Persistent problems in the Dutch health care system: learning from novel practices for a transition in health care with the UPP framework
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Chapter 1: Enduring problems in health care

‘Prinsjesdag’ 2011, Tuesday September 20th: the Dutch government presents its policy for the coming year. Part of this ritualistic unveiling of plans is the presentation of the national budget. The growing costs of health care provisions are, as always, a major concern. The percentage of total collective expenditure spent on health care provisions rose from thirteen per cent in 2000, to nineteen per cent in 2010 (Kam, 2009). Since the introduction of managed care as steering principle, in 2006, aimed at controlling the cost increase, costs have gone up by on average six per cent per year. The budget plans for 2012 thus include some more plans for cost-cuts. This time the health insurance premium compensation (zorgtoeslag) is lowered for all incomes, meant to save 600 million Euros.

While failure to get decades of cost-increase under control is a big policy concern, other actors in health care feel there are more pressing issues. A quick and random search of health care related newspaper articles shows a series of complaints. For instance, it is said that in mental health care institutions, patients often have to wait long for their first consultation, then for the diagnosis, and eventually for treatment. It then remains unclear for patients how long the treatment will take. The availability and accessibility of mental care appears to be suboptimal. In long term care facilities, it is said that there are problems with neglect (elderly in dirty diapers, many accidents), lack of staff, overdue maintenance of buildings, and overall lack of trust between clients, staff and the board. This care with a low level of acceptability is, according to a widely read newspaper, the direct result of budget cuts. In addition, it is said that all patients, especially a growing group of chronically ill elderly who have a relatively high care utilisation, are confronted with increasingly bureaucratic institutions. The above mentioned problems will only become more prominent, as it is expected that between now and 2025 the percentage of the total Dutch working population that is needed to fulfil care tasks will rise from thirteen per cent to 22 per cent (De Nationale Denktank 2006). Finally, evidence-based guidelines meant to

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2 Telegraaf, 'Osira weer op vingers getikt; Toestand in tehuizen zorgelijk', De Telegraaf, 16-3-2011, Amsterdam: B V Dagblad De Telegraaf.
3 Willems, M., 'Klachten verwaarlozing in verpleeghuis; Noodkreet NEBO: kwaliteit door bezuinigingen onder druk 'Wij kunnen niet de zorg leveren die we willen'', De Telegraaf, 4-3-2010, Amsterdam: B V Dagblad De Telegraaf.
4 Canoy, M., Have, A.t. and Oortwijn, W., 'Genees zorg van te veel regelzucht', NRC Handelsblad, 1-6-2010, Amsterdam: PCM Uitgevers BV.
safeguard quality of care are not followed, even though they are drawn up by the medical sector itself.⁶

Thus, increasing costs go hand in hand with complaints about availability, accessibility, acceptability, and quality. It seems evident that adhering to these values and costs constraints is mutually exclusive. Each governmental measure to constrain rising costs leads to quality issues. This, however, is not as clear cut as it seems. If cost control were indeed opposed to quality improvements, innovations in health care would have only one of the goals, never both at the same time. Another quick and random search however shows that many new initiatives are meant to improve care, while aiming for cost control. This suggests that a variety of actors see opportunities for what we will call optimising health care: improving it in terms of costs, quality, and accessibility. The tougher problem seems to be that such solutions often work out differently than expected.

For instance, new care paths or institutional trajectories that bring all relevant specialists concerning a disease together and that are meant to deliver better care for less money appear to have exactly the opposite effect for some chronically ill patients, like diabetes or lung patients.⁷ Another example concerns mergers between health care institutions. The underlying rationale for merging is to improve cost-effectiveness and quality. It is said, however, that precisely because of mergers, care institutions have scaled up and have become more bureaucratic, leading to more concerns about whether employees lose commitment and motivation. This would actually threaten the quality of care.⁸ ⁹

