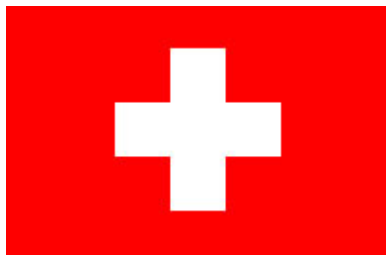


Information in health insurance plans in Switzerland, Germany and the Netherlands



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Preface

Writing this thesis is the final end of my master Health Economics Policy and Law at the Erasmus University Rotterdam. I chose the subject because of my interests in health insurance. People often do not seem to know how it works and how they can make use of it in the best way possible. I wanted to find out how well we (the Netherlands) are doing on giving information to consumers of health insurance plans compared to other countries (Switzerland and Germany). I found out that we are not doing very badly, but it could always be better and the same goes for Switzerland and Germany. Writing this thesis was not easy to do, but the more information I found, the more I liked doing it.

I would like to thank some people who made writing this thesis possible for me.

First of all I would like to thank Dr. T Laske-Aldershof who was my supervisor. She guided me through all problems I had and helped me improve my thesis.

I also want to thank Drs. L.M.H.H. Boonen and Drs. R.C. van Kleef for co-reading this thesis and make my graduation possible.

Finally I would like to thank my family and friends who always supported me and helped me to finish my thesis even when I did not know how to go on.

Abstract

In Switzerland, Germany and the Netherlands (most) consumers are obliged to have a basic health insurance. They can buy this insurance from several competing health insurance companies and can choose between several plans. In all three countries it is also possible to get voluntary supplementary health insurance for care that is not in the basic benefit package. To make sure that consumers with a high risk profile can buy affordable health insurance without the chance that insurers with more high risks going bankrupt in all three countries there is some sort of risk equalization. Because of the narrow risk adjusters in Switzerland and Germany risk selection is still a problem.

These systems indicate that consumers have to make a decision based on the information that is available on health insurance plans. The insurers are supposed to compete on price and quality, which makes it important that information should be relevant, comprehensible and credible. The choice consumers make should increase their utility to an attainable maximum. Not only should information be available, the way it is presented also influences the choices consumers make. If consumers do not understand the way the information is presented or if the information presented is not conveniently arranged, consumers will not take the time to compare different plans.

There should be enough information available for consumers to be able to compare their options. This includes information on access, costs, quality etcetera.

A first step in information presentation is educating consumers on information so they understand what they should be looking for and understand everything. Four different ways of presenting information may help to make information more comprehensible. These are using visual cues, ordering information, adding affective cues to trend data and summarizing and aggregating information.

In Switzerland, Germany and the Netherlands a lot of information is already available, but in Germany crucial information on quality and waiting times is missing. For consumers in all three countries it is quite easy to find information on the benefit package and costs. Consumers can use comparing websites and the websites of the individual insurers. Available providers are mentioned either on the websites of the insurers or on websites where all providers are assembled. Most hospitals also have private websites where information can be found.

Even though in the Netherlands the most information can be found, in all three countries information is not yet complete. The comparing websites for benefits and costs are all made by an independent third party, which makes them credible for consumers.

In Switzerland comparable information on benefit packages and costs is not offered in the best way possible, because consumers can only see it if they have it send to their home address. Quality is presented extensively, because visual cues and affective cues are used to see immediately how well a hospital is doing. The information is offered by an independent third party, but consumers want an unbiased expert source that makes the judgment and patient satisfaction judgments are not unbiased and are not from experts.

In the Netherlands information supply is the best, because there is more information available and the information is presented very well already. Visual cues and sometimes colors are added (to indicate poor quality), information is aggregated per specialism or treatment per provider, but the information is not ordered. Also the quality information on contracted providers is not aggregated with the insurance plans.

In Germany most can be done to improve the status of the information, because there is hardly any information available on quality and waiting times and the information that is given is not credible, except information on the benefit package and costs. Also the presentation on quality information is not very easy to understand yet.

1. Introduction

Consumers make choices with everything they buy, whether it is for a car or for health care and health insurance. They want to know what exactly they get for a certain price. In several countries health insurers have to compete on price and quality, which makes it important for consumers to have information and knowledge on these factors. In health care there are several problems compared to ‘normal’ goods, such as cars, which make it more difficult to buy the right insurance. Problems are that consumers often do not know what they need in the future and there is information asymmetry between doctors and patients and between consumers and insurers. When buying health insurance consumers need therefore be well informed to make a choice in what insurance they need. This means that they need to be able to compare the differences in health insurance plans. In this thesis I make clear why (good) information is important for consumers of health insurance plans and which information people need and do not need to be able to make a well-considered choice for a health plan. I have chosen to do this for three European countries, Switzerland, Germany and the Netherlands. I have chosen these countries for several reasons. The first reason is that they all have similar social health insurance systems (see chapter 1), where almost all consumers are obliged to buy at least a basic health insurance package. A second reason is because of the languages. Not all information on the content of the health insurance plans is available in English or Dutch, so I chose a second language I master, which is German. The last reason why I chose these countries is because I knew at least some information was available on health insurance plans. I chose to perform a literature study and use the available information.

The question of my study is:

What is the status of the information on health insurance in Switzerland, Germany and the Netherlands?

I will answer the next questions in my study:

1. What health insurance systems are being used in Germany, Switzerland and the Netherlands?
2. What is the use of information in health insurance and what are the requirements for comparable information for consumers?
3. Which information is needed when choosing health insurance?

4. What is the best way to present information to consumers?
5. Which information is available for consumers of health insurance plans in Switzerland, Germany, and the Netherlands?
6. How is the information presented in Switzerland, Germany and the Netherlands?

In the second chapter I explain what health insurance systems are used to make clear how health insurance is organized and financed. I will then explore the theoretical information based on papers from the United States on the use of information and on the requirements for information to be comparable (chapter 3). I also look at which information American consumers need when choosing a health plan and how this information (according to them) should be presented (chapter 4 and 5). In the last two chapters I return to information from Switzerland, Germany and the Netherlands. I start by examining what information is available and how it is presented (chapters 6 and 7).

In the discussion I consider what problems can be solved in Switzerland, Germany and the Netherlands. I also look at the problems I experienced and how they could be overcome by doing further research.

Finally in the conclusion I answer the main question and give an abstract of the thesis.

2. The health insurance systems of Switzerland, Germany and the Netherlands

In this chapter I explain the health insurance systems of Switzerland, Germany and the Netherlands. All systems are similar social insurance systems with managed competition that differ at minor points. I will look at mandatory and voluntary health insurance and the financing of the health insurance system and risk equalization.

Mandatory health insurance is insurance that consumers are obliged to buy. Next to that there is a possibility to choose supplementary or complementary health insurance.

In the financing sub-paragraph I explain for all countries which parties pay for health insurance. Risk equalization deals with the issue how competing health insurers are being compensated for high risk insured, to prevent high risks from paying higher premiums.

Switzerland

Mandatory and voluntary health insurance

Health insurance is mandatory in Switzerland, which means that practically all inhabitants have health insurance by law. The content of the basic package of health insurance is set in the Health Insurance Act¹ [1, 2]. This basic package is the same for everyone and is offered by 94 different health insurance companies (krankenkassen). All applicants have to be accepted by the health insurance companies as long as individuals live in their region (canton) [2, 3]. Health insurance is on an individual basis, which means collectivities are not possible and dependents are not covered by the insurance policy. Employers do not sponsor health insurance. Insurers are not allowed to have different prices for different enrollees, which means premiums of one insurer are the same for all enrollees for the basic package (community-rated premiums) [2].

The basic package contains various sorts of care and is specified by a legal regulation². Illness, maternity and accident are covered risks. Not all medical services and hospital services are included. A non-exclusive catalogue of diagnostic services and treatments defines the medical services included and hospital services are only included if the costs of treatment are not higher than the costs of treatment received in a shared district. A positive list defines whether pharmaceuticals, complementary medicine, and non-medical services more

¹ art 3 Bundesgesetz über die Krankenversicherung, LAMal

² Ordonnance sur les prestations dans l'assurance obligatoire des soins en cas de maladie – OPAS

generally are included. Also included are some prevention and screening measures, e.g. HIV tests, pap smears etc, and dental care concerning a serious illness [2].

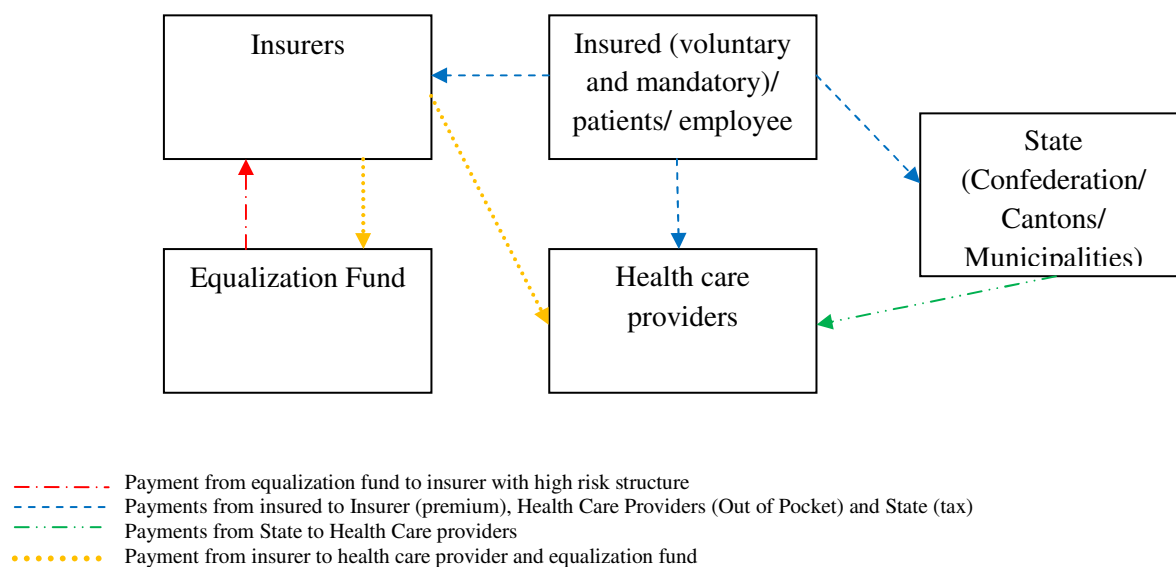
For the benefits not in the basic packages Swiss consumers have the option to buy supplementary health insurance. This can be offered by the authorized health insurance companies (LAMal insurers) and by other insurance companies (by the Insurance Contract Law). They are allowed to set different premiums and to deny applicants. There is also another sort of voluntary health insurance called 'daily cash benefit insurance'. Often this is "sponsored by employers and includes the obligations they have to continue paying wages in the event of illness or hospitalization (loss of income)" [2:38]. These insurances are also offered by LAMal insurers and other insurance companies [2].

