Section 4 presents the results, which are discussed in the concluding Section 5.

2. Background and context

After its major reform in 2006, the Dutch healthcare system is based upon the principles of managed competition. Central to the system is the idea that private health insurers, competing within social constraints, act as prudent buyers of healthcare on behalf of their enrolees [10]. In this system, all insurers are obliged to offer consumers the same standardized basic benefits package that is determined by the government. Insurers are allowed to contract healthcare providers selectively, as long as they fulfil their legal obligation to guarantee the provision of sufficient and adequate care. In addition to selective contracting, insurers have other possibilities to motivate their enrolees to visit preferred providers, for example through patient guidance services (e.g. by assigning quality labels or by waiting list mediation) or by giving patients financial incentives to choose specific providers (e.g. by requiring less co-payments). Consumers can annually switch to another health insurer or health plan (typically health insurers offer various heterogeneous health plans). Insurers have to charge the same premium to each applicant for the same health plan (i.e. mandatory community rating) but are allowed to offer (i) a premium discount up to 10% in case of a group contract and (ii) an unrestricted premium discount when people opt for a voluntary deductible. To minimise the incentive for risk selection and create a level playing field, a sophisticated system of risk equalisation has been developed that compensates insurers ex ante for differences in the risk profile of their customers. For benefits not covered by mandatory insurance, there is a separate market for supplementary insurance [10–12].

Recently, there has been much debate about selective contracting. An important provision in the Health Insurance Act (i.e. article 13) stipulates that insurers have to pay a reimbursement when patients make use of a non-contracted provider. The Dutch Supreme Court ruled that this reimbursement may not be so low that it acts as a barrier for patients to use this provider. This limits the possibilities of insurers to effectively enforce the use of contracted providers and therefore weakens the instrument of selective contracting. In December 2014, the Dutch government proposed an amendment of article 13 of the Health Insurance Act that intended to remove this restriction on selective contracting. However, the proposed amendment was blocked by the Senate and as a result the court ruling still holds [13].

In 2017, there were 24 health insurers active in the Dutch health insurance market. Since most of these insurers are part of a larger group, there are 9 independent health insurance concerns. The four largest concerns (Achmea, VGZ, CZ and Menzis) cover 88% of the total Dutch population [14]. Most insurers find their roots in former sickness funds, founded by e.g. medical associations, local communities and labour unions [15]. As a result, most insurers are still not-for-profit and organised as a cooperation.

3. Methods and data analysis

3.1. Design and participant recruitment

This study employed a qualitative approach to investigate the incentives insurers face with regard to steering on quality. To collect research data, we conducted semi-structured face-to-face interviews with CEOs. We also organized two focus group discussions, one with representatives from insurers' purchasing division (hereafter referred to as 'purchasers') and one with representatives from insurers' marketing division (hereafter referred to as 'marketers'). CEOs were interviewed because they are likely to have the most influence on an insurer's purchasing strategy. We opted for semi-structured interviews because this research method is most suitable for studying highly developed expertise [16]. We involved the purchasers and marketers because they are responsible for daily activities. We brought them together in focus groups because we wanted to ensure that wide ranging ideas would emerge, and common or contradictory experiences would be shared and debated [17].

We invited all four large health insurance companies and a selection of the small health insurers to participate (hereafter referred to as 'insurers'). Participants were invited based upon their position within the health insurance company. The selection has been based upon judgement of the researchers and has been extended using 'snowball sampling'.

3.2. Interview and focus group methodology

The aim of the interviews was to find out what incentives CEOs experience when it comes to steering on quality. The interviews lasted approximately 1.5 h each and were conducted by one member of our research team. At the beginning of the interviews, we asked CEOs to reflect freely on positive and negative incentives. We used a topic list (see appendix I) to keep the conversation going when needed or steer the conversation back in the direction of incentives and quality of healthcare. New topics were added to the topic list based on the participants' responses.

The aim of the focus group discussions was to find out (i) if employees involved in daily operations would experience the same incentives as CEOs, and (ii) if the overall strategy is translated in actual behaviour on an operational level. The focus groups were also semi-structured and lasted slightly more than two hours each. We used a topic guide that included the relevant issues (see appendix II), based on the outcomes from the interviews with the CEOs. Participants were allowed to digress from this topic list to ensure that all incentives were addressed. Both focus groups were moderated by the same two members of our research team. The other two members of our team were present as an observer.

