The Dynamics of the Dutch Health Care System—A Discourse Analysis[1]

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Abstract In this article, we analyze recent dynamics of the Dutch health care sector, a hybrid system of public, private and professional elements, in terms of clashing discourses. Although these elements are intricately interwoven, this does not mean that the system is stable. Most notably, since the eighties the introduction of more market elements in the health care system has been widely debated. Hospitals introduced different methods commonly used in businesses, for instance. The position of managers in the institutions of health care has become more central. A discourse analysis shows the concomitant patterns of institutional change in the health care sector. We distinguish four different discourses concerning health care: economic, political, medical-professional and caring discourses. These different discourses give rise to, for example, different views of good care, the character and position of the patient, and leadership in health care organizations—views that sometimes clash intensely.

Keywords: Health care system, the Netherlands, discourse analysis, institutional change, modernization, 'economization', health care management

INTRODUCTION

The Dutch health care system is a hybrid system of public, private and professional elements. Constitutionally, the Dutch State is responsible for

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the accessibility, the quality and the efficiency of health care. Nevertheless, the government has just a minor role in the realization of these aspects of health care and therefore depends crucially on the cooperation of private parties such as insurance companies, private institutions of health care and professional provision as well as a number of other organizations. The parties are mutually dependent on each other. As a result, the Dutch health care sector does not have one power center that can interfere unilaterally in the organization of health care. Decisions may simply seem to "happen." The fact that different actors contribute to the provision of health care causes confusion about the responsibility for providing good care. When many parties are involved, the contribution of separate actors is difficult to determine.

The problem of the distribution of responsibilities is aggravated by the unstable configuration between the different actors. Since the eighties, for instance, different committees commissioned by the government have argued in favor of using more market elements in the health care system. Many organizations of health care, without a profit motive, became more interested in the methods of private enterprise. Institutional changes have ensued. The management of these organizations acquired a stronger position. These developments can be labeled as "economization". In this paper we analyze the recent dynamics of the Dutch health care sector in terms of clashing discourses. We distinguish patterns in the changes arising from the clashing discourses; with consequences for the distribution of responsibilities and the way health care is provided.

We need to realize that reverence for the market, business methods and management is not unique to any health care system.[4] Like other countries, Dutch society at large has experienced a process of economization in the last decades. Discourse theory helps to discover and to analyze the patterns of institutional change in modern society in general and for the health care sector in particular. Discourse theory is not generally accepted in economics, however, but has been invoked more often with the influential publication of Klamer *et al.* (1988), and Dudley-Evans and Henderson (1993). Rather than indicating the quantitative significance of "talk" in this part of the economy (cf. Klamer and McCloskey 1995), we analyze the effects of different discourses on economic and social structures and institutions. Any use of this approach to understand developments in health care in a way that is relevant for economics is not available as far as we are aware of.

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4 Grit (1997) describes these developments for the university system.

Here, we distinguish four different discourses within health care: economic, political, medical–professional and caring discourses. These different discourses give rise to different views of, for instance, good care, the character and position of the patient, and the distributions of responsibilities between the actors involved. A discourse analysis stresses that it not only matters to understand that people can exercise "exit" or "voice" (Hirschman 1970), but that it is at least of equal importance to recognize different *voices*, certainly when trying to understand the nature of the changes in a concrete situation. Where Hodgson (1999) argues that a (capitalist) system needs impure elements to function properly, a discourse analysis points to the nature of the impurity and the ways in which elements in the system interact. The manager is a newly emerging actor, which has gained prominence as a result of "economization." (S)he requires to operate in an emerging field of diffuse goals and unclear responsibilities. The manager is at the crossroads of a number of discourses, each requiring her/him to accommodate and engage with a host of undertakings.

THE HYBRID DUTCH SYSTEM OF HEALTH CARE

The Dutch system of health care is noteworthy for its liberalism, certainly regarding its conditional acceptance of euthanasia. Also, certain categories of addictive drugs, which in other industrialized countries may solely be regulated according to criminal laws and codes, are, by contrast in the Netherlands also considered to be an issue of individual health care provisioning. People who are addicted are not only criminalized, but also medicalized. In this contribution, however, we will focus on the organizational and financial idiosyncracies of the system, and explain the developments it has undergone and still is undergoing. Dutch health care is a hybrid system of public, private and professional elements (Schrijvers 1998, Lapre 1989, Boot and Knapen 2001, Putters 2001). Constitutionally, the Dutch State is responsible for the accessibility, the quality and the efficiency of health care. An entirely public system of health care was only considered seriously for a very brief period, shortly after the Second World War. A clean break with developments in the sector such as was established in the UK with the set up of the National Health Service was not deemed attractive by the liberally inclined citizens in the Netherlands. In contrast to the system in the UK (see McMaster 2002), the Dutch system gradually developed since the early nineteenth Century. The particularities of the Dutch system are evident in the way that it is financed and organized. Rather than fully describing the system of Dutch health care (see Lapre *et al*. 1989ff, Schrijvers *et al*. 1998, SER 2000, Boot and Knapen 2001), we focus on these elements and their dynamics.