Financing of health insurance and risk equalization

In Switzerland one third of health care finances is paid for by mandatory health insurance. Almost one third is paid for by out-of-pocket payments of individuals and the State pays the last part. The State (Confederation, Cantons and Municipalities) pays subsidies for institutional providers, like hospitals and nursing homes, for prevention, home care, disability, administration and ancillary services out of the taxes paid by the tax-payers. Solidarity is an important principle, which in Switzerland means that individuals with different health risk pay the same premium, instead of individuals with a high risk pay a high premium and low risks pay low premiums.

Insurers are financially responsible [4], but are reimbursed for high risks by a risk equalization scheme, which means that insurers with a low risk structure have to pay to a common pool, called 'Institution commune'. Equalization is based on 30 different age groups, 15 groups for men and 15 groups for women and is divided on a canton-by-canton basis, so the differences between costs in the cantons are reflected. The equalization is retrospective and not prospective [2, 4]. Cantons can receive subsidies from the confederation to reduce the premiums, but only if they have paid the confederation. The amount of money a canton can receive depends on the economic status of the canton and the resident population. Cantons are obliged to subsidize the premiums for children and young people in training, living in families with low or middle income by at least 50% since 2005. About 40% of Swiss households receive subsidies for their health insurance premiums [2]. For an overview of the cash flows of the Swiss health system see figure 1.

Figure 1: Cash flows health care in Switzerland



The equalization system chosen by the Swiss government was supposed to increase consumer mobility, which would eventually lead to comparable risk portfolios, so there would be no need for equalization anymore. This should be attainable due to the fact that insurers are not allowed to deny any applicants, so risk selection was possible but not necessary. The fact a lot of risk selection is present at this moment in Switzerland proves that the system does not work properly. Until 2006 politicians did not want to change the equalization formula, but in March of that year the first national chamber passed a reform for risk equalization to include prior hospitalization. In a later stadium other morbidity adjusters should be included. The second chamber still needs to approve the reform, so it is not gone into effect [5].

Germany

Mandatory and voluntary health insurance

In Germany about ninety percent of all inhabitants has mandatory health insurance [6]. Everyone who works is obliged to have a health insurance and this is automatically arranged by law [7]. This is called the ‘Health Insurance Act’³. Only workers with a gross income higher than a fixed amount are not obliged to have health insurance, but they can take out voluntary insurance. All the insured can choose their own insurer [6]. The basic package contains medical care from doctors, care in hospitals, cure and dental care. Also medication and resources to help ill people (e.g. wheelchair, bandage materials etc) are included.

³ Gesetzliche Krankenversicherung

Homecare, prevention and rehabilitation will also be paid by the insurer companies of the ill insured [8].

The unemployed have the so called ‘Arbeitslosen- oder Rentenversicherung’ (the Unemployment and Pensioners insurance), where all insured have to pay the same amount of money. This is not the case for the insured by the Health Insurance Act, because insurance companies can set their own prices, according to pre-defined rules [9].

Seven overall organizations define the market for health insurance [10], where almost one-third of all insured in Germany is insured with the AOK-Bundesverband [11]. All seven overall organizations have various kinds of insurance plans, some are for different professions, for example especially for technical employees or companies at the VdAK [12], and some are for all such as AOK-Bundesverband [11]. Collectivities only exist if applicants join a certain specific health insurance plan, e.g. for certain professions, like doctors and medical students [13]. Insurers are not allowed to deny an applicant health insurance [4]. This means that consumers have choices for different kinds of health insurers and because the insurers can set their own prices, there is competition between them. Employers pay half of the premium and the insured pay the other half [9].

In Germany it is also possible to buy supplementary health insurance. This supplementary health insurance is offered by private and public insurers⁴. The plans offered differ in price and benefits [14].

Financing of health insurance and risk equalization

The health care pays itself almost completely by its members’ contribution (mandatory and voluntary) and the contribution of the employers [9]. Only Long Term Care (LTC) is not paid by the members’ contribution completely, the State pays half of the costs out of the taxes [15]. One of the most important principles is the solidarity principle, which means that the richer members pay for the poorer members, the young ones for the older and singles for families. This means that richer individuals pay more, not only absolute but also in percentages, for their health care insurance [7, 9]. Workers who earn more than the fixed amount and have voluntary insurance have the right to get a contribution from their employers. Employees who earn less than 325 euro’s per month don’t have to pay for health insurance, their employers have to pay it. Pensioners with mandatory health insurance also pay half of the money, the

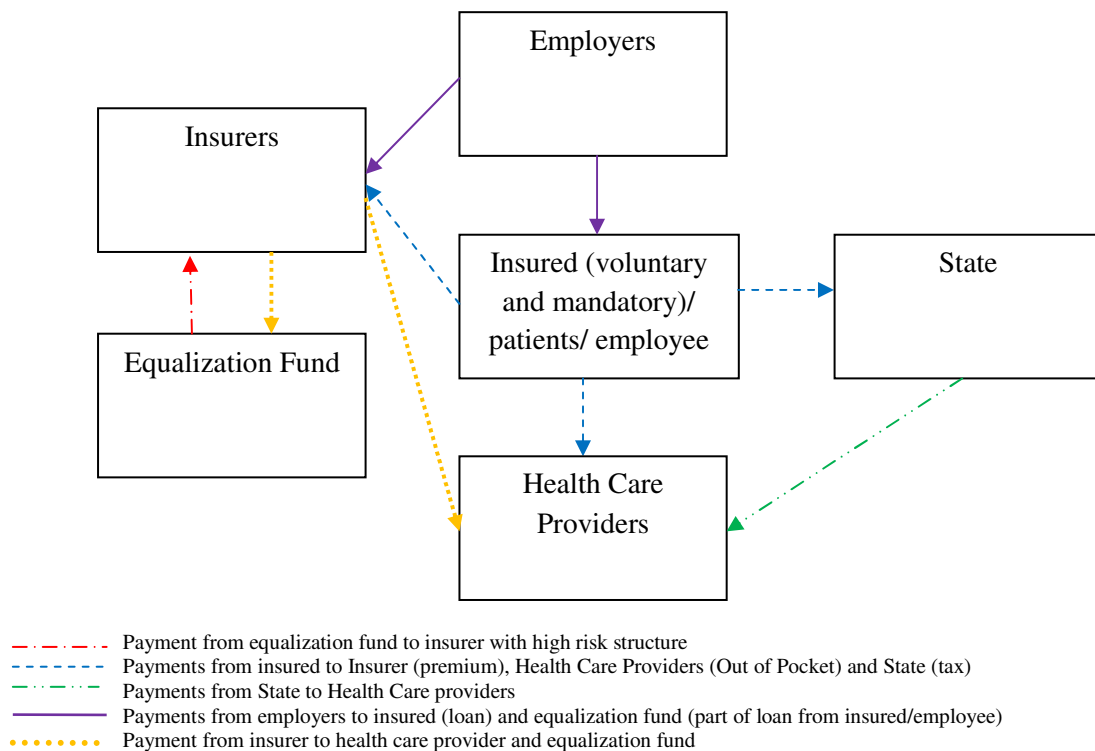
⁴ Gesetzlichen Krankenkassen

pensioner insurance holder⁵ keeps this money from the pensioner and pays it to the health insurance company. Pensioners without mandatory health insurance who choose voluntary health insurance can get a contribution from the pensioner insurance holder. All students pay for a special insurance, which is the same for all students' at all insurance companies [9].

Health insurance companies in Germany are under supervision of the German Law concerning their organization. Financially they are independent [4,10]. They rate their premiums for their enrollees by the income and the health risk. The market for enrollees is highly competitive [16]. This is only since 1996 when everyone was allowed to choose their own health insurer. To make it financially possible for poorer and sicker individuals to get health insurance a retrospective risk equalization system was introduced already in 1994. This means insurers were compensated for low-income individuals, families, age, sex and individuals with a disability to work. Insurers all have to pay to the fund for risk equalization. Risk equalization is retrospective [4,17].

For an overview of the cash-flows of the health insurance system see figure 2.

Figure 2: Cash-flows health insurance in Germany



Risk selection is allowed despite of this risk equalization scheme. Insurers are not equalized for sick enrollees, so they will ask them higher prices. To change the competition from health oriented to unhealthy oriented in 2007 the morbidity adjusted risk equalization is introduced,

⁵ Rentenversicherungsträger

by using a Disease Management Programme (DMP). Treatments that are eligible for equalization have to meet several requirements, including very high quality. This has to improve the competition for unhealthy individuals[17]. Insured can choose to be part of a DMP, if this DMP is offered by their insurer and their insurer will be compensated for the costs of the DMP-insured. There are two disadvantages in this system according to Van de Ven et al (2007). The first is that insurers want all individuals to register for a DMP-program, even though they are not sick enough, so insurers get more money from the equalization fund and the second is that insured that have an illness that is not part of a DMP-program are still bad risks and pay a higher premium [5]. This means risk-selection is still possible and risk equalization is not perfect for equal competition for all insured and applicants.

The Netherlands

Mandatory and voluntary health insurance

In the Netherlands for all individuals older than eighteen years health insurance is mandatory for the basic package. Until children reach the age of eighteen years, they are insured for free⁶. This basic package is set by the Dutch government, they decide about the context of the package and what everyone is obliged to have insured.⁷ The government decided to include the following in the basic package: medical care given by general practitioners and midwives, pharmaceutical care, medical aid, care and cure, hospital stays and transport necessary to receive care [18]. Long term care (e.g. home care) and care with very high costs that no one can afford to pay is covered by the AWBZ, which is a national insurance for health risk you cannot insure individually. Everyone who lives and/or works in the Netherlands is insured for these risks [19, 20].

Supplementary health insurance is possible for care which is not in the package. This supplementary insurance is not mandatory and not part of the Health Insurance Act [21].