As a final example may serve the managed care philosophy itself, which is based on the idea of free choice by patients. The competition that has been introduced is believed to reduce costs while leading to better quality and accessibility. Yet, results are still disappointing. Some claim that this is because patients’ freedom is actually decreasing because of hidden deals between insurers and hospitals.¹⁰ Others emphasise that patients are lacking too much sufficient, independent and reliable information about the quality of care in order to make good decisions.¹¹ Initiatives to improve this situation work out differently than expected. New Internet sites exist on which patients can review or rate their health care practitioner. These are meant to improve

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⁸ Kemenade, Y.v., 'Haal in conglomeraat de menselijke maat terug', Het Financieele Dagblad, 24-01-2011, Amsterdam: Het Financieele Dagblad B.V.
⁹ Wammes, H., "De zorg heeft een moreel kompas nodig"; Staatssecretaris over bankroet Meavita, NRC Handelsblad, 24-6-2009, Amsterdam: PCM Uitgevers BV.
¹⁰ Buijsen, M., 'De patiënt heeft straks veel minder te kiezen', Trouw, 27-7-2011, Amsterdam: PCM Uitgevers BV.
¹¹ Hasekamp, P., 'Durf voor kwaliteit in zorg te kiezen', Het Financieele Dagblad, 29-3-2010, Amsterdam: Het Financieele Dagblad B.V.
transparency, thereby promoting effectiveness and efficiency. It is said, however, that these sites actually impede quality of care. Subjective experiences of patients are put online, but the practitioner cannot participate in the debate because of his duty of professional confidentiality. Based on just one review, a patient looking for good care may choose a practitioner who is further in distance, whereas such effects of the newly created ‘transparency’ will force practitioners to avoid risks, administrate more, and follow protocols more rigidly. Not to improve his practice, but to cover himself. This all builds up to less appropriate care and higher expenditure. Moreover, the philosophy of managed care gave more room to private clinics, meant to improve efficiency, but resulting in higher costs. For instance, surgeons in these clinics appear to operate more often and earlier than in regular hospitals. The inhabitants of municipalities in which there is a private clinic are more often operated on, for instance, hernias, inguinal ruptures, or on varicose veins. These types of operations yield between 3000 and 6000 Euros, whereas a pain injection yields only a couple of hundred, and sending the patient home to get some rest a couple of tenners.

This study explores the suspicion that the failures of recent attempts at optimisation are not singular or coincidental. It seems that the same kind of issues have been debated for decades. In 1974 the Assistant Secretary of State for public health Hendriks issued a bill on health care structure (Structuurnota gezondheidszorg) that would control cost increase, while improving the quality and efficacy of health care (Van der Grinten & Kasdorp, 1999). The system of controlled competition, implemented in 2006, was based on a 20-year old report by the commission Dekker in 1987 (Van Bottenburg et al., 1999). The issues that are debated in such reports are usually framed as issues of availability, accessibility, acceptability, and quality (Toebes, 2006).

The government and its framing of these issues in terms of costs is prominent in these debates. The Dutch health care system, as most care-provision systems in the Western world, is considered to be unsustainable in its current form. From a governmental perspective, this problem of sustainability is related to the wider problem of tenability of the welfare state. Over the last 60 years, the costs of health care provisions kept growing each year without exception. Not only in absolute terms, which would be reasonable taken inflation into account, but as percentage of the gross domestic product. These problems of sustainability thus threaten availability and accessibility of care in a very direct way. However, even though the governmental focus seems to be largely at cost control, others say the problems have many more aspects. From the perspective of health care

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13 Rosenberg, E., 'Privéklinieken snijden snel', NRC Handelsblad, 17-09-2011, Amsterdam: PCM Uitgevers BV.
practitioners and care consumers, growth in costs did not lead to an equal growth in acceptability and quality of care. There might be a problem of diminishing returns.

According to some, it is even worse. Actors that recognise the paradox of higher expenditure without accompanying yield and devise a new intervention aimed at improving all four dimensions of availability, accessibility, acceptability and quality, somehow encounter opposition in a variety of ways. For instance, according to ‘De Denktank’ (2006), novel care practices are regularly discontinued after their trial period, even after being (scientifically) evaluated as effective, because no permanent subsidy could be found. One could thus wonder if the problems in health care are a problem of optimisation, rather than a continuing battle between a government that wants to cut spending and a civil society that demands more investments. Rather, it might be that it is problematic to give room to initiatives that have the potential to improve health care on all four dimensions.