The Dutch government has a minor role in the realization of the goals of health care and depends crucially on the cooperation of private parties. Some of these organizations are for-profit organizations, such as insurance companies, while some are not-for-profit organizations; still others represent professionals in the sector.[5] Organizations that are involved in the actual provision of care can be both for-profit but mostly are not-for-profit. Organizations that can set or enforce the rules and regulations in the Dutch health care system can be public (state), private, or mixed, even when the state remains constitutionally responsible. The fact that different actors contribute to the realization of health care causes confusion and misunderstanding, not just among scholars studying the system, but among patients and even for the parties playing an active role in the system. Issues of responsibility and accountability are not easily resolved.

It is clear that in the period immediately following the Second World War the state played a dominant role in health care provision. It endeavored to provide both good health care, as well as to control costs in a period of reconstruction. As Van Zanden (1997) showed, all of the different (political) parties in the Netherlands banded together to recover economically from that war. Over the years, in the 1960s and 1970s, power shifted from the state to groups in civil society. Legislation permitted the state to devolve responsibilities for the delivery of services to other parties. Nevertheless, private, for-profit initiative was treated with some suspicion. Indeed, while most health care providers were private parties, they tended to be either ideologically or religiously inspired, as opposed to profit-oriented (Putters 2001).[6] Yet, partners in health care provision not only have a common goal, but are also motivated by their own interests, which often are mutually exclusive. Since the mid to late 1980s there has been pressure from private parties as well as from the state to make a shift towards private, for-profit provision of health care. Nevertheless these changes have occurred very gradually.

In the coalition governments that must typically be formed in the Netherlands, different interests were generally balanced and accommodated—major swings in government policy are quite rare in the Netherlands. Interdependencies also make major revisions in the health care system highly unlikely. The seemingly endless talks and negotiations that result from such

5 Again, to complicate the issue, these are not necessarily unions of which employees can be members, but may also be organizations that represent medical practitioners as a profession and thus focus on patients' health issues more than they do issues of personal labor relations.

6 A similar pattern of provision can be found in other areas of the delivery of Dutch welfare services, such as education.

changes tended to be blamed for sclerosis in the health care system as well as in Dutch society. Characterizations such as "the Dutch disease" were used then, and not only in relation to public finance. Of more recent times is the recognition of the positive aspects of such negotiations, and the so-called "polder model" in general (Visser and Hemerijck 1997). In relation to the health care system, Van der Grinten (2002) remarks that this way of communicating makes sure that the parties are involved in the process of formulating and executing policy. In the early stages of this process all relevant parties are involved, signaling problems, and ensuring commitment. Important breaks with existing policy that will meet resistance are thus "neutralized." Despite these considerations and the realization among the parties involved of mutual dependence, the polder model in the health care sector, as much as elsewhere, sometimes looks more like an armistice than a happy marriage.

As noted, although the Dutch State is responsible for *ensuring* the provision of "good" health care for every citizen, delivery is a matter of cooperating with other parties. This is apparent in both the financing of the system as well as the delivery of care—some €35 billion in 2000 (7.9 percent of GDP, an increase of 75 percent since 1988). Only 5 percent of this budget is directly financed by the state from its general exchequer. Much of the remainder comes from various personal insurance schemes, which can be compulsory and optional, where the latter covers any additional health risks beyond the compulsory range of defined conditions. By law every citizen needs to be insured for so-called "special diseases" that require long-term care. This Exceptional Medical Expenses Act, or AWBZ, is a percentage of the first slice of individuals" income taxed at the lowest rate. Provision of this care was in kind for a long time. In recent years, in a process of "economization", which we elaborate on below, experiments have started to provide people in need of such care with a budget to allow them to make choices about how they would like to be cared for.

In addition, it is a legislative requirement for individuals earning less than a certain threshold income to be insured according to the ZFW, or Social Health Insurance Act, by a specific Social Health Insurance Agency. The payment consists of a nominal part that is equal for everybody thus insured, as well as a part that is a percentage of one's income. In fact, the Dutch government's income-related policy (and indeed the distribution of income in the country) is partially visible in the way that a majority of the population is insured for health care. Unsurprisingly, this method of imposing solidarity is not uncontroversial. Mainstream economists, particularly, suggest that it generates "improper" incentives; inducing individuals to consume more health care than they would otherwise. Payment of the nominal fee is mandatory when people register with an insurance company. Provision of health care is in kind. Until 1992 Social Health Funds were

Table 1: Costs of Dutch Healthcare by kind of care
(Dutch Guilders, '000,000, current prices; % change on previous year

	1988	*1992*	*1996*	*2000*
Hospitals	14,643	18,607 (+27%)	20,694 (+11%)	23,554 (+14%)
Mental health care	2,289	3,855 (+68%)	4,506 (+24%)	6,127 (+36%)
Handicapped, provisions	3,647	4,524 (+24%)	5,595 (+24%)	6,748 (+21%)
Elderly, provisions	8,364	9,955 (+19%)	11,182 (+12%)	13,170 (+18%)
Extramural care	7,759	9,450 (+28%)	8,023 (–15%)	9,846 (+23%)
Pharmateucal supplies	3,970	5,524 (+39%)	6,746 (+22%)	8,240 (+22%)
Preventive care	589	760 (+29%)	1,334 (+75%)	1,603 (+20%)
Overhead, misc.	2,215	2,895 (+31%)	3,162 (+9%)	5,289 (+74%)
Total	44,178	55,570 (+26%)	61,242 (+10%)	74,902 (+22%)

Source: Boot and Knapen (2001: 251).
Note: data on 2000 in Boot and Knapen (2001) are projections. SER (2000) and Ministry of Health, Welface and Sports (2001) provide actual data, but offer different categories. Where category descriptions match, the actual and projected amounts are similar.

separate, not-for-profit organizations responsible for a particular region of the country; people had to register with the Fund in their region. Since then, the public, not-for-profit funds have been privatized and entered into competition with other insurance companies that now also offer Social Health packages. Citizens can now choose from among them. Interestingly, civil servants can reclaim a large part of their insurance fees from their employer. As the ZFW includes proportionately more older people who tend to have a greater need for health care, privately insured citizens are compelled by law to help finance this facility—a law that requires people to show solidarity with others in society running up to 50 percent of their personal insurance premium.