3.3. Analysis

We analysed the data using the 'thematic network approach' as described by Attride-Stirling [18]. All interviews and focus groups have been transcribed verbatim. The texts were coded, using the qualitative data analysis and research software *ATLAS.ti*. Based on expert judgement, prior to analysing the data the research team composed a code book. During the process, codes were adjusted and supplemented, applying an iterative and circular process until data saturation was achieved. Coding has been executed by a team of four researchers. To avoid bias, all data was coded twice, each time by a different researcher. Results were compared and differences were discussed until consensus was reached on the definite codes that were attributed to the data. Next, we clustered the codes into broad categories of interrelated incentives that emerged from the data. The classifications into main and subcategories of incentives are also based on consensus reached in extensive discussions among the researchers.

After coding and grouping of codes, we were able to make various analyses to identify themes and patterns. To get an impression of the relative importance of the various incentives, we counted the number of codes per incentive and per cluster of incentives for each of the stakeholders separately and for all participants together.

4. Results

All four large insurers and one of the five small insurers were willing to contribute to our study. Jointly these insurers represent more than 90% of the Dutch health insurance market. All the CEOs of the five participating insurers were willing to give an interview, two of them choose to also involve a colleague in their interview. The focus group with purchasers was composed of six participants, i.e. four general purchasing policymakers and two hospital care purchasers, from five different insurers. The focus group with marketers was composed of five participants, all active in both consumer and corporate market segments, from three different insurers. In total eighteen participants from five different insurers participated in our study.

4.1. Thematic analysis

From the data we identified 14 incentives (7 positive and 7 negative incentives) that insurers face when considering to steer on quality. We clustered these incentives into three broad categories (see Table 1). The first category encompasses the driving forces around the social responsibility of insurers; i.e. incentives that relate to the role and (lack of) legitimacy of health insurers as purchasing agents. We labelled this category as "license to operate". Competitive incentives to steer on quality (or to refrain from it) are clustered in a second category and are related to increasing market share. This category is labelled as "competitive advantage". The third category of incentives we distinguish – labelled as "financial results" – is related to the presence (or absence) of a financial business case of steering on quality.

Table 1
Categories and incentives [note that (+) indicates a positive incentive and (-) indicates a negative incentive.]

Licence to operate	Competitive advantage	Financial results
Social mission (+)	Patient guidance (+)	Positive business case (+)
Legal obligation (+)	Need for transparancy (+)	Negative business case (-)
Negative role perception (-)	Consumer preferences (+)	
Legal hurdles (-)	Employer preferences (+)	
	Reputational risks (-)	
	Consumer indifference (-)	
	Lack of transparancy (-)	
	Patients insensitivity to steering (-)	

In Table 2, we provide an overview of the frequency with which the incentives in these categories are mentioned by the different internal stakeholders. The overall picture emerging is that insurers are caught in a struggle between positive and negative incentives, with negative incentives slightly dominating. Financial incentives seem to play a secondary role relative to the other two categories of incentives to steer on quality. Furthermore, we found several interesting differences in incentives experienced by the various internal stakeholders within the insurers. In general, for CEOs the positive and negative incentives seem to balance each other, while for purchasers and marketers the negative incentives seem to be more important. Purchasers are especially negative about the potential competitive advantage of steering on quality.

We also observed some differences between insurers. Most significantly, there was a strong difference in role perception between the four large insurers and the small insurer. Stakeholders from the large insurers were convinced that steering on quality is an essential task of a health insurer. By contrast, stakeholders from the small insurer emphasized that quality is a matter between patient and physician in which a health insurer should not interfere. We also discerned subtle differences between the major insurers, reflecting their respective purchasing policies. For instance, one of the insurers interprets steering on quality as avoiding unnecessary care, whereas other insurers have a much broader interpretation of quality.

When we look more closely to the various incentives within each of the three categories, more interesting differences can be observed. These are discussed below.

4.2. Licence to operate

All participants spoke extensively about the notion that the licence to operate as a health insurer is given to them by society. We discerned two positive and two negative incentives in this category that balance each other in frequency mentioned (see Table 3).

Social mission is the most frequently mentioned positive incentive for steering on quality. This concerns the key role that insurers are given in the Dutch health care system. As one of the CEOs said:

> *"I'm here for the public good, our social role. That's my mission, my responsibility. That's where I will be judged upon, after ten years"*, Participant 7

To some extent, insurers see themselves as part of the public system rather than private enterprises. Insurers feel having a social duty to fulfil, and improving quality of care is part of that duty. Occasionally, participants linked the social mission to the legal obligation of insurers to steer on quality. The Health Insurance Act explicitly mentions the responsibility of insurers to look after the quality of care. Hence, as some participants argued, it is not a matter of being incentivised or not, it's the legal obligation of insurers to promote quality of healthcare.

