Models of Man and Models of Policy: Reflections on *Exit, Voice, and Loyalty* Ten Years Later

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STALKING THE DEBATE ABOUT HEALTH POLICY IN the United States are two models of man. The first is that of *homo economicus*: a lonely, self-regarding and rational shopper in the marketplace. The second is that of *homo politicus*: a social animal whose habitat is the world of political activity. In turn, each model of man yields a different policy prescription. Adopting the economic model of man tends to lead to the advocacy of competition in the health care market, unfettered by restrictive professional practices or distorting tax concessions. Adopting the political model of man tends to lead to the advocacy of institutional solutions to the problems of health care delivery: the use of planning and regulatory mechanisms. In the former case, it is competition that ensures responsiveness to consumer preferences. In the latter case, it is institutionalized political activity that guarantees responsiveness to citizen wishes.

Instinctively most of us probably feel somewhat uneasy about this dichotomization of man. Applying either model to the problems of health care policy seems, in many ways, unsatisfactory. The rational shopper model may capture some aspects of the health care consumer, but does not begin to incorporate the very complex patterns of behavior or the relations between providers and consumers in this field. Nor is the political model entirely satisfactory. It assumes that political

Milbank Memorial Fund Quarterly/*Health and Society*, Vol. 58, No. 3, 1980

0160/1997/5803/0416-14 $01.00/0

activity is a natural way of life, when we know that in fact political apathy tends to be the norm. Consequently the assumption of producer responsiveness—implicit in both models—is highly questionable. The economic model, it may be argued, neglects issues of professional dominance. The political model, it may be said, neglects issues of bureaucratic dominance. Moreover, health care has some of the characteristics of both a private and a public good: that is, it affects both those individuals actually receiving it and society at large. Thus a hospital not only benefits the patients (and staff) but also brings contingent reassurance to the surrounding population. The challenge of health care policy is therefore how to combine sensitivity to both consumer preferences (the economic model) and citizen wishes (the political model): what the consumer wants, the citizen may wish to deny him, or vice versa.

It is problems such as these that may help to explain the impact of Hirschman's (1970) *Exit, Voice, and Loyalty* since it was published ten years ago. On the face of it, the subsequent infiltration of this book into the intellectual repertory and footnotes of the health care literature may seem odd: there is no explicit discussion of health care in the book, and Hirschman has made no extended attempt to apply his insights to this particular field in his later reflections on his original work. In practice, however, the importance of his book lies in its pioneering endeavor to bring together the two models of man within the same framework of analysis: to rub together the intellectual sticks provided by two disciplines—economics and politics. If the resulting fire still burns, it is because the debate about health care policies continues to revolve—as I have sought to argue—around competing models of man. This, indeed, is why a discussion of Hirschman's work remains as relevant today as when his book was first published.

Hirschman's book starts with a puzzle. In the economist's paradigm, the response to deteriorating performance by a firm (or public service organization) is exit by the consumers. That is, consumers take their custom elsewhere, so giving the required alarm signals to the firm (or organization) to improve its product or service. If the alarm signals are heeded, then the performance will pick up again. If they are ignored, the firm or organization will go out of business, and its products or services will be provided by others. All will be for the best in the most efficient of all worlds. In reality, as Hirschman (himself an economist) points out, things do not work out so neatly or conveniently. Firms (or

organizations) may actually welcome the exit of particularly demanding customers, and may tacitly conspire with each other to shuttle such troublesome customers back and forth between them. Exit may, in other words, inhibit complaints. The signals provided by exit may be ambiguous, in the sense that they may not give a precise message as to what it is that actually disgruntles customers. Such signals may therefore not provide the information required to adjust performance to consumer preferences.

So we come to voice, or what might be called political activity. In Hirschman's analysis, this is an essential complement to exit: the two models of man join hands, and the trick is to find (for any relevant area of policy) the best combination of voice and exit. Voice, in contrast to exit, is rich in information. It denies firms (or organizations) the easy and inviting option of getting rid of the most demanding customers. In turn, decisions by individuals as to whether to employ the exit or the voice option will depend on the degree of loyalty that they feel to the firm or organization in question: a high degree of loyalty is likely to inhibit exit and may encourage voice.