The weights of the different kinds of insurance indicated in Table 2 has changed quite substantially over time as some kinds of care were moved from one category to the other. Boot and Knapen (2001) see no reason for such shifts

Table 2: Health Insurance in the Netherlands (2000)

Category of insurance	*Number of people insured (000s)*	*% of total health expenditure covered*
AWBZ	15,900 Ψ	41
ZFW	10,023	36
Private insurance, other	5,692	18.2 ‡
Uninsured	185	†

Source: SER (2000).
Note: This is an incomplete listing of insurance types. Due to rounding percentages do not sum to 100. It is common for citizens to register for multiple health insurance plans
‡ Including 'additional' insurance.
† These amounts are included under ZFW, see text.
Ψ Almost all Dutch citizens; see text.

that are related to the intrinsic issues of Dutch health care. An important characteristic of the way in which health care is funded in the Netherlands is its institutionalized solidarity. The exact way solidarity is institutionalized changes over time, and particularly with the advent of the economic discourse, but the need for solidarity itself is not generally disputed.

A number of societal developments have given rise to an increasing demand on the system of health care in the Netherlands. The Social Economic Council (SER 2000) lists demographic, technological, economic and social-cultural factors as the major fields where increasing demands arise.[7] With the state in a position where it must assume responsibility but has few instruments to actually control the process, budgets have risen sharply the last years despite the introduction of measures to prevent that from happening. When pressure in society mounts, the state is called upon by the different parties to either contribute from the general means or rule that certain action be taken. The costs related to rules issued will only partially fall on the party advocating them.

7 Aging, population growth, IT, increasingly better and more expensive medical equipment, growing wealth, Baumol effect, emancipation of patients, position of the chronically ill are the more concrete issues highlighted. This Council is part of civil society where typically issues are discussed between stakeholders before decisions are made. Interestingly, however, from the perspective of "economization" is how the stakeholders are chosen. Previously, they were chosen in different councils on the basis of their medical expertise. In the SER, only representatives of employers, employees and objective "members of the Crown" participate, the Netherlands being a constitutional monarchy. There is a strong tendency for advice from the SER to be adopted as government policy.

Deregulation has not had the expected effects of a state that retreats and leaves things to the market, and has paradoxically led to a situation where more regulation has been introduced rather than less.

Measures introduced have mostly focused on controlling the quantity of health care the system provides (van Andel and Brinkman 1998, Boot 1998). Specifically, the number of hospital beds, medical doctors, and care facilities are strictly regulated. In addition, the government also dictates which treatments should be included in Social Health Insurance packages. Insurance companies can then set the premium they wish to charge, but will be subject to pressure from the market as well as from the government not to set these premiums too high. This pressure is of a moral nature as well. Regulating the provision of health care through quantitative instruments has been a long standing policy, recently complemented by regulation of the accounting prices that providers of health care can be expected to get refunded upon provision of care. Regulation has also been extended to the prices of medicines provided through General Practitioners, important in controlling costs as this is the first gatekeeper in the system. The government has issued a number of laws to these effects in the recent past. Quantity regulation by the government, combined with the increasing demands, has resulted in waiting lists for all kinds of health care treatments. Waiting lists have been the prime symptom of the problems faced in the system.

At the same time, the government has tried to deregulate the sector in the past years by permitting commercial hospitals. Most hospitals have been private foundations under auspices of which a majority of medical specialists are self-employed. Possibilities to establish partnerships of private individuals with a profit motive in this private-not-for-profit setting are being extended. The establishment of separate policlinics and clinics located at firms is now permitted. Some of these bodies are being launched by conventional hospitals, as a means of alleviating problems related to waiting lists. Arguably, the upshot of this is an environment where participants experience a perverse incentive structure. Providers" remuneration is regulated, and only includes variable costs of any treatment. This provides an incentive for them to plan the intensive care at full capacity, as variable costs comprise a relatively large share of total costs. By contrast a ward—where the opposite is true and fixed costs are a much larger part of the total—may not be fully booked even when medical considerations would point to it. It is not difficult to see how waiting lists would result from such a situation. Providers of health care are mostly private parties, but they cannot determine the capacity of the care they wish to provide themselves. Separate councils determine that in the future providers of health care will need to arrange for capital funds from the market under competitive conditions.

The hybrid Dutch health care is not static. To understand these developments, and the paradoxical elements in the system, it is not very helpful to characterize it as "perverse", "inefficient" or "counterproductive." This would be an approach that does not result in an explanation of the process leading to the situation as it is. Nor is it an approach that would allow for the formulation of ways to improve upon the situation. In this article, we explain how the Dutch health care system has evolved from the perspective of discourse theory.