Consumers of health insurance can choose between 35 health insurance companies [22], which offer different health plans. Insurers are not allowed to deny clients for the basic health insurance package and they are not allowed to make differences between high risk and low risk clients. Each insurer is allowed to set his own premium [23]. This means that competition between health insurers is possible. Insurers are allowed to make a distinction between high risk and low risk consumers when accepting and pricing the supplementary insurance [23, 24]. This means even greater competition between insurers, because they can offer different

⁶Art. 2 Zorgverzekeringswet

⁷ Art. 10 Zorgverzekeringswet

packages for the supplementary insurance, so consumers can choose the content of their own benefit package [24].

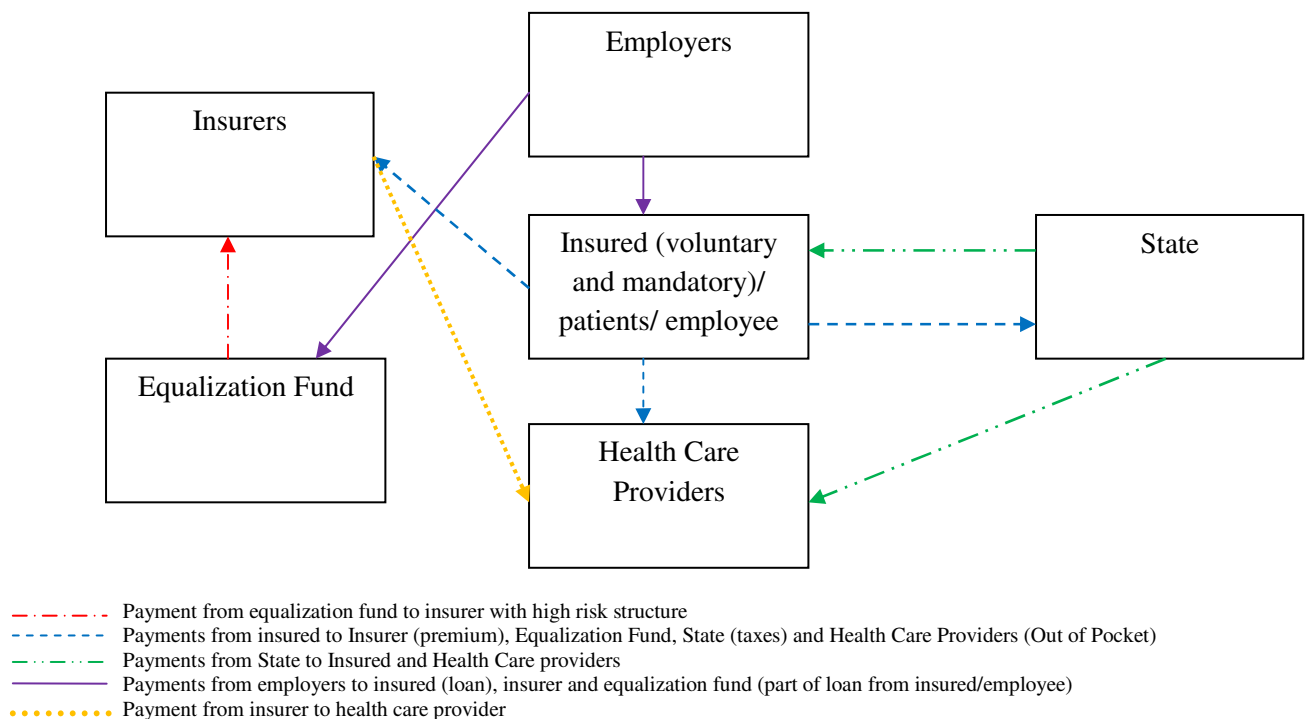
Financing of health insurance and risk equalization

In the Netherlands the care of the AWBZ is paid for by all workers, they pay a percentage of their income to the AWBZ, with a maximum of 300 Euros per month [25].

Insured pay different payments for health insurance. They pay a nominal premium to the health insurer of their choice. The nominal premium pays half of the total for the basic health insurance. Second they have to pay an income related premium, which is taken from their wages by the employers. For the income-related premium there are two tariffs, a high tariff of 7,2 % and a low tariff of 5,1%. If individuals have to pay the high tariff, the employer pays a compensation for the employee. Employers pay the income-related premium to equalization fund [5,26]. Since 2008 insured also have to pay at least 150 Euros out of pocket for care that is part of the mandatory health insurance. They can choose for a higher out-of-pocket payment for a lower insurance premium. Low income insured can also receive an allowance from the state for their health insurance [21].

For an overview of the Dutch health insurance system see figure 3.

Figure 3: Cash-flows health insurance in the Netherlands



In the Netherlands there has been prospective risk equalization since 1993, but the insurance companies⁸ were not very highly responsible for their finances. Later on insurance companies had more financial responsibility, up to 54% in 2004, but at this moment not as much as in Germany and Switzerland, where insurers are financially responsible for 100% [4, 5, 27].

The Netherlands apply the most risk adjusters. In 2000 age, gender, urbanization, entitlement for sickness fund membership (e.g. disability) and 'historical costs' were used as risk adjusters. After 2000 some new risk factors have been added. These are Pharmacy-based Cost Groups (PCGs), Diagnostic Cost Groups (DCGs) and being self-employed. This means the Netherlands have the most extensive risk equalization system at this moment and according to Van de Ven et al (2007) this is not a perfect system yet, but it is a fair system [4,5].

For all three countries it is clear that most individuals have mandatory health insurance for the basic package and there is a possibility for voluntary supplementary health insurance. With both the mandatory and the voluntary insurance consumers have to make choices between several insurance companies and health plans. All systems are mostly financed by the premiums paid by the insured. In Germany the State does only pay for Long Term Care, which is different for Switzerland and the Netherlands, where the State pays more. In all countries risk equalization is not yet perfect, which makes risk selection possible.

In Table 1 I have collected all the information to compare the different countries.

Table 1: Insurance and finance of Swiss, German and Dutch health care system

	Switzerland	Germany	The Netherlands
Health insurance			
Mandatory	yes	yes, for 90%	yes (children under 18 years are insured for free)
Premium differentiation allowed between HI?	yes	yes	yes
Premium differentiation allowed within HI?	no	yes	no
Open enrollment for basic package?	yes	yes	yes
Collectivities?	no	no	yes
Employers sponsor?	Only for daily cash benefit insurance	yes	yes

⁸ Insurance companies were divided in sickness funds and private insurance companies. The insurance funds mentioned here are sickness funds.

Table 1: (continued)

Basic package	yes	yes	yes
hospital	yes, but maximum	yes	yes
medical services (e.g. by doctors)	yes, but maximum	yes	yes
prevention	some	yes	yes
Pharmaceuticals included?	only from 'positive list'	yes	not all
supplementary health insurance possible	yes	yes	yes
Financing			
Insured payments	yes, insurance premiums and out-of-pocket	yes	yes, insurance premiums and out-of-pocket
State payments	yes	only LTC	yes
Solidarity	risk-solidarity	income solidarity	income and risk solidarity
Insurers financially responsible?	yes (a)	yes (a)	partly(b)
Risk equalization?	moderate	moderate/fair	fair
Risk equalization factors(c)	age and gender	age, gender, income, disability entitlement for sick leave payment	age, gender, urbanization, entitlement for sickness fund membership, historical costs, PCGs and DCGs
Retrospective/prospective?	retrospective	retrospective	prospective
Risk selection possible	yes, and it could be a problem	yes, and it could be a problem	yes, but not a problem

(a) 2007

(b) 2004

(c) 2007

In the next chapters I continue first by explaining the theory of what the use of information is, what the requirements for comparable information are, which information is needed and how information is best presented. In chapters 6 and 7 I explain how well Switzerland, Germany and the Netherlands are doing and what actions are necessary to help consumers make a well-considered choice for a health plan. I start in chapter 3 with the use of information and the requirements for comparable information.

3. The use of information and requirements for comparable information

In this chapter I explain why information is important in choosing a health insurance plan. In the second paragraph I explain what the requirements for comparable information are.

The use of information

Providers and plans will only compete on costs and quality if consumers are able to compare the relative costs and quality of a health plan. To be able to compare, consumers need information about the plans and the providers. This could be information from their memory, but if this is not enough, they have to search for more information [27,28,29]. According to Hibbard, Slovic and Jewett (1997) and Sainfort, Bridget and Booske (1996) economists use the utility theory to examine consumers' behavior in financial decision making [28,30]. This utility theory is the basis of "the policy of providing information to increase informed choice" [28:401]. This means that if individuals are well-informed, they will make choices that will increase their utility, until their maximum utility is reached. The only possibility to reach this is if individuals are informed completely, knowing the consequences of their decisions and knowing all the alternatives. In health care this is a problem, because health care is too complex for this theory in the sense that individuals often have not set preferences, their preferences change during the decision process. The complexity of making decisions in health care lies in the number of variables that have to be considered when making a decision. According to this view it is important how information is presented [28,30,31,32]. Evidence from the United States showed that "information presentation methods designed to assist consumer decision making can be used to reduce the cognitive demands made by presented information to help consumers understand the experience of choice and to highlight the meaning of information" [32:171]. I will come back to this at a later moment.

Requirements for comparable information

Information to compare health plans has to meet several requirements. The information should be relevant, comprehensible and credible. Also the information should be publicly available and individuals should be able to see all the available information and should be able to remember it when they are making a decision [33,34,35].

Relevant means that the offered care by the health plan is personally adjusted for the applicant. Relevance is different for every single person. Sex, education, socioeconomic status, age, marital status, family size etcetera play a role in the preferences of consumers.

Most individuals are not interested in plans that offer care they don't need. For example young healthy individuals are not interested in care for older unhealthy individuals, they are more interested in the costs of a plan [28,34,35,36].

Comprehensible means that individuals can understand the offered information. Terms should be clear, performance indicators should be explained. Research shows that sorting health plans into good and bad plans makes it easier to understand and if the information is conflicting individuals will compare on single important elements. Precise and concrete elements, like prices, are than preferred over vague and not-precise elements, like quality. Information is also more comprehensible if individuals can compare information collected from individuals like themselves [28,37,38]. Survey-based data are better to understand than records-based data [34].