At the same time, participants highlighted the hurdles they face when they try to execute that mission or obligation. The most important hurdle insurers identify is the legal restriction on selective contracting as explained in Section 2 (i.e. the reimbursement entitlement included in Article 13 of the Health Insurance Act), making it difficult to obstruct access to low-quality providers. As one of the participants said:

Table 2
Relative frequency in which the various categories of incentives were mentioned (in percentages and total also in absolute numbers).

Internal stakeholders	*Categories of positive incentives*				*Categories of negative incentives*				Total percentage	Total number of quotes
	Licence to operate	Competitive advantage	Positive Financial results	Total positive categories	Lack of licence to operate	Competitive disadvantage	Negative financial results	Total negative categories		
Purchasers	21	4	12	37	15	30	18	63	100	73
Marketers	9	27	4	40	24	34	2	60	100	108
CEOs	22	23	9	53	18	25	3	47	100	241
Mean	17	18	8	43	19	30	8	57	100	422

Table 3
Relative frequency in which the incentives related to insurers' license to operate were mentioned (in percentages).

Internal stakeholders	*Positive incentives*			*Negative incentives*		
	Social mission	Legal obligation	Total positive incentives	Negative role perception	Legal hurdles	Total negative incentives
Purchasers	18	3	21	5	10	15
Marketers	7	2	9	8	16	24
CEOs	15	7	22	4	14	18
Mean	13	4	17	6	13	19

> *Ärticle 13, that's a fundamental flaw. Article 13 should have been changed, then our position would be much stronger, we could really make choices. But it did not happen"*. Participant 7

Some participants went even further and questioned the role of insurers in the domain of healthcare quality. Despite the perceived social mission to enhance quality of care, these participants expressed doubts whether steering on quality is a task that suits the insurer and whether insurers would be able to obtain a position in this domain. The medical profession, according to these participants, has its own responsibility to improve quality. Insurers should not interfere with that responsibility.

The overall picture is a struggle between the obligation to act upon the expectations of society and the limited room offered to fulfil these expectations. This struggle is experienced by all different internal stakeholders within the insurer. All groups experience a strong positive incentive to steer on quality based on their social mission. In addition, all participants argue that in practice they face several legal hurdles that prohibit the execution of their social mission.

4.3. Competitive advantage

Based on the data derived from the interviews and focus groups we discerned eight specific incentives related to potential competitive (dis)advantages for insurers to steer on quality. Table 4 shows the relative frequency with which these incentives were mentioned.

The data shows a struggle between the competitive pro's and con's that come with steering on quality. On balance insurers seem to perceive more competitive risks than benefits emanating from steering on quality.

An important disadvantage that participants frequently mentioned is 'lack of transparency', referring to the common observation that quality of care is ill-defined and that there is a lack of publicly available reliable indicators. For virtually all sorts of care there is much debate about what constitutes quality and how it should be measured [9,19]. Steering on quality is therefore a difficult enterprise for insurers, given that practically all decisions can (and most likely will) be debated. In addition, participants frequently referred to consumer indifference to explain why an insurer would refrain from steering on quality. Consumers are mainly interested in the price of a health plan, participants explained, and are much less interested in the efforts of an insurer to improve quality of care. Hence, doing so has limited added value to the competitive profile of an insurer and avoiding the topic could save a lot of energy and resources. Additionally, participants made clear that steering on quality involves reputational risks. Consumers don't trust insurers, participants explained, and think that their initiatives to steer on quality only serves the interests of the insurer [19,20]. Several participants extensively described how their initiatives to improve quality of care were consequently misinterpreted by the public and described the reputational risks that were involved. One CEO vividly sketched the dilemma he faced when he felt morally obliged to end the contract with certain low quality providers:

> *"We went into this with the thought: this can cost us 100.000 customers"*. Participant 4.

Occasionally, participants mentioned that they perceived no advantage in steering on quality because of patient's insensitivity to steering. An insurer has very limited influence on a patient's choice for healthcare providers, according to these participants, because most often there is a referral from another healthcare provider (e.g. GP). This may mitigate the effectiveness of insurers' efforts to steer patients to certain providers.

Table 4
Relative frequency in which incentives related to the perceived competitive advantage of steering on quality were mentioned (in percentages).