UNDERSTANDING INSTITUTIONAL DYNAMICS: DISCOURSES AND THE MODERNIZATION OF SOCIETY

How is the seeming incongruity of simultaneous institutional stability and change explicable? Institutions are purported to have persistence, but do not remain static indefinitely. The rise of the welfare state, for example, was accompanied by substantial changes in the shape and role of many institutions in society. The state started to take care of the well being of its citizens. The scope of the political realm enhanced in two respects. The government interferes more in the life of citizens on the one hand, while at the same time citizens are more eager to deal with political issues. In keeping with Michael Foucault (1971), who has been de prime instigator of the approach, we employ and develop a discourse analysis. Foucault himself has, of course, shown the approach to be highly insightful to understand developments in society at large by analyzing the prison system, sexuality, clinics, and insanity.

The dynamics of institutional change is patterned, however. In order to understand the patterns of institutional dynamics, we need to recognize something of the ideals and problems of modern society. In the last centuries, many societies have undergone a process of modern rationalization. Following classic thinkers such as Georg Simmel (1990 [1907]) and Max Weber (1968 [±1920]), we can distinguish three aspects of this process of rationalization: growth of knowledge (an increase in the body of knowledge), functional differentiation (the division of society into relatively autonomous subsystems) and social progress (the creation of more wealth and well-being and the increase in opportunities for human action). Weber and Simmel did not regard rationalization as unproblematic, of course. Simmel, for example, pointed to loss of character, while Weber discussed loss of freedom and the growing problem of value pluralism. This paper also presents a critical analysis of paths of rationalization.

Rationalization—or modernization in philosopher's terms—is not an unequivocal and unidirectional process, but follows different routes (Grit 2000). The kind of knowledge we need for solving policy problems shifts from political

and legal knowledge to a more economic one, where issues such as cost–benefit analyses and management information are emphasized. The body of knowledge that players in society act upon changes over time, as discourses become more or less dominating. As a consequence, the institutions in society fluctuate where the state, the market or civil society vie for prominence. The market and market-like mechanisms have become more dominant in the last two decades. Rationalization, also when of the economic type, can have ambiguous outcomes and unintended consequences. Rationalization of one kind thus almost of necessity evokes responses from another discourse emphasizing a different but also modern kind of rationalization. Discourse theory enables one to investigate these dynamics. We distinguish clusters of rationality, which we can typify as different discourses of modern rationalization.

A discourse is a coherent set of heterogeneous elements such as metaphors, speech, official documents, models and also customs and objects with a symbolic meaning. There are different modern (sub-) discourses related to health care in society. Four of them have shaped health care thus far: political, economic, caring and medical-professional discourses. Each of these discourses attempts to provide a coherent view on modern rationalization in health care—each expressing the ideals of modernization in a different way. Each provides a perspective on the knowledge and skills required in health care, and a view of how the demarcation from, and interactions with, other institutional domains should be organized. Each has an idea of what progress means. As a result, each has its own instruments with which social order may be regulated.

The different discourses are not similar *qua* status and importance. Political discourse had its golden age at the end of the 1960s and 1970s, before economic discourse took the lead in many western societies in the eighties. We describe economization as the advance of the economic discourse. It is tempting to see a coincidence between a discourse and one social institution, for instance between economic discourse and the market. Each discourse would then have its own vehicle for realizing progress in society. This view is problematic, as it ignores the heterogeneous nature of these institutions in the first place, and because it tends to focus on a discourse in isolation of the other discourses in society. Markets differ significantly between each other; an "entrepreneurial" hospital that uses business methods is not the same as firms such as Royal Dutch Shell or IBM. In a way, then, the advance of economic discourse in the eighties and nineties entails not only that the domain of the market expanded, but also that the economic discourse spread into different domains. The economic discourse as a style of thought, a direction for thinking about the way in which (social) problems are to be solved (helped) shape the formal and informal

institutions of society. Institutions and discourses in society are rather mutually constitutive.

What is the impact of discourses on actors? Actors internalize a (dominant) discourse; they become conduits of a discourse. However, this does not imply that discourses completely determine the thought and acts of human actors (cf. Berger and Luckman 1971). The heterogeneous elements of a discourse make up a coherent whole, but they are not completely and compellingly structured and institutionalized. The opportunity to choose some specific elements of a discourse and their flexible meaning leaves room for the actor to maneuver. Actors can *translate* a discourse to their own situation and wishes, but, again, not unlimitedly so (Grit 2000, Davis 2002, Dolfsma 2002). Patients" associations, for instance, can use economic discourse to argue for more autonomy for patients. Consumers (patients) should thus have more freedom in choosing the products (the kind of health care) they like. This would imply that restrictions on the supply-side should be abandoned. The government may defend these restrictions in delivery with a reference to the same discourse, but using another aspect of this discourse: the cost and efficiency of the system. We need therefore to analyze how concrete actors use different discourses. In effect, discourse theory entails detailed empirical analysis of an extent that goes beyond the scope of the present paper.

DISCOURSES ON HEALTH CARE

Four discourses of modern rationality shape the system of health care. In this section, we will develop these four ideal typical discourses of health care. In the Dutch system of health care, other discourses such as the legal one are less important and have always followed the lead of the four discussed here.