The optimal mix of exit and voice will, naturally, depend on the precise nature of the situation at issue. At one extreme, imagine a highly competitive market in which firms manufacture virtually identical products. In such a situation, exit may well be the response best calculated to convey the appropriate warning signals to the firm whose product is deteriorating in quality. At the other extreme, imagine (to take an example discussed by Hirschman) the public school system. Here, exit, such as switching children from the public to the private school system or moving to the suburbs, may simply reinforce the trend towards deterioration. If the most articulate parents, most sensitive to issues of quality, vote with their feet instead of engaging in voice—that is, traditional pressure group activities—then, Hirschman argues, there will be no incentive to those responsible for the public school system to try to arrest or reverse the process of deterioration. The policy implication is clear. Relying on policy models based on *homo economicus* may bring about perverse results in certain conditions, and it may be necessary to invoke *homo politicus* to redress the balance.

There are a number of problems about Hirschman's conceptual framework (Barry, 1974), and in applying it to specific policy areas. Some of these he has himself identified in subsequent reflections on his book (Hirschman, 1974, 1975). For example, the original argu-

ment tended to assume that exit would be costless and that voice would be expensive, and that there would be a consequent asymmetry in the likely reactions to deteriorating performance. But, as he himself has pointed out since, this is an over-simple view. Exit carries costs, such as the search for information or breaking the mold of existing habits (as in the case of divorce, or exit from marriage). Conversely, voice may be valued as an activity in its own right—setting aside any costs—in the sense that Aristotelian man engages in political activity because this represents his fulfillment as a human being.

More seriously, perhaps, Hirschman's neat antithesis between exit and voice does not—as Barry has pointed out—capture all the available options. It is possible to exit and, having done so, either to complain (i.e., use voice) or to remain silent. Similarly, it is possible to reject the exit option out of loyalty, but to reject voice also and remain silent. Further, Hirschman's analysis is applied to a very specific kind of situation: the *deterioration* in the quality of a product or service. But, as I shall try to argue in discussing the application of his ideas to health, it is important to bear in mind that—especially when it comes to heterogeneous services—discontent may stem from dissatisfaction not with falling quality but with the mix of types of product offered. Again, Hirschman's treatment of loyalty is somewhat sketchy: it is treated as a residual, to explain what otherwise cannot be accounted for in his analysis. Yet, and again this is highly relevant when it comes to health, the deliberate manufacture of feelings of loyalty might well be considered as a defensive strategy by threatened producers: certainly the doctor-patient relationship is highly charged with emotion and is manipulable (indeed, it could be argued that we need a model of *homo sociologicus* to complete the picture convincingly). Many services have symbolic outputs whose function is precisely to reinforce loyalty (Edelman, 1971).

These are important criticisms but, in a sense, they are beside the point when it comes to assessing Hirschman's influence. If, a decade after the publication of his book, his ideas are still bubbling away through the literature, the explanation does not lie in the formal rigor of his analytic method. His influence stems, I would argue, from the style of thought he introduced into the discussion of a wide range of issues, including health policy; he prompts interesting questions rather than providing ready-made solutions. Overall, the significance of his work has been admirably summed up by Young:

> Hirschman's contribution to a dynamic theory of public service organization is several fold. First, he teaches us to combine our consideration of political and economic forces. Second, he isolates the key mechanisms—exit and voice—and, in so doing, puts the focus on the *clients* or *consumers* as the key element for controlling organizational performance. Third, he identifies the essential channels through which organizations receive information about, and incentives to improve, their performance. Fourth, he instructs us that when these channels are not properly structured, organizational behavior can be expected to deteriorate. (Young, 1974:52)

So it seems eminently worthwhile to make use of the insights provided by Hirschman by applying them to the field of health care policy. Specifically, to return to the point made at the beginning of this essay, what does his analysis imply for the continuing debate over whether a competitive or an institutional model is most appropriate for the organization of health care? Which market—the economic or the political—offers the best deal?