Internal stakeholders	*Positive incentives*					*Negative incentives*				
	Patient guidance	Need for transparancy	Consumer preferences	Employer preferences	Total positive incentives	Patients insensitivity to steering	Lack of transparancy	Consumer indifference	Reputational risks	Total negative incentives
Purchasers	0	3	1	0	4	4	16	5	4	30
Marketers	8	7	5	6	27	4	16	7	7	34
CEOs	9	8	4	1	23	4	7	7	8	25
Mean	6	6	3	3	18	4	13	7	6	30

We found interesting differences between the purchasers on the one hand and CEOs and marketers on the other. The purchasers almost only talked about the potential competitive disadvantages of steering on quality. Marketers and CEOs also perceive these risks but at the same time mentioned potential competitive advantages as well. For instance, both CEOs and marketers emphasized the importance of 'patient guidance'. An insurer can present itself as a guide that helps the patient to find the provider with the highest quality of care and thereby discern itself from other insurers. This distinction can create a competitive advantage. As one of the participants of the focus group with marketers said:

> *"When a policy holder finds us, and asks our help with case management* etc.*, you see a large increase in the satisfaction about our services"*. Participant 18

Also, participants of the focus group with purchasers pointed out that creating transparency on healthcare quality is essential to protect market share, especially when an insurer limits access to certain providers based on quality criteria.

> *"We need to be able to explain why we make choices that a hospital doesn't like. Indeed, if a patient is informed that we did not buy enough care (from a specific hospital), the reason why needs to be clear"*. Participant 10.

Furthermore, some CEOs and marketers also mentioned that consumer and employer preferences can be an incentive to steer on quality. Even though most consumers focus on the premium, some also expect an insurer to steer on quality. Steering on quality could result in an improved competitive profile towards these consumers. Similarly, initiatives to improve quality of care can be an important selling point in acquiring employer-based group contracts.

Overall, for those responsible for purchasing the competitive risks of steering on quality clearly outweigh the competitive advantages. For CEOs and marketers the overall picture is less negative, but on balance there does not seem to be a compelling competitive advantage for insurers to steer on quality of care.

4.4. Financial results

Participants also discussed the financial impact of steering on quality (see Table 1). On the positive side, participants argued that improving quality can avoid costs. According to CEOs and purchasers, a substantial share of the care that is provided is inappropriate and does more harm than good. Examples that are mentioned are prostatectomies or mastectomies, which are known to be unnecessary in some cases. By making sure that these unnecessary interventions are avoided, insurers could at the same time reduce spending and improve quality.

On the negative side, participants from the purchasing divisions argued that the positive business case for steering on quality is still purely theoretical. As one participant asserted:

> *"There are many opportunities when it comes to quality but it won't be an investment. To put it bluntly; it will not lead to a lower premium, rather a higher one"*. Participant 12.

The reason given for the absence of a positive business case is that possible gains often lie very far in the future and are highly uncertain. Furthermore, many gains are immaterial – such as a better quality of life – or may turn out to be financially negative, such as additional life years gained in poor health.

Interestingly, CEOs primarily emphasized the positive business case. Purchasers, in contrast, referred more often to the negative business case, suggesting that the expectations of the CEOs might be too optimistic.

5. Discussion

In health care systems based on managed competition, insurers are expected to contract providers that offer good quality care at the lowest possible price. To what extent insurers actually meet this expectation, however, is unclear. In Dutch health care system, managed competition was introduced more than a decade ago. Many preconditions of the managed competition model have been fulfilled [1]. Therefore, the Netherlands provides an interesting setting to investigate more in depth whether and how insurers have taken up the expected role as prudent purchasers of care. To date, the available evidence suggests that health insurers have been increasingly effective in containing cost. However, so far the role of quality in insurer-provider negotiations has been quite limited [4,6,8].

In this study, we investigated whether insurers experience incentives to steer on quality and whether the various stakeholders within an insurer experience similar or different incentives. Our study is the first study that offers a comprehensive overview of insurers' incentives for steering on quality, directly obtained from insurers themselves. Furthermore, it is also the first study to investigate the different incentives faced by the responsible actors within insurers (i.e. CEOs, purchasers and marketers).

5.1. Key lessons and limitations

A key finding of our study is that the Dutch system of managed competition offers insurers ambiguous incentives to steer on quality, with negative incentives slightly dominating. The most frequently mentioned reasons for insurers to refrain from steering on quality are legal hurdles and the lack of transparency about healthcare quality. The perceived social mission – the moral obligation to act upon the public goals of the system – appears to be the most important positive incentive. Our findings may explain why insurers so far had limited focus on quality in their contractual negotiations with providers.

We also conclude that the different stakeholders within an insurer have diverging views on the incentives they face. For CEOs, the positive and negative incentives both play an important role. By contrast, however, purchasers and marketers primarily point at the negative incentives as the dominant determinants. Purchasers seem to have little affinity with possibilities to strengthen the competitive profile of an insurer through steering on quality, whereas marketers and CEOs perceive various competitive advantages. Our findings may explain why health care providers, when negotiating contracts, sometimes report a discrepancy between the expressed views of the CEOs (e.g. in the media) and the actual contracting practices by the insurers' purchasing divisions. It may also explain why consumers do not perceive much difference between insurers with regard to the health plans' quality of care.