Over the last decade, a new academic field of study dealing with system innovations and transitions has emerged. This field of study deals with systemically embedded problems, usually labelled persistent problems, that threaten the sustainability of, for instance, agricultural, mobility, and energy systems. The underlying idea is that if, 1) problems exist that have been difficult to solve for decades, and 2) novel practices that acknowledge these problems and try out new solutions continuously fail, there must be a systemic component. These novel practices, usually referred to as niches, experience resistance against their solution, even though they arguably can help to deal with problems of sustainability (Grin et al., 2010). This field of study only recently became involved in the health care domain (Grin & Rotmans, 2006). This dissertation explores the nature of problems in the Dutch health care system that threaten its sustainability. To be able to do this, an analytical instrument for analysing system deficits is developed.

1.1 The nature of contemporary problems in health care

Current Western health care systems are seen as very successful in banning out deadly infectious diseases and prolonging life. In these systems, governments play a vital role in constructing, supporting, and controlling health care facilities. In the Netherlands, for instance, the government created preconditions under which civil society could develop health care (Van Heffen & Kerkhoff, 2004: 188) by means of the 1956 Health Act (Gezondheidswet). However, current systems face problems of tenability, and accompanying problems of failing optimisations of these systems. This section introduces the nature of contemporary problems in health care.

In most Western countries, the right to health is constitutionalised and translated into national policies. The implications of this right are strongly embedded in national health laws and policies (Van Heffen & Kerkhoff, 2004)
— even though the notion itself is almost never mentioned (Toebes, 2006). This right must be understood as a right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for the realisation of the highest attainable standard of health. Besides public health care services, this includes underlying determinants of health, such as access to potable water and adequate sanitation; an adequate supply of safe food, nutrition, and housing; healthy occupational and environmental conditions; and access to health-related education and information, including sexual and reproductive health (Toebes, 1999). This does not imply that the state is ultimately responsible for the health status of its inhabitants. The UN Committee on Economic, Social, and Cultural Rights states that both the individual’s biological and socio-economic preconditions and a State’s available resources have to be taken into account. Genetic factors, individual susceptibility to ill health, and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual’s health (CESCR, 2000). The right to health thus is not a right to be healthy, but rather a right to a number of freedoms and entitlements relevant to a person's health. This right to health — in terms of the governmentally supported care provisions aimed at helping people to be able to function in society — is subdivided into four domains, or principles: availability, accessibility, acceptability, and quality. The implications of these principles are taken into account in drafting new laws and policies (Toebes, 2006). Over the last century, Western states have increasingly been able to adhere to these principles.

**Availability**, as formulated by the UN Committee on Economic, Social, and Cultural Rights, points to the responsibility of the state to make sure that functioning public health and health care facilities, goods, and services, as well as programs, are available in sufficient quantity (Toebes, 2006). **Accessibility** has been described in the ICESCR General Comment as the idea that “health facilities, goods, and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party”. It has four overlapping dimensions: non-discrimination, physical accessibility, affordability, and information accessibility (CESCR, 2000). **Acceptability** is described as follows: “All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and lifecycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned” (Toebes, 1999; Toebes, 2006). **Quality** of care relates to care being culturally acceptable, as well as scientifically and medically appropriate and of good quality.

In concurrence with the success — and partly because of the success — of modern health care systems, changes on what the historian Braudel would call the *longue durée* level, also known as the sociotechnical landscape level (Geels, 2002; Geels & Schot, 2007), took place. A shift occurred in the
kind of medical complaints of the population that the system has to respond
to, which is called the epidemiological transition. Whereas the system
emerged when people died mostly of contagious diseases, nowadays chronic
and degenerative diseases threaten the health of the population (Mackenbach
& Van der Maas, 2008). In 2003, the diseases with the highest prevalence
were those regarding neck and (lower) back complaints. Eczema holds the
second position. In terms of deaths, lost years, and disability adjusted life
years, coronary heart diseases, which are age and life-style related, rank
highest. In terms of loss of quality of life and decreasing the possibilities of
people in everyday life, anxiety disorders and depression score relatively high
(Mackenbach & Van der Maas, 2008: 45-9).