In the first place, asking such questions in the context of Hirschman's conceptual framework compels further analysis of just what we mean when we talk about "consumers" and the "product" in the field of health care. The health care market (Stevens, 1974) is characterized by a high degree of uncertainty about the product, "about which diagnostic and treatment procedures are most apt to prove efficacious." Moreover, the standard consumer strategy of seeking information through a process of trial and error may not always be appropriate in the health care market. Trading in a Ford for a Chevrolet may be a reasonably satisfactory way of obtaining information about the comparative performances of two cars; shopping around from doctor to doctor is somewhat less satisfactory, since the performance of the first physician may actually affect what the second one can do. (To take an extreme case, the freedom to shop around in order to find the most competent physician is hardly relevant to the patient who has not survived the operation by the first surgeon consulted). Lastly, the search for medical care tends to be contingent on something happening to us: so, at least in the case of sudden, acute illness, the incentives to seek information may be greatest at precisely the time in our lives when we are physically least able to shop around.

From this, it follows that—to the extent that we are concerned with exit as a corrective mechanism in the health care market—we should

also be concerned to minimize the information costs or, to put it positively, to equip the shopper with the evaluative know-how required to make a sensible choice. This would suggest either more emphasis on "full disclosure" (Stevens, 1974:38) or using proxy consumer groups to generate relevant information (Young, 1974:54).

But there are a number of problems about this approach. For example, the question of how to assess the quality of medical care is notoriously contentious. There is little agreement even among the experts (e.g., McAuliffe, 1979), so that equipping the consumer with adequate information is no easy task. More centrally still, it is not self-evident that exit is necessarily an effective corrective mechanism, because of the heterogeneous, complex character of health care, which consists of delivering not only a number of very different technical procedures, but also of an environmental package (waiting rooms, hospital rooms, etc.). A consumer might well be satisfied with the technical treatment provided, but highly incensed about the quality of the environment in which it has been provided. If, then, he or she chooses to protest by using the exit option, the consequent signal to the producer is ambiguous. Exit, as Hirschman rightly stresses, is poor in information: in complex services, it provides little or no guidance as to the precise nature of the dissatisfaction. Moreover, any system of health care tends to shape the expectations of its own consumers: cross-nationally, there is some evidence (Kohn and White, 1976) that health care consumers tend to be satisfied with what they get, however different the nature of the delivery system. This reinforces the point made earlier about the capacity of health care systems to generate loyalty, and helps to explain why silence is so often the norm.

But it could still be argued that exit plus voice might provide both the incentives and the information required to persuade producers to respond to consumer wishes. Are there any mechanisms, in short, that could allow consumers both to vote with their feet and, having done so, to continue to exert pressure? The classic example of exit followed by voice in the health care market is, perhaps, the malpractice suit. However, this is generally not felt to be a very satisfactory mechanism because of its arbitrary character and its perverse effects on medical practice. For example, one study has shown that there is little correlation between the number of malpractice suits a hospital attracts and such measures of quality as are available (Department of Health, Education, and Welfare, 1973). An alternative approach might there-

fore be to argue for forms of consumer participation (Stevens, 1974): the deliberate creation of channels of influence through which consumers, having chosen to exit, can transmit information about the precise nature of their dissatisfaction.

The creation of such mechanisms of consumer representation may help to meet some of the difficulties inherent in relying on a strategy of exit followed by voice. But such strategy, it might be said, requires a considerable degree of altruism on the part of the disgruntled consumer: having made his exit, why should he bother to press for improvements that will benefit others? To the extent that representative bodies lower the cost of voice, by acting as proxy political activists, this objection may be weakened. Conversely, however, it could equally well be argued that the mere existence of such bodies will paradoxically weaken the incentive to exert voice because of the well-known free-rider problem inherent in all collective action (Olson, 1965). If we know that others are taking action anyway—and suspect, furthermore, that adding our voice will make little or no difference to the likely outcome—why bother to do anything, particularly when we have already made our exit? Economic man, balancing the costs and benefits, almost certainly would remain silent, though political man, with a regard to the public interest arguments involved, might decide otherwise. Consequently, it does not seem that creating new mechanisms for articulating consumer voice will necessarily solve the problems created by exit followed by silence.