Credible information is information that individuals can trust to believe. Individuals have clear preferences about what information from what sources they believe. According to Lubalin (1996) "they want an unbiased, expert source of judgment about health care quality" [34:44]. Other information sources individuals trust are family members, friends and their doctors. If plans and employers are involved in the data collection, consumers distrust the information [34,38,39].

Research shows that if information is publicly available and explicitly given to consumers, it is more visible and there is a bigger chance they read it. Still this information needs to be understandable and relevant to the readers if they want to use it [34].

If too much information is offered, individuals get confused and are not able to remember everything they have been reading. Individuals will only remember what is in their own interest at that moment and they use the information not effectively [31]. Peters, Dieckmann, Dixon, Hibbard and Mertz (2007) show in their article that giving individuals more information does not imply that they use this information and it does not imply that they can make better decisions due to this extra information. They even show that consumers understood the information about quality of hospitals better when less information was offered. The more important measures should be made clearer and easier to understand [32].

Information is important in making a decision about what health plan a consumer needs. Only if consumers are able to compare the information health insurers and providers will compete to deliver the best quality for the lowest costs. Comparable information means that the information is relevant, comprehensible, credible, publicly available and visible and easy

to remember. In the next chapter I explain what information consumers need in making a well-considered choice of a health plan.

4. Information individuals need in choosing a health plan

In the previous chapter I described that consumers need information to make a decision on a health insurance plan. But what kind of information do individuals think is relevant in choosing the right plan? In this chapter I describe what kind of information consumers in the United States think they need.

Too much and too complicated information is not going to help individuals in choosing a health insurance plan as we already saw in the previous chapter [31,32]. Consumers only seem to change plans if they are not satisfied with their current plan. Good information can help consumers to choose whether they should change and if so, in what plan they can find what they need [36]. Consumers seem to make a decision based on the potential loss and gain they will experience. Hibbard (2003) bases this conclusion on the fact that more than half of all Americans think that health insurers only want to make profit and insured don't get all their costs reimbursed [31]. This means the content of benefit package is important for consumers, people need to see what is covered and know what to expect.

Studies have been performed on what more consumers want. Lubalin (1999) mentions in his article a list of thirteen information elements given by consumers that they think is important in choosing a health insurance plan:

- “(1) access (to chosen doctor, to specialist, length of time to get an appointment, ability to get care when needed, telephone access);
- (2) amount of paperwork;
- (3) benefits;
- (4) choice of provider (of doctors, of hospitals, ability to keep one's own doctor);
- (5) communication/interpersonal skills/ caring of provider;
- (6) convenience (of choosing doctor, getting care, location);
- (7) coordination of care;
- (8) costs;
- (9) courtesy and manner of physicians and staff;
- (10) hospital ratings;
- (11) good value for money;
- (12) plan administrative hassles; and
- (13) quality (of care overall, of particular types of care, of providers).” [34:72]

In the following paragraphs I examine all these elements. Other researchers may have found more information elements, but I only concentrate on these thirteen elements.

Access

Consumers want to know to which doctors they have access and what the waiting times are. Information on waiting time should be precise and not about satisfaction of other consumers, because tolerance is different for everyone. Also access on information via telephone is important, for example when making an appointment or getting advise [35].

Health plans that have difficult access to doctors loose enrollees and will not attract new enrollees [36]. In choosing a health plan information on access is thus important.

Amount of paperwork

The amount of paperwork is mentioned in several papers as a possible problem for consumers [34,36,39,40]. If consumers have to fill in several forms to get enrolled or to get reimbursed, the amount of paperwork could be too much and they are not interested to join a plan. The less paperwork consumers have to do, the more satisfied they are. Insurers where most of the paperwork is done for consumers will attract more new enrollees. Information on the amount of paperwork is therefore important.

Benefits

As already mentioned before, consumers want to know which benefits are included in their package and they want to be able to compare this to other plans. Consumers want to know what to expect and what the alternatives are [31,35,37,40]. Not knowing the contents of a plan can be decisive in choosing another insurance plan. Consumers with more need, will be more interested in the content of the package than consumers without need [36].

Choice of provider

An important factor in choosing health insurance plans is that patients have access to their preferred doctor [38]. For a patient his relationship with his doctor is very important, so if someone's doctor is not in a plan, that person is probably not going to choose that plan. Knowing the preferences of patients/consumers is a first step to contract the right providers. The problem is that individuals all have different preferences and that all doctors have a different personality. For example persons with a specific (chronic) disease indicate that they want information on specific specialists. Information on access should be as completely as possible, including the possibilities for seeing a preferred doctor that is not in the plan [36,40]. Information about doctors should be complete and consistent for consumers.

Communication/interpersonal skills/caring of provider

Insensitive and not communicative providers are not preferred by consumers. Consumers want to know how others think about the communication, interpersonal skills and caring of providers [35,36].

Convenience (of choosing doctor, getting care, location)

Not only contracting preferred doctors is important, but also the convenience of choosing a doctor and getting the care the consumer needs, at a preferred location. The location of a doctors' office plays also a role in choosing an insurance plan [36,39,40]. If a provider is difficult to reach, consumers will seek for another plan with doctors that are easier to reach.

Coordination of care

Coordination of care is important because patients want to know where and when to go if they need care. An insurer that contracts providers with good mutual coordination and coordinates with the providers itself is preferred [34].

Costs

One of the most important factors in choosing a health insurance plan is about the costs of the premium and the out-of-pocket payments. Most consumers are cost sensitive, so the higher the costs of a health insurance plan, the lower the chance a consumer will want that plan. If consumers can avoid making out-of-pocket costs they will use this possibility, especially if they have a fixed income [32,34,35,36,37,40].

Courtesy and manner of physicians and staff

Information about the courtesy and the manner of the providers is important because it can give patients trust in the physicians and staff. [39].

Hospital ratings

Hospital rating should not only be on technical quality of the staff, but also about the patient's perspective on how they experience the received care. Mortality rates are difficult to interpret and are often not used by consumers, however they seem to remember negative information on deaths in hospitals in the media [34,35]. When hospitals are rated it is easier for consumers to choose the high quality hospitals with less information [32].

Good value for money

Good value for money is about having a good relation between price and benefit. So when consumers know what the content of the package is and they know the price, they can decide themselves if they get good value for money.

Plan administrative hassles

Not only the amount of paperwork is important but also a quick provision of administrative services, such ID-card and reimbursement is very important for consumers and could play a role in choosing a health insurance plan. For example, consumers do not want to wait months before they get reimbursed. Administrative problems should be avoided [40]. Information about 'good' administration could help attract enrollees to join a plan.

Quality (of care overall, of particular types of care, of providers)

Quality of doctors in a plan is the most important factor in choosing a health plan. A plan with low quality doctors will not attract many enrollees even if the costs are low. Not all quality indicators are good quality indicators. The most useful ones are patient rating and preventive indicators according to consumers. Not useful are performance measures of adverse events, such as how many patients get ill after using a drug [37,39,40].

In this chapter I described all important factors of information that play a role in choosing a health insurance plan. The thirteen factors contain a lot of information, which could be even too much for consumers. The way to present it can play an important role on how consumers use the information [28]. How information should and should not be presented I explain in the next chapter.

5. Information presentation

Information about health insurance is not as easy to understand as for example information about buying a new car. Most of the time it is not available and if it is available, people do not always understand the content or the consequences of their choices. Consumers who do not understand how to choose a health plan or think it is very easy to choose a health plan do not seem to spend much time in deciding what they want. Also preferences play a big role in searching for information. If consumers have set preferences they search for information about that subject and their decision is based on only that information. But before presenting any information to consumers, they should be able to understand the information. Consumers should be educated about the content of the information and the consequences. Only then consumers can use the information effectively and efficient [30,34,36].

In this chapter I explain how information is best presented for consumers so they can understand and evaluate the information in a clear and easy way.

In the previous chapters I explained that there should be enough, but not too much information available for consumers. If consumers have the possibility to navigate through information, they spent more time searching and access more information. Their preferences then can change because their attention is drawn to other aspects of health insurance than what they were searching for. Giving layered information could help consumers navigate through all the available information. Consumers start with global information and they can easily find more specific information if they want to [30,35]. An example of this method is given by Hibbard (1997):

“[...] consumers might be guided first through a process of decision making about benefit packages and option levels; their choices would thus be narrowed before they tackled the information on quality. Thus, consumers could choose high-performing plans within a narrower band of choices” [28:407].

Choosing will already be more easily when taking small steps, but even then there is still a lot of information that is difficult to compare. Consumers should be able to evaluate the information, to give meaning to the information. If consumers can not evaluate information on a subject, they will not use it, even though it might be important information. Consumers want to understand if the information is about something they desire or do not desire. Presentation of information should therefore be evaluable and understandable. Hibbard and others (2002) examined four possibilities of presenting information to consumers of health

plans. Other researchers may have found more information presentation possibilities, but I only examine these four ways of information presentation.

The first method is using visual cues. These should help make it easier to distinguish the high quality plans from the lower quality plans. Hibbard and others used stars to make the distinguishes, ★★★ for above average performance, ★★ for average performance and then ★ for below average performance. They compared the outcomes of the choices with outcomes of participants choosing from a stacked-bar-only format. This last group chose the high quality plans less often than those choosing based on the stars. Using visual cues can help consumers to choose high quality plans over low quality plans.

The second experiment was about ordering the information from high to low quality. The results of the experiment show that consumers could more easily choose the high performance plans if the plans were ordered from high to low quality than if they are not ordered. Even when a budget was included, consumers could still maximize their possible quality.

In the third experiment affective cues were added to trend data. Hibbard and others used pluses (+) and minuses (-) to indicate positive and negative trends of HMOs. The pluses and minuses helped consumers choose HMOs with a positive trend. If the pluses and minuses are not added, consumers have more difficulty choosing a HMO with a positive trend. The information was better understood after adding the pluses and minuses.

The last method was summarizing and aggregating the information. Here different measures were combined into one measure, which made it easier to compare information. Participants did have problems weighting quality factors consistently, but the different forms of summarizing and aggregating information influenced the decision makers (e.g. layered information).

In their article Peters and others (2007) also found that visual cues were helpful, but that it is important to use the right cues. Traffic light might help the high numerate respondents, but may have hurt the low numerate [32].

The four methods of presenting information show that the way information is presented has an influence on the choices consumers make. Consumers find it more easy to compare information if there are visual cues, if the information is ordered, if affective cues are added and if the information is summarized or aggregated [41].