Closely related to this is the demographic transition: because of the
success of the current welfare system as a whole and of improved living
conditions, people live longer, eventually dying of general ‘wear and tear’. In
other words, people die of old age and expect to be taken care of
(Mackenbach, 2010). Also, technological progress, leading to new and often
expensive medical tools, contributes to the different environment the health
care system has to operate in.

It is said that these changes have been putting the system under
pressure, leading to problems regarding adherence to the principles of
availability, accessibility, acceptability, and quality. In 1991 the commission
Dunning (1991) stated: the expectation that all care arrangements will
continue to stay available for everyone who needs it, seems unjustified,
because of an aging population, increase in chronic diseases, technological
progress, and an increase in demand for all kinds of forms of health care and
social services. In other words, because less people have to provide for the
needs of an increasingly demanding population, making choices becomes
inevitable (Commissie-Dunning, 1991: 10). The apparent ever-increasing
communal costs of public health services are thus said to pose a threat to all
health services, and, as a consequence, to the constitutionalised right to a
number of freedoms and entitlements relevant to a person’s health.

### 1.1.1 Availability, accessibility, acceptability, and quality
under pressure

Western governments are dedicated to adhere to the principles of availability,
accessibility, acceptability, and quality of care, and have developed an
elaborated system of laws and regulations, and accompanying regulatory
bodies, in order to govern the health care system. An important element of
those laws and regulations concern the financial systems. In most developed
countries, health care systems are driven by financial structures, most of
which are based on public insurance systems (WHO, 2004; Eldis, 2007). Over
the last decades, these systems have started to face problems concerning
tenability. The main challenge in the 1990s was retaining quality against a
backdrop of economic decline and rising costs. The main problem, however, was not economic recession, but the fact that medical technical research and its cost consequences were growing much faster than the economy. The basic conflict in modern health care provision thus lies between the technically possible and the financially affordable. According to Thai et al. (2001), in developed countries the high technology component of health costs accounts for 50-60 per cent of the current cost increase, while increasing service volume and the change in age structure account for another 30 per cent and five to ten per cent respectively. As a result the ‘everything to everyone at any time’ principle cannot be realised. In the Netherlands, the Health Care Insurance Board (College voor Zorgverzekeringen; CVZ),¹⁴ which co-ordinates the implementation and funding of the Cure Insurance Act (Zorgverzekeringswet; Zvw) and the Exceptional Medical Expenses Act (Algemene Wet Bijzondere Ziektekosten; AWBZ), calculated that the costs of the insured care between 2000 and 2005 went up from 27.6 billion to 41.5 billion Euros. CVZ estimates a cost increase of 5.5 per cent every year in the coming years (Strikker et al., 2006). The Council for Public Health and Health Care (Raad voor de Volksgezondheid en Zorg; RVZ) argues that the aging population in combination with the advancements in medical technologies, which are usually expensive, raise severe doubts about the tenability of the health care system (RVZ, 2006).

Even though costs keep on rising, numerous concerns about the quality and accessibility of care exist. For instance, people with medically unexplained physical symptoms, the chronically ill, or people who are terminally ill not always appear to benefit from the care interventions professionals have to offer. In these cases, treatment is aimed at repressing symptoms or prolonging life instead of cure. Problems with quality occur despite the progress of medical knowledge and technology (Van den Bos, 1989; Reuzel, 2004; M’charek et al., 2005; Dirkzwager & Verhaak, 2007). An example is care for people with low back pain. Some individuals with acute low back pain develop sub-acute and then chronic low back pain when initial treatment failed. Of this group, a high percentage is referred to pain clinics and centres, where multi-disciplinary techniques utilising non-pharmacologic, pharmacologic and anaesthesiologic interventions are variably beneficial. Most chronic low back pain patients, however, continue to have significant degrees of pain, are significantly limited in their functional capacity, and become emotionally altered by their chronic pain condition. A broad range of options has been advocated, yet a lack remains of well-designed and appropriately conducted clinical trials to evaluate the efficacy of these treatments. Furthermore, a systematic review of antidepressants treatment options for chronic back pain concluded that these treatments produce only a moderate symptom reduction, and another recent review concluded that: “Many drugs