So far, the discussion has been in terms of an atomistic market for health care: the implicit assumption has been that individual consumers deal with individual producers. Now let us complicate this picture (and make it more realistic) by introducing institutional providers. Imagine a city where three health maintenance organizations (HMOs) control the market and are competing for customers. Imagine also a family of three: the husband worried about a possible coronary, the wife expecting a baby, and a three-year-old child suffering from chronic asthma. The first HMO has a high reputation for the quality of its coronary and maternity care, but the pediatrician is notoriously unwilling to turn out at nights in emergencies. The second HMO has excellent maternity services and a responsive pediatrician, but its coronary care facilities are suspect. The third HMO scores high on acute and pediatric services, but low on maternity.

What, then, are the choices for the family faced with such a di-

lemma? If they exit from one HMO, they will only solve one problem at the price of creating another. In this situation, the consumer has a direct incentive to use voice in order to try to correct a deficiency (not, it must be stressed, necessarily to be equated with a deterioration in service provision). Unfortunately, as Hirschman points out in a different context, it does not follow that producers have an incentive to respond: a circular, and self-balancing, procession of consumers in search of the ideal package may suit all three HMOs very well. In this instance, introducing an element of consumer representation or participation into the governance of each HMO may indeed be the most effective solution: i.e., the implication would seem to be that creating mechanisms for articulating voice may be most important in those situations where exit does not provide a satisfactory option for the consumer. As this example would suggest, the problems of finding an appropriate balance between exit and voice in health care spring from the fact that consumers are not purchasing a product but a complex and heterogeneous package of very different services.

A further peculiarity of the health care market must be noted here, if only as an aside. Most consumers in the United States do not pay directly for the product or package, an obvious fact that raises an intriguing question, in the context of the kind of analysis prompted by Hirschman's approach. The literature generated by *Exit, Voice, and Loyalty* has produced, as noted above, a number of suggestions for strengthening the opportunities for voice by individual consumers. Yet this is to ignore the fact that most consumers are already collectively organized as members of insurance schemes such as Blue Cross. One of the missing elements in the American debate about health insurance, insofar as a transatlantic spectator can judge, is any discussion of the consumer *qua* consumer of insurance policies: why, in fact, insurance schemes are not considered as a mechanism for transmitting voice. If one of the problems of health care is the need for some kind of proxy organization to evaluate services and to articulate consumer voices, why not use existing organizations? The obvious answer may be that membership in insurance schemes tends to follow employment rather than individual choice. Even this answer, however, leaves the puzzle as to why there have been no suggestions, in the American context, for using insurance schemes as mechanisms of voice. Certainly the European experience would suggest that there is some scope for introducing an element of consumer representation in

such schemes: for example, in both Germany and France there is a system of elections to the boards of the *kassen* or *caisses* that operate the insurance system.

To return to the main theme, however, there is a third model of health care organization that requires analysis. So far, we have considered an atomistic market of individual consumers and producers and a market with competing institutional providers. But the Hirschman framework of analysis would seem to provide a strong case for creating a monopoly provider of health care, something along the lines of Britain's National Health Service (NHS). This assertion follows from his discussion of the public school system, already cited. If a health care system combining public and private provision permits easy exit, then the result will be (as in the case of schools) to encourage precisely those with the most demanding standards to leave the public domain. Consequently, there may follow a process of self-reinforcing deterioration in the public sector—a prediction, drawn from Hirschman's analysis, that is certainly not falsified by American experience. In short, a pluralistic system will encourage self-regarding economic man to consult only his own interests, with perverse effects for the collectivity at large. In contrast, a monopolistic organization locks consumers into the system, and forces them to engage in voice—to act as political animals—whether they want to or not, pursuing the collective welfare. Moreover, voice provides the information that is essential in such a heterogeneous service as health, where the producers require signals not only about deterioration in quality but also about the appropriateness or adequacy of what is being provided.

Is the inference from this type of analysis that the United States should be moving toward the adoption of something like Britain's NHS? Not quite. For at this stage in the argument we meet again the peculiar paradox of health care: that, by and large, people like what they get, and what they are accustomed to. Despite its obvious shortcomings—poor physical conditions in hospitals, long waiting lists for some conditions—the NHS is extremely popular (Klein, 1979a). As this would indicate, it is possible not only in theory but also in practice to generate loyalty. In the case of the NHS, it could be argued that its most important symbolic output is equity—i.e., perceived fairness in dealing with people, regardless of their financial circumstances—which inhibits both voice and exit.