Information is only useful for consumers if they understand it and know how to use it. Education and a clarifying presentation make it easier for consumers to compare the available information.

6. Available information in Switzerland, Germany and the Netherlands

In this chapter I describe what information is available for consumers of health care plans in Switzerland, Germany and the Netherlands. In all three countries internet gives the most information on health care plans and there are possibilities to compare different insurers on internet websites.

To be able to compare the three countries I look at the information elements I used in chapter 4. An overview of all information elements of the three countries can be seen in table 2.

Switzerland

In Switzerland comparing health insurers is difficult, because 94 different health insurers operate per canton. The same health insurer can charge different prices per canton. To be able to compare consumers have to choose the canton and town/zip code first and then get some information, mostly about prices. Other information, such as the benefits, has to be found on the websites of the health insurers or even by just searching internet. In the next paragraph I describe whether the information elements described in chapter 3 can be found for Swiss consumers. It is not possible to describe all health insurers, so I chose for three insurers, Sanitas, Kolping and Allnova, which all have comparable information on their websites and are quite easy to find for consumers. I chose Kolping, because it offers HMO-insurance and I chose because Sanitas and Allnova both offer ‘normal’ basic and supplementary insurance.

Access

In Switzerland consumers can choose between HMO-insurance and non-HMO-insurance. HMO-insured are only allowed to contracted providers. Information about these providers can be found on the websites of the insurers. Doctors, therapists and other providers are listed for example by canton, which makes it easier to find [42,43,44,45]. Information about waiting times of the providers is not available.

Amount of paperwork

Consumers can choose to get the information they need by email or ‘normal’ mail. Sometimes information can only be send by mail and not by email, which makes the amount of paperwork higher [46,47].

Benefits

The benefits of the supplementary health insurance can be found on the websites of the insurers. On comparing websites consumers can indicate what they want in their package and next a list of different health insurers that offer that benefits is shown on the screen[46,48].

Choice of provider

Most health insurers do not offer HMO-insurance, which means that the insured can go to every doctor they want. Information about available doctors in HMO-insurance can be found on the website of the insurer [43]. Insurers that do offer HMO-insurance provide information about the available doctors on their websites.

Convenience (of choosing doctor, getting care, location)

Choosing a provider can be done by searching on the internet, where there are several lists of available providers, per canton, per town. Also on some individual websites there are lists of providers [49,50,51]

Costs

Comparing premiums is very easy for Swiss consumers. There are different public websites available where consumers can compare the prices of the basic packages. For supplementary insurance consumers can choose what they want in their package and get a list of all insurers that offer that insurance and the corresponding prices. It is also possible to calculate the premiums on the website of the insurer [46,47,52,53,54].

Hospital ratings and quality (of care overall, of particular types of care, of providers)

Information on hospital quality can be found on www.comparis.ch. There are several different patient satisfaction studies accomplished, about overall satisfaction, infections and medical mistakes [55]. There is also a comparison available on the different insurance companies [56]. Hospitals and other providers can get an EQUAM certificate if they suffice the indicators set by EQUAM. EQUAM measures not only the structure of the hospitals and provider, but also the conditions of the care and cure processes. The indicators include effectiveness of treatments, access, patient satisfaction, stability of the system, use and control of medical offers, costs of care and information and system description. Consumers can find which HMO-providers, network practices and individual doctors have a certificate [57].

Good value for money

Consumers can decide themselves if they get good value for money, by comparing the prices, the benefits in the package and the quality.

Communication/interpersonal skills/ caring of provider,

In studies about patient satisfaction important factors are communication, interpersonal skills and caring of provider, which are compared to the highest, lowest and mean scores of all hospitals [58].

Coordination of care,

The comparison on www.comparis.ch shows how well doctors are working together with nurses according to patients in a hospital. The table shows the percentage of the patients that were satisfied with how doctors and nurses were working together and this is compared to the highest scoring hospital, the lowest scoring hospital and the mean of all hospitals (see appendix 1). There is no information on individual doctors and nurses, only on hospital level [58].

Courtesy and plan administrative hassles

Information on courtesy and plan administrative hassles for consumers is not available.

Information is available in Switzerland, but the information is not very easy to find and it is not very compact. Consumers need to search on different websites and compare much themselves. Price and benefits are the most easiest to compare, but if consumers want to compare the contracted hospitals of an insurer, they have to search for all the hospitals themselves.

Germany

In Germany there are seven overall health insurance organizations for health insurance. Before selecting a health plan, an individual needs to know whether he can join a profession-specific plan or need to join a general plan. After selecting an overall organization consumers can choose often from different sub-organizations that offer the health insurance. Because it is too much to use the websites of all insurers I restrict this research to three different insurers, AOK (the largest company), Barmer and Audi Betriebskrankenkassen. I chose AOK because it is the largest insurer in Germany and it offers insurance for everyone. Barmer offers

insurance for consumers that work and Audi Betriebskrankenkassen offers insurance in certain regions. Barmer and Audi Betriebskrankenkassen both are members of bigger overall organizations, respectively VDaK and BKK. They both offer specific insurance for working groups, such as for people who work at the train company or technical employees.

Access

In Germany insured can not always choose the provider they want, this depends on the insurer. Some insurers have contracts with providers and their enrollees can only go to these providers if they want (full) reimbursement of their costs. Other insurers offer consumers to go to every legally recognized provider and reimburse all costs [59,60,61,62].

Amount of paperwork

On the websites of the insurer consumers can request information on how to join an insurer. Consumers can download or fill in a form to get information [63,64,65] .

Benefits

Consumers can compare benefits in two different ways. They can use comparing public websites, where they fill in the benefits they want in their package and the possible insurers are shown. The other way is to look at the websites of the insurers, where they can find the different packages the insurer offers [66,67,68,69,70,71].

Choice of provider and convenience (of choosing doctor, getting care, location)

Insurers that have contracted providers have a list on their website where consumers can choose from. Other providers can be found on other websites on internet [72,73,74].

Costs

Consumers can compare costs of insurance plans on comparing websites and on the websites of the insurance companies. Information will be send to their home address if they request it [66,67,68,69,70,71].

Hospital ratings and quality (of care overall, of particular types of care, of providers)

There is not much available information on hospital ratings and quality yet. There is only one website from overall insurance organization VDaK with some information on quality, for example how many complications there are after treatment and whether these results are

distinctive or not. A second possibility to get information on quality is from a scientific information organization, but consumers have to pay for this information. Here consumers can find information on quality of medical services and the relation between costs.

The German government is assuring quality by introducing the mandatory KTQ-certification for hospitals. Other providers are not obliged to have certification. The certificate is not only about quality, but also about the whole process of a patient's hospital stay, from the moment he arrives until the moment he leaves. The providers that already have the certificate can be found on the website of the KTQ-certification [75,76,77]. The government also mentions quality as very important and give advice for consumers on how to recognize good quality, for example verifying whether a hospital has already KTQ-certification [78,79,80].

Good value for money

Consumers have to decide for themselves whether they get good value for their money by comparing price, package and available quality.

Coordination of care

One of the main objectives of the Disease Management Program is to coordinate care better. For diseases that are not in DMP care is not very well coordinated yet [81]. In 2006 there were six DMP programs, three are used nation wide (Type 2 DM, CHD and Breast Cancer) and three are only used in some regions (Type 1 DM, COPD and Asthma Bronchiale) [82].

Communication/interpersonal skills/ caring of provider, courtesy and plan administrative hassles

There is no information available on communication, courtesy and plan administrative hassles for consumers.

The Netherlands

In the Netherlands the most important public website for consumers is www.kiesbeter.nl. On this website consumers can find a lot of information on health plans and health care providers. Information on this website is given by the insurers, the hospitals and public health investigators (Inspectie voor de Volksgezondheid). The website is a product of RIVM (Rijksinstituut voor Volksgezondheid en Milieu, Governmental institution for public health and environment) by order of the department of Public health, Welfare and Sport (VWS) [83].

More information can be found on the private websites of the health insurers themselves. Because it is too much to investigate the websites of all insurers I restrict this research to three different insurers (CZ, Unive and FBTO). CZ and Unive both have contracted providers, but FBTO does not have contracted provider, which means consumers can go to all providers without additional payment. In this paragraph I explain whether the information elements are (partly) available or not.

Access

There is only information available on waiting times of hospitals. Consumers can find on the website www.kiesbeter.nl whether a hospital has waiting times and how long these waiting times are in weeks for every hospital for treatments and/or for a certain specialism. Hospitals in the Netherlands have maximum acceptable waiting times that are set by the government. These are called the 'Treeknormen'. Insurers can mediate for their insured to get the fastest treatment possible [84,85,86].

Amount of paperwork

The amount of paperwork is different for all health insurers. With some insurers it is already possible to send the bills by internet and it is not necessary to do this by 'normal' mail. This makes it easier for consumers to send their bills [87]. With some health insurers the bill will be send directly from the health care provider to the insurer if they have mutual agreements [88]. Consumers that want to switch often have to fill in a health declaration to be accepted for supplementary insurance. Joining an insurer can be done by using the private websites of the insurer and the insurer will end the old insurance plan for the consumers [89].

Benefits

The benefits of the basic package are the same for all insurers and insured. Insurers can only offer different packages for supplementary health insurance. Information on the different packages can be found on the websites of the insurers, or insurers send it to consumers by mail. Further, www.kiesbeter.nl provides extensive information. Consumers can choose between several packages with different benefits for supplementary health insurance[90,91,92].

Choice of provider

CZ and Unive have contracts with providers, but FBTO does not. On the websites of the individual insurers it is possible to find which providers they have contracted [93,94]. Also on www.kiesbeter.nl consumers can see which insurers have contracts with a certain hospital [95]. Insured can go to every provider they want, but it is possible that not all costs are reimbursed if they go to a provider that is not contracted.

Convenience (of choosing doctor, getting care, location)

On internet consumers can find almost all hospitals and other providers, e.g. on www.huisartsen.nl and www.kiesbeter.nl. Hospitals have their own internet-addresses. On kiesbeter.nl consumers can search the addresses by typing their own zip code, so they can find a provider in their neighborhood. It is also possible to search for providers that are not in their direct neighborhood. On www.huisartsen.nl consumers can find all general practitioners [96,97].