Caring discourse

In a caring discourse, benevolent people, who feel the responsibility to ensure that everyone's basic needs are met, provide good care (see Tronto 1993). This duty derives from the fact that people are part of a community. This discourse gives much attention to the role of informal care in our health care system. People working in an organization providing health are motivated by values like benevolence and personal sacrifice. Health care organizations (should) show the same characteristics as communities. Parents, teachers or medical instructors have an important role to pass on this normative "knowledge" to the new generation. The caring discourse is the most explicit about the underlying

values—the muteness of other discourses about values does not mean of course that they are value-free. A caring discourse holds that morally authoritative or competent persons should govern health care organizations. If the quality of health care must be enhanced, the involvement of such people for those who require care is needed.

Medical–professional discourse

From the viewpoint of medical discourse, good care has something to do with a professional attitude. This attitude consists of elements like expertise, autonomy, collegiality and a patient orientation. A medical discourse implies care should only be given if there is a medical necessity to do so, based on medical knowledge and insights. Care should be evidence-based, where increasingly evidence of the quantitative kind is what medical doctors seek (see Upshur *et al*. 2001 for a critique).[8] Doctors can better decide than patients or their family which medical treatment is required when. This discourse epitomizes the medical expertise of the professionals in their treatment of patients (rather than their social abilities), and also gives credit to medical doctors who function in the administration of health care organizations. On the macro level, health care policy should be based (mainly) on medical knowledge. The medical discourse expects improvements in health care from professional methods such as evidence-based medicine and innovations in medical technology.

Political discourse

Political discourse highlights the importance of the principle of citizenship, which invokes responsibilities and duties. Organizations have a public responsibility to guarantee the access for every citizen. To participate in society, citizens must be of good health. Information about the role of health and sickness in society is required. Representation is key to the process of governance at all levels, with some commentators advocating a system of national health service. Policy making and the quality of health care would be enhanced when citizens or patients are represented in separate bodies. Patient organizations should therefore participate in the decision making of organizations providing health care. Appropriate policy is also realized with the help of a system of checks and balances.

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8 Objectivity, certainly quantitatively, is itself a modernist goal, emanating from Descartes. Weber talks about "demystification" in this context, and holds money to be a prime means to achieve objectivity (Weber 1996).

Economic discourse[9]

According to a economic discourse autonomous consumers are the best judges of their own welfare. Health care should respond to the needs or demand expressed by its consumers; intervention in their decisions is needless and even undesirable. The use of management ideas and techniques ensures consumers" preferences are met. Health care organizations should thus base their decisions on management information, gathered for instance by market research. Economic discourse idealizes the market: health care organizations should operate on the same principles as private companies. This discourse has a tendency to use financial incentives, output standards and efficiency requirements to improve health care. These economic means are necessary and deemed to be the most appropriate in a world of competition for scarce resources. Personal budgets for consumers of health care are a logical instrument to suggest. Even though health care organizations are focused on patients, these still have a passive role in developing policy, as they are a source of information and not participants in decision making. Managers can best occupy the leading functions in these organizations.

Table 3 summarizes the discussion of the four discourses. The table indicates what consequences a change of discourse has on, for instance, the view of good care, and the knowledge we need for health care policy.

In practice a mix of discourses can be seen, sometimes even embodied in the same person. A discourse may become more prominent as the role of others declines. At the beginning of the twentieth century, the caring discourse was prominent. For instance, elite members of the strictly separated "pillars" of Dutch society founded hospitals. After the Second World War both the medical and the political discourse became stronger. The seventies were the heyday of political discourse. In 1974, the Ministry of Health launched the Memorandum on the Structure of Health Care ("Structuurnota Gezondheidszorg"), which can be considered as an attempt of the government to more effectively control the health care sector (Schut 1995). The memorandum did not envisage a system such as the British NHS, but it did argue that the state should take up central responsibility for "a well structured, democratic and effective system of health services." Policy should no longer be left to the other agencies in the health care sector. The efforts of the government to constitute a program of comprehensive

9 There are, of course, some links between economic discourse and neoclassic theory, but economic discourse is broader than and not always consistent with the key axioms of the mainstream approach in economics. Neoclassical models of the demand for health and health care were already popularized in the health economics literature in the 1970s (see Grossman 1972, and for an on-going theoretical discourse, Picone, *et al*. 1998, and Reid 1998).

Table 3: Four discourses to shape healthcare

	Caring discourse	*Medical discourse*	*Political discourse*	*Economic discourse*
Good care	Benevolence	Professional attitude	Citizenship	Consumer sovereignty
Area for special attention of knowledge	Knowledge of values like charity and generosity	Medical knowledge	Knowledge of societal relations and effects	Management information
Ideal domain	Community	Profession of doctors	State	Market
Steering of health care by	Moral authoritative persons	Medical doctors	Politicians or elected representatives	Managers
Resources for better care	Involvement, charity	Evidence based medical treatment, medical innovation	Participation, public responsibility	Financial incentives, competition, entrepreneur-ship

health planning failed, partly because of the resistance of the different parties from civil society. Political discourse subsequently lost some of its popularity to economic discourse in the eighties. Markets, management, entrepreneurship and consumers became the prominent concepts and terminology in the domain of health service. The existence of different routes to modernization of health care therefore does not mean that "anything goes," however. Instead, it allows one to distinguish patterns and direction in the dynamics of the health care system.