In turn, this would suggest that when quality deteriorates, one possible reaction is for consumers to rally to their organization. Certainly there was no evidence of an increase in exit from the NHS—i.e., an increased number of subscribers to private insurance—in Britain during the mid-1970s (Klein, 1979b) when there was much talk of a crisis of morale and declining standards (Royal Commission, 1979). Indeed, the prevailing rhetoric of crisis during this period suggests another intriguing application of the Hirschman thesis: it indicates that exit and voice may be options for service providers as well as for service consumers. In particular, a near-monopoly service like the NHS may give a greater incentive to service providers than to service consumers to use voice to articulate their grievances, a strategy frequently pursued by Britain's doctors (Powell, 1966). Such an outcome is even more likely in the circumstances of the 1980s when the choice of exit through emigration seems likely to be increasingly limited, and therefore service providers will increasingly be locked into the system. The point explains why one of the characteristics of all national health services, in all nontotalitarian countries, is a periodic confrontation between public authorities and the medical profession. Voice, in the sense of political or industrial action, becomes the main weapon of service providers.

Of course the NHS is not a total monopoly. There is, in Britain, a small private sector: about one in twenty of the population is covered by private insurance. It could therefore be argued that it is precisely the existence of this safety valve that accounts for the lack of voice from consumers, the conclusion that would be drawn from Hirschman's illustrative example of the public school system. If the most demanding health care consumers can exit, why be surprised that there is so little voice? This indeed is the view taken by the Labour Party, and explains its hostility to private practice. As against this, it has also been argued (Birch, 1975) that the possibility of exit is a necessary condition for the exercise of voice. The more tightly the consumers of any service are locked into the system, the more inhibited they will be in voicing their grievances, for fear of retaliation from the service providers; even if they are dissatisfied with the quality of the service provided, they are likely to take refuge in silence in such circumstances. One conclusion that might be drawn is that the more the health service organizations acquire a monopoly, albeit perhaps

only a local monopoly, the more important it becomes to have proxy bodies capable of exercising voice on behalf of consumers who may be afraid of articulating their own grievances.

But the Hirschman thesis helps to explain at least one feature of the British NHS to which American critics (for example, Lindsay, 1980) frequently draw attention: the persistence of queues. Waiting lists are predominantly, though not exclusively, for nonurgent, elective procedures. In contrast, there is no queueing for acute conditions. And this is precisely what would be expected, on the basis of the Hirschman analysis, from the special characteristics of the private sector. The private sector in Britain does not offer a comprehensive alternative to the NHS: it concentrates overwhelmingly on precisely the kind of conditions for which there are waiting lists in the NHS, so giving paying customers a chance to circumvent the queue. It is therefore not surprising that the incentives to the NHS to get rid of waiting lists are blunted: the most exigent consumers have no reason to use voice, since they can buy exit. In contrast, there are fewer opportunities for exit in the case of life-endangering illness, and (predictably therefore) the NHS offers a better service in such cases. Also in conformance with Hirschman's thesis, the NHS is extremely poor in the provision of privacy and comfort within the acute sector; this, again, is what might be expected from the fact that those who put a high value on privacy and comfort can exit to seek them in the private market.

Using this kind of analysis also raises some troublesome questions of equity. The apparent inequity of the exit option is self-evident: it seems to provide a built-in bias toward the better off, who can buy improved services for themselves at the cost of those who cannot afford to leave the system. But the voice option does not guarantee equity, either. As Hirschman has pointed out, the ability (and willingness) to use voice may not be distributed equally among all consumers. Indeed, there is ample evidence to be drawn from the political science literature to show that willingness to engage in political activity, or to participate in civic affairs, tends to be associated with such factors as education, income, and age. So a system designed to encourage voice may have its own built-in biases as well, a conclusion that is of special relevance to health care policy, given the fact that the interests of consumers may often be in competition with each other.

The problem is, essentially, that a given population of consumers is

not homogeneous but comprises four groups, with differing potentials for exit and voice:

Group 1: Voice potential high, exit potential high.
Group 2: Voice potential low, exit potential high.
Group 3: Voice potential high, exit potential low.
Group 4: Voice potential low, exit potential low.