Costs

Consumers can compare prices by using the websites of the insurers and www.kiesbeter.nl. On the last website it is possible to compare two or more insurers at the same time. Consumers have to specify whether they want supplementary care or not and what they want in their package for supplementary care. The program shows the list of the insurers and their costs [92].

Hospital ratings and quality (of care overall, of particular types of care, of providers)

www.kiesbeter.nl and on www.independen.nl (a private site) are the best known websites which consumers use to compare hospitals and quality [98,99]. On www.kiesbeter.nl there are relative scores for different treatments and different specialism's and several different mortality rates. Not for all specialism's and diseases information is available [100].

Consumers can see how well a provider is doing based on quality indicators, judgment of general practitioners, patients and according to the website www.kiesbeter.nl [98].

In the Netherlands providers can get different quality certifications, such as HKZ, MIK-V (for nursing homes), INK, the bronze quality mark and the silver and golden quality mark. INK is more about management of providers, where HKZ, MIK-V and the bronze, silver and gold quality marks are more about quality, patient satisfaction and medical failures [99]. Providers

that have a HKZ certificate can be found on the website of HKZ. An independent third party carries out the certification[101].

Another possibility to get information is from 'de consumentenbond', which is a general consumer organization. Their mission is to make it easier for consumers to choose the best product. The 'consumentenbond' has a special guide on health, where tests are published concerning several health issues, e.g. hospital quality, treatments quality etc. Only members of the 'consumentenbond' receive this information. Interested non-members can buy the guide [102,103].

These websites do not have all information for all providers on hospital ratings and quality available yet. Information on treatments and specialism's is more and more available, however information on individual doctors and nurses is not available.

Good value for money

As said before consumers can compare health insurance plans and providers on www.kiesbeter.nl and www.independer.nl and decide for themselves if they get good value for their money, based on the package, price and the quality of the (contracted) providers.

Coordination of care

For some diseases care is more coordinated than for other diseases. Good examples are breast cancer care and diabetes care [104,105].

Courtesy

On www.kiesbeter.nl information can be found on the courtesy of providers per health insurer. Insured gave a statement on how well the doctors and other health care givers are doing according to them. The more stars an insurer gets, the better it is performing, so the more stars on courtesy, the better the doctors and other health care providers are performing [105].

Plan administrative hassles

On www.kiesbeter.nl consumers can find how well insurers are providing information on reimbursement and out-of-pocket payments [106].

Communication/interpersonal skills/ caring of provider

There is no information available on communication for consumers.

For the Dutch consumers there is a lot of information already available but it is not complete yet. The government is working on especially quality indicators for providers, such as hospitals, nursing homes and home care. Also patient safety is becoming more and more important [107]. Consumers can compare information and it is quite transparent due to the available websites.

In Switzerland information can be found on access, except waiting times, amount of paperwork, benefit, choice of provider, convenience, costs, hospital rating and quality and communication. No information can be found courtesy and plan administrative hassles. In Germany no information can be found on waiting times, communication, courtesy and plan administrative hassles. Only little information can be found on hospital ratings and quality.

In the Netherlands almost all information elements, except communication, can be found, but not all elements can be found extensively.

Table 2: Information in Swiss, German and Dutch health care system

Information available?	Switzerland	Germany	The Netherlands
Access	partly	partly	yes
Providers	yes	yes	yes
Waiting Times	no	no	yes
Amount of paprwork	yes	yes	yes
Benefits	yes	yes	yes
Choice of provider	yes	yes	yes
Covenience	yes	yes	yes
Costs	yes	yes	yes
Hospital ratings and quality	yes	not much	yes
Good value for money	Consumers have to decide for themselves	Consumers have to decide for themselves	Consumers have to decide for themselves
Communication/interpersonal skills/caring of provider	yes	no	no
Coordination of care	yes, but only on hospital level, not on individual level of doctors	only for DMP	partly
Courtesy	no	no	yes
Plan administrative hassles	no	no	partly

All three countries have a lot of information available on health insurance plans, but the most is to be found for Dutch consumers, especially on waiting times and hospital ratings and quality. Switzerland is the only country that has information on communication, interpersonal skills and caring of the provider available. Still in all countries information is not perfect yet and a lot has to be done to make sure all information is available. In the next chapter I describe how the information is presented and how easy it is to find for consumers.

7. Information presentation in Switzerland, Germany and the Netherlands

In the previous chapter I described what information is available for the Swiss, German and Dutch consumers. In this chapter I explain whether this information meets the requirements mentioned in chapter 2, how this information is presented and how easy it is to compare different health insurers. I describe this only for costs, benefits and quality, because most information can be found on these subjects.

Requirements for comparable information

As said in chapter 2, information should be relevant, comprehensible, credible, publicly available and visible. Also there should not be too much information, because then consumers are not able to remember everything they have been reading and can not use the information effectively. In the next paragraphs I explain for all three countries whether the information meet the requirements to be comparable.

Switzerland

In Switzerland, as I described in the previous chapter, information is not very easy to find. Comparison websites only give information about the benefits and costs and not about other information elements, quality information can only be found on separate public websites. Consumers can choose what benefits they want in their package and get information about which insurers offer these benefits for what price. The only way to get the information is to provide personal data, such as name, address, working status and income [43,46,52]. This means that the information consumers receive is relevant for them, because it is adjusted to their preferences, sex, social economic status etc. Quality information is also relevant, because consumers can find information on the hospital they are interested in.

Quality information is also comprehensible because it is clear and performance indicators are explained. Consumers can immediately see how well the hospital of their choice is doing (see later this chapter) compared to other hospitals. Information on prices and benefits is comprehensible because on the several public websites consumers can find what the benefits mean and what a HMO is.

Information in Switzerland is not very credible, because most information is given by the insurers or is based on patient satisfactory studies. Patient satisfactory studies are less credible because no technical information is used. For patients it is difficult to decide whether the treatment or surgery was performed right, there only concern is to get well. For example if a patient gets complication, it does not mean the doctor made a mistake, it could be an allergic

reaction, but the patient might not be satisfied. There is not much information available that is given by an independent third party.

Another problem is that information is only partly publicly available and visible. Consumers have to wait for information until they receive it by email or at their home address. It is also not very easy to find information, consumers have to search the internet to find it. Positive is that the (contracted) providers are quite easily to find on the websites of the insurers. For insurers that have no contracts with providers consumers have to search on internet to find all providers. There are several websites with for example hospitals, doctors and other providers [44,45,49,50,51].

It is not easy for consumers in Switzerland to compare the health insurance plans, because they have to do much themselves and they have to depend on their own experiences and that of others around them. Even though patient satisfaction studies are informative, consumers also want technical information judged by an independent third party added.

Germany

The information consumers can find in Germany is relevant for consumers. They can find information on prices and benefits and can choose the benefits that are relevant to them. It is also easy to find the relevant providers for the health insurance plan of their choice. Information on quality is very difficult to find, because there is not much available yet. Consumers can only see for some providers whether they have a KTQ-certification, so only for some consumers this is relevant information.

Information is not always comprehensible, because the numbers used are difficult to understand (see later this chapter). Only information on benefits and costs is comprehensible. Information is also not very credible, because most information is given by insurers and not by independent third parties.

Costs and benefits are publicly available, because all consumers can find information on these subjects. Quality information is only partly publicly available, only the part that is offered by insurer VDaK. Other information consumers have to pay for.

If consumers have found all available information it is very difficult to compare it, because there could be too much to make it possible to remember.

The Netherlands

Like in Switzerland and Germany the available information is relevant in the Netherlands. Consumers can choose what benefits they want in their package and they can choose between

several insurers that offer these benefits and compare the prices. Quality information is not available for all providers yet, so consumers can only find information from providers that have information available. Waiting times can be found on a website for every hospital and all specialisms the hospital offers. Consumers can easily choose the hospital and then choose the specialism they need care for. The waiting times are shown in weeks, which is very understandable for consumers and it is objective [84,85].

Information on www.kiesbeter.nl is both survey-based (patient-satisfactory surveys) and records-based (relative scores per hospital) [108]. Consumers can choose what information they understand best and use that. It could be that consumers do not understand all survey-based information, because it consists of relative scores, which makes it less comprehensible. Costs and benefits are more comprehensible, because consumers already chose what benefits they wanted and prices are clear.

Most information is credible in the Netherlands, because it is given by independent third parties. The quality information is offered by the providers themselves, but external parties perform control visits to make sure the quality is as the provider said it is [109]. On www.independen.nl quality information is also based on indicators and opinions of general practitioners, which makes it more credible.

In the Netherlands almost all information is publicly available. Only information from the 'consumentenbond' is not publicly available, because consumers have to pay for this information.

Also in the Netherlands, like in Switzerland and Germany, there could be too much information available for consumers to use it effectively. If consumers have gathered all the available information it is very difficult to compare because they still have to order it themselves.

Information presentation

In the following paragraphs I examine for every country how the information is presented. I look at the four different presentation methods I described in chapter 4, visual cues, ordering information, adding affective cues to trend data and summarizing and aggregating information.

Switzerland

The presentation of the information on costs and benefits can only be valued if consumers fill in the forms and get the information send to them by mail or e-mail. For me it is not possible to evaluate this.

The presentation of quality information on hospitals is more conveniently arranged than the information on costs and benefits. Consumers can choose between hospitals if they want to see the results and they get aggregated information on one website (see appendix 1). Consumers can get more detailed information by clicking on a link to a graph. On the webpage with the aggregated information consumers can see whether the hospital is doing better or worse than other hospitals on medical mistakes. This is shown by affective cues ((+) for doing better compared to other hospitals and (-) for doing worse compared to other hospitals). In the graph consumers can see how well the hospital is doing on several issues compared to the hospital with the highest, lowest and mean score. The comparing scores in the graph are shown with signs where the hospital with the highest score is signed with Δ (blue), the hospital with the lowest score is signed \circ (pink) and a chart is used for the mean scores of all hospitals. The hospital that is compared is shown in a green chart [55,58]. The comparison of the insurers is ordered from highest scores to lowest scores.

In Switzerland no visual cues are used and information is not ordered, only affective cues are added and information is summarized.

Germany

Comparing benefits and prices for private health insurance is very easy in Germany by using comparing websites. Consumers can indicate what they want in their package and they get the benefits with the corresponding costs. If consumers want more specific information there is a possibility to get information send to them by mail. The output is not ranked, so consumers have to rank themselves [66,67].