A possible weakness of our study is that participants could have given politically correct or strategic answers. Just because the license to operate is so important, particularly CEOs may have deliberately emphasized social responsibility. We tried to minimize this potential bias, by comparing the answers of CEOs to those given by various employees of the same companies in a different setting (i.e. focus groups). Furthermore, all participants were informed we would not report any statements that could be linked to individual respondents. Another possible limitation is the background of the purchasers, given that their purchase domain (primary care, secondary care, mental health care, etc.) may bias their answers. We tried to minimize this by inviting purchasers with a general responsibility for insurers' purchasing policies.

5.2. Implications

Our study has important implications for policymakers. A major challenge in any healthcare system is to provide third party purchasers with the right incentives to steer on quality of care. As the Dutch experience shows, managed competition is not automatically a sufficient driver for third party payers. Currently, the incentives for price competition seem to be much stronger than those for quality competition. To date, the negative incentives to enhance quality are at least partly offset by the social responsibility to enhance quality of care, which is broadly perceived by all health insurers. This may be due to the fact that all Dutch health insurers are non-profit organisations, and almost all CEOs have actively witnessed the major reform of the system in 2006. They know what the public goals of the reform were, and act upon it to prove that the system is working. But what will happen if new CEOs, with different perspectives on the insurer's mission, take over the wheel and/or insurers would become more profit-oriented? This question is particularly interesting given that in 2018 the first foreign, for-profit insurer entered the Dutch market [14]. If the perceived social mission becomes less pronounced, the negative incentives to steer on quality may become dominant. Therefore, reinforcing positive and counteracting the negative incentives seems to be crucially important. One way to do this, is improving the publicly available information on quality. In this perspective, improving access to meaningful, reliable and understandable quality indicators that effectively support consumers in their choice of providers and health plans is important. Empirical evidence shows that a significant proportion of patients is willing to change their behaviour because of quality information, and that insurers can successfully steer patients with the combined use of quality information and financial incentives [21–23]. Hence, improved quality information may reduce the negative incentives to steer on quality, such as reputational risks, lack of transparency and consumer disinterest. It could also strengthen positive incentives, such as consumer trust in selective contracting and the competitive advantage of investing in quality improvement. Eventually this might even make it politically feasible for the government to remove the prevailing legal restriction on selective contracting. The road towards increased transparency of quality can take many forms. In addition to industry-sponsored voluntary disclosure and government-enforced mandatory disclosure, private third party certifiers might adopt disclosure regimes to satisfy market demand for quality information [24]. In the Netherlands, since 2014 the National Health Care Institute has been assigned with the task to provide universal access to comprehensible and reliable information about quality of care, e.g. by implementing the ICHOM standards in cooperation with health care providers and health insurers [25,26].

For insurers, our findings imply that a better alignment of incentives for different internal stakeholders is urgently needed. One way to achieve this, is by altering the way insurers are typically organized. Instead of the traditional and common way of organizing different core functions (e.g. marketing and purchasing) in separate divisions), insurers could be organized along the lines of the most important market segments. Both marketers and purchasers could be part of a multidisciplinary team tailoring purchasing activities towards the needs of a specific market segment. In this setting, purchasers would collaborate with marketers in order to find out what the needs of specific market segments are and use this information as input for their negotiations with providers. This organizational redesign may increase the value of insurers' activities in the domain of quality and therefore may contribute to changing the current primarily price driven health insurance market into a market in which quality will play a more prominent role.

6. Conclusion

In the current Dutch healthcare system based on managed competition, insurers face conflicting incentives to steer on quality of care. Furthermore, the incentives for the various internal stakeholders within insurers are not properly aligned. To enhance insurers' ability and legitimacy to steer on quality, improving the publicly available information on quality seems to be of crucial importance. The system would also benefit if insurers would seek more alignment within their organisations in order to tailor their purchasing activities more towards enhancing quality of care.

Author contributions

KCFS developed the study concept. KCFS, LHHMB, FTS and MV performed the data collection. KCFS and LHHMB were responsible for analyses of the data in Atlas.ti. All authors were involved in interpretation of the data, drafting and reviewing the manuscript. All authors have approved the final version.

Conflict of interest

Karel Stolper was employed at CZ Groep at the time of the study. This research, however, was conducted independently outside the employment of CZ Groep but with their consent.

Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:https://doi.org/10.1016/j.healthpol.2018.08.018.

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