This situation suggests that different kinds of institutional arrangements may be appropriate for different sectors of the health care system, depending on the characteristics of the consumers who use them.

Specifically, this very simple scheme shows why there are certain health service clients in group 4—such as the mentally handicapped or the elderly infirm—who appear to get a rough deal in *all* health care systems, whether the American or the British. Given the low voice and low exit potential of this group, it is inevitable that resources will be directed disproportionately to those consumers who rank high on both counts: hence, no doubt, the international phenomenon of high expenditure on the acute hospital sector and high technology to the neglect of other areas. There is no need to invoke, as so often happens, a medical conspiracy to explain this; the phenomenon is adequately explained by Hirschman's framework of analysis.

The puzzle, rather, is to explain why those in group 4—the most disadvantaged, those lacking in both market and political power—get any resources at all. To ask this question is to underline a curious gap in Hirschman's approach. The value of *Exit, Voice, and Loyalty,* as I have tried to show in these variations on Hirschman's theme, is that it is enormously stimulating, that it sparks off illuminating questions. But its limitation is that its focus is the behavior of *consumers* within specific organizational settings: economic man dominates even in political behavior (Barry, 1974)—the reconciliation of the two models of man remains somehow incomplete, even though Hirschman has used his approach to analyze the behavior of voters and governments. Yet, as argued earlier, we are interested in health care not only as consumers, actual or potential. We may also be interested as citizens who happen to believe that adequate and comprehensive health services for all sections of the population are a public good. In a sense,

therefore, although Hirschman allows us to understand better the politics of the health care arena, he does not help us as much to understand the political market in which decisions about health care are taken. Yet, in many ways, this is the crucial issue. Hirschman's work has sensitized us to the problems involved in designing the mechanisms required within the health care arena, or any other organizational arena. But the introduction of those mechanisms will depend on political decisions taken outside the health care arena. So perhaps we still need another volume from Hirschman: the politics of exit, voice, and loyalty.

References

Barry, B. 1974. Review article: *Exit, Voice, and Loyalty. British Journal of Political Science* 4:79–107.

Birch, A.H. 1975. Economic Models in Political Science: The Case of *Exit, Voice, and Loyalty. British Journal of Political Science* 5:69–92.

Department of Health, Education, and Welfare. 1973. *Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice.* Washington, D.C.: U.S. Government Printing Office.

Edelman, M. 1971. *Politics as Symbolic Action.* New York: Academic Press.

Hirschman, A.O. 1970. *Exit, Voice, and Loyalty.* Cambridge, Mass.: Harvard University Press.

———. 1974. *Exit, Voice, and Loyalty:* Further Reflections and a Survey of Recent Contributions. *Social Science Information* 13(1):7–26.

———. 1975. Exit and Voice: Some Further Distinctions (unpublished). A shortened version appeared as "Discussion," *American Economic Review* 66(2) (May 1976):386–389.

Klein, R. 1979a. Public Opinion and the National Health Service. *British Medical Journal* (12 May):1296–1297.

———. 1979b. Ideology, Class and the National Health Service. *Journal of Health Politics, Policy and Law* 4(3):464–490.

Kohn, R., and White, K.L., eds. 1976. *Health Care: An International Study.* Oxford: Oxford University Press.

Lindsay, C.M. 1980. *National Health Issues: The British Experience.* New York: Hoffmann-La Roche, Inc.

McAuliffe, W.E. 1979. Measuring the Quality of Medical Care.

Milbank Memorial Fund Quarterly/Health and Society 57 (Winter): 95–117.

Olson, M. 1965. *The Logic of Collective Action.* Cambridge, Mass.: Harvard University Press.

Powell, E. 1966. *Medicine and Politics.* London: Pitman Medical.

Royal Commission on the National Health Service. 1979. *Report.* London: Her Majesty's Stationery Office.

Stevens, C.M. 1974. Voice in Medical-Care Markets: "Consumer Participation." *Social Science Information* 13(3):33–48.

Young, D.R. 1974. Exit and Voice in the Organisation of Public Services. *Social Science Information* 13(3):49–65.

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