Comparing benefits and prices for the mandatory health insurance is a little more difficult, because additional information is asked for. It is only possible to compare health insurers with the health insurance a consumer is enrolled with. The output is ranked from lowest to highest costs, which makes it easier to compare. A column with the savings compared to the current health insurance plan is added[68,110].

Consumers can also find the benefits on the websites of the insurers, where they can choose between a lot of possible benefits, complete plans and bonuses [69,70,71].

Quality information is available per provider and it starts with explaining about the number of treatments done and the number of available personnel. The provider is compared to other providers by treatment by numbers from zero to nine, where all numbers have a different not ordered explanation, but are explained as conspicuous positive (numbers 3,4,5,6), inconspicuous positive (numbers 1,2,8) neither conspicuous, nor inconspicuous positive (number 0) and remaining (number 9) on quality. The difference between conspicuous and inconspicuous lies in the moment of the measurement (first time or second, third time etc.). Only a hospital (or treatment) with number 6 can say it has good quality (see appendix 2) [111]. This ordering makes it quite difficult for consumers to compare health care quality because they have to look at all the providers and treatments and they have to understand the numbers. Also information is not available for all providers. Quality comparing can also be done by the consumers themselves, based on the advice provided by the government, their own opinions and that of relatives.

Comparing whether consumers get good value for their money is therefore possible, but time-consuming and the quality of all providers is not measured yet.

The presentation of the information in Germany is not very good yet. Only one website makes it easy for consumers to compare the different health plans by price and benefits. Comparing quality is even more difficult than comparing costs and benefits, because it is more difficult to understand and consumers have to check all the hospitals separately from each other. No visual cues and affective cues are added, information is only partly ordered and only partly summarized and aggregated.

The Netherlands

Consumers can compare benefits and prices on the same website. Like in Germany and Switzerland consumers can indicate what they want in their benefit package and it is shown which insurers offer these benefits to what costs. It is possible to compare the current health insurance plan with other plans, but also to compare two or more other plans. Consumers can compare the costs, but also the service of the insurer. This is shown in an extra column with a grade and stars (***). The higher the grade or the more stars, the better an insurer is doing compared to the mean of all insurers on service [91,112].

For insurers that have contracts with providers it is possible to find the information on the websites of the insurer by contacting the insurer via e-mail or telephone. Consumers can search for providers that are close to their home, but also further away. On the comparing website consumers can find all providers working in the Netherlands [93,94].

Quality comparison can be done both on www.independer.nl and on www.kiesbeter.nl. www.independer.nl provides information on more treatments than www.kiesbeter.nl. Comparison on both websites can be done by specialism and treatment.

On kiesbeter.nl hospitals are compared to the average performance of all providers by A, B, C, D and E, where A means much better than average and E means less than average performance (see appendix 3). It is possible to compare more than two providers at the same time [99,113].

On www.independer.nl it is also possible to compare more than two providers. When choosing a treatment or specialism all hospitals (in a zip code) are shown, with some global quality information and after that the consumer can choose from what provider he/she want to know more quality information, so information is layered. The information here is presented by stars (★), where one (red) star means poor, two stars means sufficient, three stars means good and four stars means excellent. There are also grades given by patients, where a higher grade means a better performance according to the patients [114,115].

With all the information available consumers can compare with what plan they get the best value for their money, but they have to do a complete comparison by themselves when including costs, benefits and quality.

In the Netherland visual cues are added and information is aggregated and summarized. Only some information is ordered and no affective cues are added to trend data.

Table 3: Requirements and presentation of information in Switzerland, Germany and the Netherlands

	Switzerland	Germany	The Netherlands
<u>Requirements</u>			
Relevant	yes	yes	yes
Comprehensible	yes	partly	yes
Credible	yes	no	yes
Publicly available	yes	partly	yes (except for 'consumentenbond')
Too much available	yes	yes	yes
<u>Presentation</u>			
Visual cues	no	no	yes
Ordered	no	partly	partly
Affective cues added	partly	no	no
Summarized/aggregated	partly	partly	partly

It is clear that for the Netherlands the information is most easily to find and to compare, but in neither of the three countries it is easy to make a full comparison on costs, benefits and

quality. In the next chapter I discuss what in all countries needs to be done by health insurers and the government to make it easier for consumers to compare and to choose the best value for their money.

8. Conclusion and discussion

Conclusion

The object of this thesis was to answer the question:

What is the status of the information on health insurance in Switzerland, Germany and the Netherlands?

To be able to answer this question I first answered the following questions:

1. What health insurance systems are being used in Germany, Switzerland and the Netherlands?
2. What is the use of information in health insurance and what are the requirements for comparable information for consumers?
3. Which information is needed when choosing health insurance?
4. What is the best way to present information to consumers?
5. Which information is available for consumers of health insurance plans in Switzerland, Germany, and the Netherlands?
6. How is the information presented in Switzerland, Germany and the Netherlands?

Switzerland, Germany and the Netherlands are using similar social insurance systems where (most) of the inhabitants are obliged to buy a basic health insurance package and have the option to buy supplementary health insurance. All three countries also use some sort of risk-equalization, but only in the Netherlands this prevents risk selection.

To help consumers make a well considered choice they need information. Information should be relevant, comprehensible and credible. It should also be publicly available, visible and consumers should be able to remember it.

When choosing a health insurance plan several information elements should be available, including information on access, amount of paperwork, benefits, choice of provider, communication, interpersonal skills and caring of the provider, convenience, coordination of care, costs, courtesy and manner of physicians and staff, hospital ratings, good value for money, plan administrative hassles and quality. Important when offering all these elements of information is to educate consumers and make sure it is not too much information for consumers to process.

Next to giving information the presentation could also make it easier for consumers to understand and process. Visual cues, ordering information, adding affective cues to trend data and summarizing and aggregating information could be of great help for consumers.

In Switzerland Germany and the Netherlands much information can be found, but the most can be found in the Netherlands, where there is at least some information on all elements, except communication. In Germany there is not much information to be found on hospital ratings and quality.

In the Netherlands it is also the most easily to find information and to compare it, although in Switzerland information on quality is very well presented and therefore easy to process.

All three countries are already doing quite well on giving information on health insurance to consumers. Much information can be found on internet or consumers can ask information from their insurance company. Quality information is less easy to find than information on costs and the benefit package and it is difficult to compare costs, benefits and quality at the same time. Because consumers should make a well considered decision on these three subject insurers should not only compete on costs and benefits, but also on quality of the (contracted) providers and there own quality so they can make sure that consumers get the best treatment possible. In all three countries information is not complete and is not presented in the best way possible, which makes it more difficult for consumers to make a well-considered choice.

Discussion

In this paragraph I describe for the three countries what can be done to make it easier for consumers to compare the available information and what information should be added. I also describe what the limitations of this study are.

As said in chapter 2, information should be relevant, comprehensible and credible, but before giving information to consumers health insurers and governments should make sure the consumers understand information. If consumers do not understand the information, they can never use it the right way or will not even use it at all. This means that all countries have to give education on health insurance to their consumers who do not understand the concept of health insurance and the available information.

Switzerland

In Switzerland it is most difficult to find information on health insurance. Costs, benefits and quality are most easily to find, but on waiting times and the health insurers there is hardly anything to find. First there should be more information available and there should be a possibility to compare all aspects of health insurance.

The presentation of the information should be clear and easy to understand, by using for example stars, or it should be explained so consumers can immediately see what are good providers or health insurers. Step by step choosing is already possible, which makes it easier for consumers to select their preferences for benefits and costs, but still a lot has to be done in Switzerland. Also quality of the (contracted) providers should be added as choosing option.

Germany

In Germany there is also a lot that can be done to make it easier for consumers to compare health insurance plans. First the information should be more credible, so more unbiased third parties should give or evaluate the information. Second the output on the websites should be ranked from low to high costs (or high to low costs) so consumers can immediately see what plan is cheapest.

Also there should be more information on quality and waiting times available on all providers and not on some providers. The quality information should at least be ranked and should be more easily to understand than what is used now. Adding stars for different treatments or specialism's could help people choose the provider with the best treatment they need.

Like in Switzerland, there should also be a possibility to compare the quality of the (contracted) providers, so consumers can use quality in choosing health insurance plans.

The Netherlands

In the Netherlands consumers can get the most information, but also there it is not complete yet. Costs and benefits are easy to compare. However quality information is incomplete, because it is not available for all providers. To compare quality of the (contracted) providers with the health insurers, consumers have to do a lot themselves. Also in the Netherlands comparing could be made easier by using a more complete comparison, including costs, benefits and quality.

It is clear that there is a difference in available information in Switzerland, Germany and the Netherlands. Especially in the Netherlands there is more and qualitative better information

then in Switzerland and Germany, while in Switzerland and Germany competition between insurers and hospitals exists already longer. Also in these countries insurers are more financially responsible than insurers in the Netherlands. There could be several reasons for these differences. First is that because in the Netherlands competition started later, insurers, providers and the government used internet as the most important way of communicating on information and in Switzerland and Germany internet was not used very much when competition started, so they had to use other ways to communicate with consumers and internet is just used recently.

A second reason could be that in the Netherlands internet is used more often generally, so internet has evolved more then in Switzerland and Germany. Dutch consumers might use internet more intensively than Swiss and German consumers, but there are no numbers that ground this hypothesis.

A third reason could be that the Dutch government is more focused on quality of care than in the Swiss and German governments. In chapter 5 I already mentioned that the German government just recently started to put a focus on quality by mentioning it on the website and draw attention to consumers on quality. In Switzerland the government does not mention quality either very much.

This means that Switzerland and Germany can learn from the Dutch government in increasing and making the available information better.

This study has some limitations. A first limitation is that in Europe there has not been much research about what consumers want in health insurance, so the theory based on this comes from research in the United States. It is not said that consumers in Switzerland, Germany and the Netherlands want exactly the same as in the United States. The research in the United States was mostly done for consumers of Medicare and Medicaid and only partly on private health insurers. The American system is not the same as in Switzerland, Germany and the Netherlands, which may indicate that consumers have different preferences, because some information elements may have different values in the systems for consumers. More research on this has to be done before a generalization is possible. It was not in the scope of my research to examine the actual needs of Swiss, German and Dutch consumers.

A second problem is that, while examining the information available, I almost only used information that can be found on internet. There are also other possibilities to get information, such as advertisement on television, radio, newspapers etcetera. The only way I could have

examined this was by a qualitative research in Switzerland, Germany and the Netherlands and this was not in the scope of my research.