THE ADVANCE OF ECONOMIC DISCOURSE IN DUTCH HEALTH CARE

In these last two paragraphs, we sketch in broad strokes developments in the Dutch system of health care, particularly in terms of the way in which discourses relate to one another. The advance of an economic discourse is outlined in this section. For instance, notions of markets, competition, entrepreneurship and consumer sovereignty in the Dutch health care discourse have all been heavily influenced by an economic discourse. Indeed, the rise of management in health care provision may also be viewed as an attempt to address perceived agency problems that act to inflate costs and reduce efficiency. Moreover, this heightens

the importance of measurability and quantification, redolent of this take on modernization.

Promising markets

In the eighties the economic-political climate for many Western countries changed. Economic discourse advanced and market forces were "unleashed". The state had to retreat. Politicians, such as Thatcher, Reagan and erstwhile Dutch Prime Minister—now High Commissioner for Refugees of the United Nations—Lubbers, showed more sympathy for the market than for the state, which was perceived to be overburdened with ideals and expectations. This, of course, affected the health care sector in the Netherlands. The first committee, which emphatically pleaded for strengthening the market orientation in the system of health care, was the Committee on Structure and Financing Health Care, or the Dekker Committee (1987). The fact that Dekker, former chief executive of Philips, led the committee was also a signal of the new times: businessmen instead of politicians or medical professionals had authority. According to the committee, increased efficiency is needed to guarantee the quality and accessibility of health care. Financial incentives should improve efficiency as well as flexibility. The state should merely safeguard the accessibility and quality of care, for instance by making sure that everybody can afford some measure of health care. The advance of economic discourse does not only imply a growing orientation to the market, but also a growing popularity of economic metaphors: competition, entrepreneurship, consumers, and management rhetoric generally. Not all of these developments can be summarized as the advance of the market. Market orientation is only one of the characteristics of an economic discourse.

Competition

Economic discourse expects much from competition. In the entire health care sector, according to Dekker (1987: 13), competition should be introduced "not only for insurers, but also for suppliers of care there will be situation of competition, given a specific quality." Therefore the Committee expected a decrease of costs through the implementation of market-oriented reform. This reduction of costs in combination with competition between insurers would lead to lower insurance premiums. "Competition is an effective means against the spiral of increasing costs and premiums" (Dekker Committee 1987: 13). Nevertheless, the Committee was aware of the risks of competition, and argued that the market for health care should continue to be regulated. Insurance

companies should not have the unlimited freedom to select clients. Universal access to health care system through a regulated market was to be ensured.

Every provider was to deliver high quality health care, but, as one would expect in markets, there was potential for product differentiation. The exit option that now would become available should stimulate suppliers to compete for a market share and be more open for consumers" wishes or preferences. They can no longer expect their clients to remain loyal. The idea of product differentiation and the exit option created a need for information about health care accessible to consumers. A leading Dutch magazine, *Elsevier*, part of Kluwer Publishers that has a strong profile in medicine, started rating hospitals. The highest expectation of the positive effects of competition is from insurance companies. They must offer their clients low premiums, high service and good care. In the 1990s, the government adopted measures for more competition both within and between Social Health funds and private health insurers.

Entrepreneurship, of sorts

Methods and ideas used in business organizations came to be highly regarded. "Societal entrepreneurship" was a concept that sprung from the economic discourse, an (attempted) translation of the economic discourse into another context. The concept implies a particular attitude and work method for the care sector. The National Council for Public Health (RVZ 1996) started to promote the hospital as an enterprise, albeit working on a regulated market. The Council expected important improvements when hospitals function as an enterprise. Greater freedom for organizations such as hospitals means that they would become more responsive to the needs of their "customers," and hence will have an incentive to act (more) efficiently. The notion of societal entrepreneurship is to incorporate the societal context of organization in the health care sector.

Consumer sovereignty

The notion of consumer sovereignty is reflected, for instance, in the recent introduction of personal budgets. This has the objective of increasing the transparency of health care costs. Personal budgets replaced provision of health care in kind. Patients receive a lump sum with which they procure health care themselves. Consumers choose their own provider, which can be a person or an organization, and enter into an agreement. Personal budgets are now possible for care for the mentally handicapped, care for people who cannot leave their home and have difficulties undertaking domestic activities, and under certain restrictions for mental health care. Such budgets can be requested if clients need care

or support for at least three months. In 2001, more than 40,000 people made use of a personal budget and the number of participants is likely to grow.

Managerialism

Managers and management principles have advanced rapidly in organizations of health care over the last two decades. Increased recourse to, and developments in, "robust" accounting systems, marketing instruments, restructuring (downsizing), strategic plans, and management information systems have accompanied the increased power of managers and the accompanying diminishing influence of clinicians and the medical–professional discourse. This range of information was, at best, lacking due to the previous institutional arrangements, where health care organizations were financed through a lump sum from the insurer, which would be cut if not consumed entirely. In such a system, there is no reason to control costs. Forced by the government, hospitals started a Diagnosis Treatment Combination (DTC); a system of output pricing. From 2003 every treatment will be priced; providers of health care will receive remuneration per treatment. Hence, it is envisaged that should the costs for any surgical procedure be higher than the remuneration health care providers receive, they will lose money, thereby stimulating greater efficiency.