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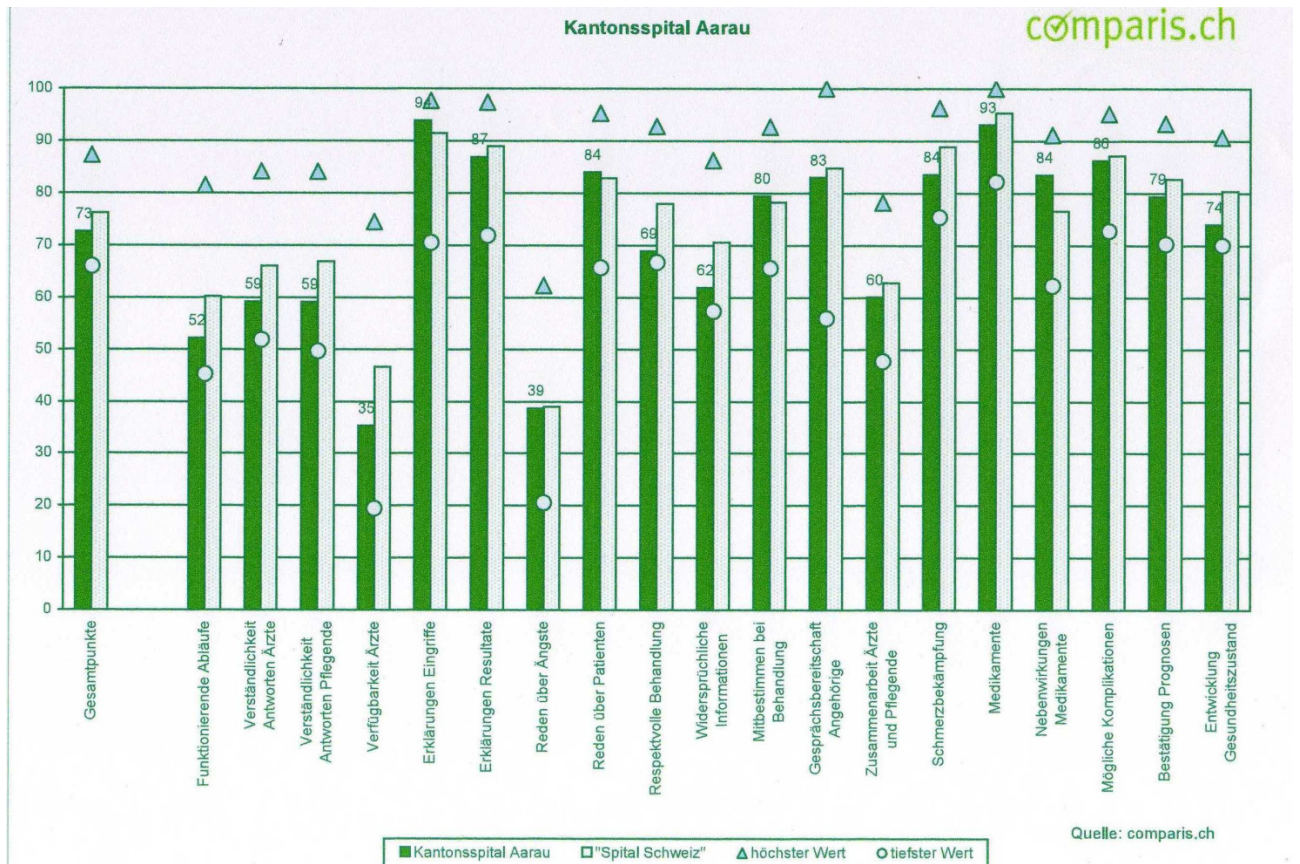
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Appendix

Appendix 1: Example of information presentation in Switzerland



Source:

http://www.comparis.ch/krankenkassen/spitalfuehrer/grafik/patientenzufriedenheit_22_DE.pdf

Appendix 2: Example of information presentation in Germany



Hofgartenklinik Aschaffenburg

C-1.2 A.I Qualitätsindikatoren, deren Ergebnisse keiner Bewertung durch den Strukturierten Dialog bedürfen oder für die eine Bewertung durch den Strukturierten Dialog bereits vorliegt

Leistungs-bereich (LB) und Qualitäts-indikator (QI)	Kenn-zahl-bezeichnung	Bewertung durch Struk. Dialog*	Vertrauens-bereich	Ergebnis (Einheit)	Zähler/ Nenner	Referenz -bereich (bundes-weit)	Kommentar/ Erläuterung
<u>Hüftgelenkersatz:</u> Ausrenkung des künstlichen Hüftgelenks nach der Operation	Endo-prothesen-luxation	8	0,14 - 3,98	1,1%	entfällt	≤ 5%	Vorjahr: 0,6%
<u>Hüftgelenkersatz:</u> Entzündung des Operations-bereichs nach der Operation	Postope-rative Wundin-fektion	8	0,14 - 3,98	1,1%	entfällt	≤ 3%	Vorjahr: 0,6%
<u>Hüftgelenkersatz:</u> Ungeplante Folgeoperation(en) wegen Komplikation(en)	Reinter-vention wegen Kompli-kation	8	0,91 - 6,40	2,8%	entfällt	≤ 9%	Vorjahr: 0,6%
<u>Kniegelenkersatz:</u> Entzündung des Operations-bereichs nach der Operation	Postope-rative Wundin-fektion	8	0,00 – 3,55	0,0%	entfällt	≤ 2%	Vorjahr: 0,0%
<u>Kniegelenkersatz:</u> Ungeplante Folgeoperation(en) wegen Komplikation(en)	Reinter-vention wegen Kompli-kation	8	0,24 – 6,90	2,0%	entfällt	≤ 6%	Vorjahr: 0,0%

*: Erläuterung zur Bewertung durch Struk. Dialog

Ziffer	Erläuterung
8	Ergebnis unauffällig, kein Strukturierter Dialog erforderlich
1	Krankenhaus wird nach Prüfung als unauffällig eingestuft
6	Krankenhaus wird nach Prüfung als positiv auffällig, d. h. als besonders gut eingestuft
2	Krankenhaus wird dieses Erhebungsjahr als unauffällig eingestuft, in der nächsten Auswertung sollen die Ergebnisse aber noch mal kontrolliert werden
3	Krankenhaus wird ggf. trotz Begründung erstmals als qualitativ auffällig bewertet
4	Krankenhaus wird ggf. trotz Begründung wiederholt als qualitativ auffällig bewertet
5	Krankenhaus wird wegen Verweigerung einer Stellungnahme als qualitativ auffällig eingestuft
9	Sonstiges (In diesem Fall ist auch der dem Krankenhaus zur Verfügung gestellte Kommentar in die Spalte 8 zu übernehmen.)
0	Derzeit noch keine Einstufung als auffällig oder unauffällig möglich, da der Strukturierte Dialog noch nicht abgeschlossen ist

C-1.2 A.II Qualitätsindikatoren, bei denen die Bewertung der Ergebnisse im Strukturierten Dialog noch nicht abgeschlossen ist und deren Ergebnisse daher für einen Vergleich noch nicht geeignet sind

Eine Veröffentlichung der Ergebnisse ist an dieser Stelle ausgeschlossen, um Falschinformationen und Fehlinterpretationen zu verhindern.

Source:

<http://www.klinik-lotse.de/pdf/2006/260960024-00-2006-pdf.pdf>

Appendix 3: Example of information presentation in the Netherlands

sBeter.nl - Ziekenhuizen, IJsselland Ziekenhuis - Ha... <http://www.kiesbeter.nl/Zi>

De kwaliteit van ziekenhuizen wordt gemeten in de vorm van indicatoren. De gegevens worden verzameld door de Inspectie voor de Gezondheidszorg.

In de tabel staan relatieve scores (A, B, C, D of E) weergegeven. Het geeft aan hoe een ziekenhuis scoort vergeleken met andere ziekenhuizen in Nederland.

Een **A score** geeft aan dat het ziekenhuizen een **betere score** heeft dan het gemiddelde van alle ziekenhuizen.

Een **E score** geeft aan dat het ziekenhuis **lager scoort** dan het gemiddelde in Nederland.

Elke kwaliteitsindicator heeft een toelichting. Klik hiervoor op het ?-icoontje.

Klap alles in

Klap alles uit

Aandoening/Kwaliteitsindicator	IJsselland Ziekenhuis	Havenziekenhuis	Erasmus MC Soestdijk
Alle indicatoren [klap in]			
% Afgezegde operaties	0,4 (B)	0,2 (A)	4,0
% Complicatie-registratie	60,0 (D)	57,9 (D)	75,
% Diagnose borstkanker binnen 5 dagen	95,5 (B)	98,9 (A)	91,
% Doorligwonden	7,4 (D)	4,2 (C)	2,4
% Galwegletsel	0 (B)	0 (B)	0,5
% Heroperaties aan dikke darm	7,4 (C)	3,6 (B)	15,
% Heropname bij hartfalen (jonger dan 75 jaar)	8,2 (C)	17,9 (E)	23,
% Heropname bij hartfalen (ouder dan 75 jaar)	6,8 (C)	15,0 (E)	11,
% Oogcontrole bij suikerziekte	-	100,0 (A)	-
% Operatie gebroken heup binnen 1 dag	92 / 90	47,0	90
% Overlijden na beroerte (jonger dan 65 jaar)	5,3 (D)	6,1 (E)	1,7
% Overlijden na beroerte (ouder dan 65 jaar)	7,8 (D)	5,4 (C)	7,0
% Overlijden na hartinfarct (jonger dan 65 jaar)	0 (B)	-	6,1
% Overlijden na hartinfarct (ouder dan 65 jaar)	9,4 (C)	-	12,
% Veilig medicijngebruik	0 (C)	0 (C)	100
Aantal operaties verwijde lichaams-slagader	54,0 (A)	7,0 (C)	78,
Aantal slokdarm-operaties	12,0 (B)	0 (A)	73,
Elektronische patiënten-gegevens (ICT)	8,0 (C)	6,0 (E)	10,
Borstkanker	[klap uit]		
Darmkanker	[klap uit]		

of 3

Source:

<http://www.kiesbeter.nl/Ziekenhuizen/Kwaliteit/Vergelijk/?behandelcentrum1=2936&behandelcentrum2=3036&behandelcentrum3=841285>