Of course the foregoing is predicated on the presumption that measures can be generated accurately. If this is not the case then by its own internal logical economic discourse predicts a potentially profound resource misallocation. In practice however, adherents of economic discourse were mostly silent about these possible dangers. The analysis above, based on discourse theory, shows that a reductionist interpretation of developments in Dutch health care is inadequate. Popular interpretations such as the imperialism of the market, the dominance of neoclassical thinking, or the hegemony of management do not recognize the complexity of the developments. Discourse theory shows how heterogeneous elements are related (Table 3), and how different discourses relate to one another.

CLASHING DISCOURSES

Although economic discourse dominated in the eighties and nineties, other discourses have not been completely eclipsed. The dominant role of economic discourse has been subject to recent critical scrutiny. There are at least two reasons why economic discourse lost its appeal: disappointments and negative side effects. Discourses clash especially on views of responsibility and consumer sovereignty.

Disappointments

The reality of the process of economization has differed markedly from its predictions. Disappointments with economization in general, and failed deregulation of, for instance, the national railway system and telecom in the Netherlands in particular are strongly associated with this. The promises of better results all around through market-orientation have not materialized.

Despite recent reforms, there is still no unfettered market for health care. Paradoxically, the state did not retreat. Although opportunities for private (for profit) initiative expanded, the government wanted to control costs and therefore deemed it necessary to issue a number of additional laws to that end. Notably, it was the government and not the market that forced a reduction of costs relative to GDP in the eighties. The introduction of the fixed budget system created a strong pressure on health care organizations to reduce costs. "Deregulation" is thus a heterogeneous phenomenon. The nineties showed a mix of supply regulation and use of the market mechanism. The budget system was combined with more competition between insurers. One of the problems around the introduction of the market mechanism is that insurance companies do not have sufficient bargaining power against health care suppliers. As parties that mediate between consumers and providers of health care, they cannot make hospitals and other providers of health care such as General Practitioners increase quality and lower the prices. The market is highly fragmented (regionalized) and a *de facto* exit option does not exist. The reason for this is partly, curiously enough, the process of economization itself, as the concentration of providers of care is a consequence of economization.

Negative side effects

Economic discourse would argue that private organizations should be fully accountable. As the political climate in the last two decades changed in favor of more competition and independence from the government, parties in the health care sector adapted. Hospitals, insurance companies, but also General Practitioners rapidly concentrated their activities. Larger organizations are in a better position to develop policy, compete and negotiate with suppliers and customers. The market share of the largest four insurance companies, for instance, increased from 35 to 64 percent during the years between 1986 and 1992. The market of health care suppliers showed the same trend of mergers and joint ventures, not only between hospitals but also between hospitals and other providers of health care. Large groupings are quite common. Due to the regional, almost local nature of the market for health care, concentration on

the supply and demand sides of the market nevertheless led to asymmetrical market relations between providers and insurers. The vast majority of patients do not look for health care beyond their region (Brouwer *et al*. 2002). Patients may use web-sites that provide information on waiting lists, but primarily because they want to know how long they must wait and not to consider a different provider of health care. In many areas outside the Randstad Metropolis (with cities like Amsterdam and Rotterdam) there is only one hospital in a patient's immediate vicinity. As insurance companies have now become responsible for ensuring that care is provided, limited capacity resulting in waiting lists only aggravate the problems. For insurance companies, the exit option by refusing a contract with a supplier is not feasible. Consumers can (have their representatives) sue insurance companies should they not be able to go to the preferred hospital, mostly the nearest one.[10] On the other hand, GPs, for instance, may refuse to accept somebody if this person does not live in the local vicinity. Therefore, an insurance company, which cannot normally refuse a client, has to reach an agreement with a regional or local provider of health care if it has clients in that region. This may be a plausible source of increasing as opposed to the predicted decreasing insurance premiums despite increased recourse to the market.[11] The Dekker Committee and others who advocated economic discourse did not expect this since they ignored how actors can translate the new discourse on health care to their own situation. Economic discourse increases health care costs, as providers of health care started merging in order to be protected against market pressures, and patients stressed their role as consumer in terms of choice without being very sensitive to prices.

The partial retreat of the state has created a vacuum. Insurers and health care providers seem eager to fill this responsibility gap. Yet no single actor takes full responsibility, not even the state with its constitutional obligation. Hospitals, insurance companies, professional associations and the government accuse each other of causing problems such as waiting lists. The Dutch polder model may work in many cases, but does not seem to work when fundamental changes in policy are needed, at least in the eyes of some actors. The problem is partly the advance of economic discourse that invokes itself as an exclusive discourse and has to some extend undermined the "polder" model. Economic discourse can

10 Consultations typical of the hybrid Dutch ("polder") way of making decisions between most parties involved, though not the patients, has led in 2000 to the formulation of so-called Treek-norms about acceptable waiting time for the most general types of medical care provided by hospitals. These are not legally binding, and have been subject to litigation to make them clearer (see, e.g., Friele *et al*. 2001).

11 Maarse *et al*. (2001) claim that deregulation has increased the costs of health care.

deal with private or atomistic individuals, but is mute when social responsibilities come into play. However, if fundamental changes are needed, other discourses need to be drawn into the discussion.

As noted, personal budgets—long discussed, and recently introduced—have been enthusiastically welcomed. Discourses other than the economic one have pointed to the risks of such budgets along lines suggested in Table 3. When money is introduced in a relationship, at the disposition of the patient, this can result in a profound change in people's perceptions of their "situation."[12] Informal, voluntary care at the moment forms an important part of the total care provided (Rasker 1993). The providers of informal care may come to perceive of their care as having (potentially) a monetary value, and stop providing it (cf. Frey 1997). Free riding will start to occur; shared facilities may not be adequately funded anymore. An immediate consequence may be increasing costs, when budget holders (have to) substitute informal, unpaid care by formal, paid care. An important question is thus: Can we provide the same quality of care at the same cost without having some measure of solidarity? Health care is not (always) an entirely individualistic matter. Care provided by relatives and friends is often perceived as highly valuable by the patient as well (Rasker 1993). Caring and political discourse recognize involvement with and solidarity between people, whereas economic discourse is confined to an individualistic representation of behavior.

Economic discourse invokes strong assumptions about consumers' capabilities. In case of sickness, many people are in a situation of dependence; the exit option is less feasible. A caring discourse can better signal the weakness of consumers on the market for health care. Finally, medical discourse can signal another potential danger: the existence of information asymmetries between the doctor and the patient. How can patients know what questions to ask? Patients may not always have a good picture of what they need. The customer is not always right. Human beings are more diverse than economic discourse suggests. Other discourses are better at understanding such characteristics as solidarity, dependency and ignorance, and the consequences of them for the provision of health care.

Disappointments, negative side effects and limitations of economic discourse signal that a permanent dominance of economic discourse is not likely. In the

12 This is, of course, a hotly debated issue, with Simmel (1990) and Titmuss (1970) for instance arguing that money will destroy altruism and personal relations, and Zelizer (1997) taking a more cautious view.

translation of one modern discourse on rationalization to concrete institutions, compromises, ambiguities and unintended consequences arise that become the focal point of people's attention. Such developments are most visible at the level of concrete institutions or roles. The manager is a prime example of that (see Box).

Box: Managers—Praised and Accused

One consequence of the advance of economic discourse has been the changed role of the person directing an organization of health care. As economies of scale were sought, and specialization progressed, the manager both moved and was pushed to a position where he was the only one who could mediate between the internal world of the professional organization and the external sphere, society. Internally, the role of the manager developed from a facilitator for the wishes of the doctors to a strategic player in an organization. Externally, more room for negotiating with sections of the government and other parties such as insurance companies opened up. Economic discourse was the language he had to understand and communicate in most eloquently.

After an initial period, managers are now coming under attack. People lament mismanagement, the lack of compassion of managers and managers being more concerned with establishing and maintaining their own position. The general impression is that hands at the desk substitute for hands at the bed. Two accusations stand out: the incompetence of managers and the growth in the number of managers. Blame for malfunctioning of the system shifted from the government to the managers. The lamentations about management are paradoxical, however: people expect a lot from management, but are at the same time skeptical about the kind of plans management will develop. Managers are located where market, government and civil society meet, and are often not equipped for their new, more complex role in society. Managers have to deal with the public or societal (moral) responsibility of their organizations. Negotiations are not only found in the arenas generally associated with it: parliament, political parties, trade unions, et cetera. In different "systems," or what Beck has called "subpolitics," one finds it as well. Beck (1997: 99) observes, "[T]he political constellation of industrial society is becoming unpolitical, while what was *un*political in industrialism is becoming *political*." The retreat, in some respects, of the state did not imply more freedom for the manager. Instead, the manager has to deal with more and different actors, such as patient platforms and

journalists. Through a process of democratization, the manager can expect criticism and pressure from more sides than before. The government or the ministry no longer protects the management in case of problems. Indeed, they issue more rules that managers need to follow.

To deal with these new dilemmas, managers must also make use of political, the caring, and the professional discourses. However, research shows that managers are not acquainted with political and moral talk (Bird and Waters 1989). A second problem is that the management theory they are taught is silent about functioning in a public sphere. There is, thus, a real danger that the different actors involved in this sector cannot communicate with each other. If they do understand each other, they are likely to have dissimilar ideas about the solutions for the problems faced. How must waiting lists be reduced? Should solidarity play a role, and if so, how should it be institutionalized? The manager must learn from and communicate in terms of the other discourses, but may be unable to do so.

CONCLUSIONS

Entrepreneurship in the Dutch system of health care is said to be chained (Putters 2001). This assumes, however, the possibility of a perfect market to be possible, and in health care in particular. This assumption underlying the process of "economization" can be doubted on theoretical terms from a perspective of social and institutional economics as well as from that of discourse theory. Societal reality is never as perfectly malleable as some discourses of modern rationalization assume. Existing formal and informal institutions, and discourses that help shape them, need to be analyzed. As discourse analysis shows, changes in the health care system reflect broader societal developments, accompanied by organizational and normative changes in the different institutions. The dynamics of the Dutch health care sector is patterned due to interdependencies between formal and informal institutions that have arisen and persist. The dynamics of the Dutch "polder model" in health care can most usefully be understood as a patterned interaction between discourses. Without a single center of power, state, market civil society discuss, interact. Institutions emerge as a consequence of it. Currently, as the economic discourse wanes, the search is for a new division of tasks and responsibilities. Any new division will be a temporary one. Goals by which people evaluate a system constantly change. In addition, institutional arrangements suggested by a discourse have unintended consequences that will be what the other discourses will focus on when claiming that changes are necessary, that a new approach is needed.

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