¹⁴ The Dutch governmental institute College voor zorgverzekeringen (CVZ) is both an advisory and executive for the statutory health Insurance.
used for back pain are no more, or only slightly more, effective than placebos. Others have side effects that outweigh their usefulness in relieving pain. On the basis of the evidence, no drug regimen can be legitimately recommended for back pain”. The World Health Organization Advisory Panel likewise concluded that there is no single treatment superior to others for relieving chronic back pain (Apkarian et al., 2009).

An example of problems in the care for chronically ill patients is the care for diabetes patients. According to a RIVM-report (2005), in 2003 there were 600,000 people with diabetes mellitus in the Netherlands. The total costs for diabetes care were estimated at 735 million Euros, which was 1.3 per cent of the total spending on health care in the Netherlands. The largest part, 45 per cent, was spent on medicines and care appliances (Baan & Poos, 2005). For this group of patients, blindness, kidney failure, amputations of limbs, heart failure, and atherosclerosis are all complications that might occur in the life of a diabetic person sooner or later, depending on how well they keep control over their blood sugar level. Control thus is an important issue, and as a consequence also in the contact between patient and physician (Freeman & Loewe, 2000). Due to the well-developed equipment to check and regulate, the chance to die directly as a result of a badly regulated blood sugar level is small. The Dutch Diabetic Federation (NDF: Nederlandse Diabetes Federatie) tries to promote multidisciplinary and patient centred care in which education of the patient and involving the patient in caring for their disease are important elements. Different studies, however, show that implementing this kind of care is not a straightforward task. It is suggested that these implementation problems are related to the specificities of diabetes care, whereas the health care system is traditionally organised around acute and episodic illnesses, diabetes is a complex multi-systemic chronic disease (M’charek et al., 2005).

A third group of patients that exemplify problems with quality and acceptability of care are terminally ill patients. Because no cure is possible, optimal care is considered the highest achievable goal. Therefore, it seems logical to apply the newest health care technologies available, like medicines, diagnostic tools, or medical aids for support at home, with the aim to either turn the process around and find a cure in the end, or at least to buy time. Here the problem of diminishing returns is said to be especially prominent. In New Hampshire, United States, the Dartmouth Medical School argues that ‘More care does not mean better care’ (Mahar, 2007). Several studies compared spending on and outcomes from health care interventions between different states in the United States. These studies showed several counterintuitive conclusions. Firstly, patients who receive the most intensive, aggressive, and expensive treatments fare no better than those who receive more conservative care. In fact, the outcome of the former is often worse. In high-cost regions, patients with the same disease have higher mortality rates, very likely due to medical errors associated with increased use of acute-care
hospitals (Fisher & Welch, 1999). Secondly, it appears that in regions where the spending is already relatively high, costs increase at the highest pace. The researchers argue that this is caused by the supply-driven nature of the health care system; the higher the supply of hospital beds, the bigger the chance you will end up in one, and the more doctors that will come around to examine you. Again, this does not lead to better care or lower death rates (Fisher & Welch, 1999). More interesting is that sometimes patients do not opt for more care when they are terminally ill because they feel they have nothing to gain, whereas the care providers tend to offer more, sometimes experimental, interventions (Reuzel, 2004).15

1.1.2 Movement on the axes body-mind and care-cure

Current problems in health care can be seen as the result of a shift from one quadrant of the axes body-mind and care-cure to another quadrant. The current health care system developed in a context in which the focus was on cure of the body (Mackenbach, 2010). Infectious diseases and such were very much a physical issue, aimed at eradicating the intruders. This turned out to be a very successful approach. Current issues in health care appear to ask for a focus on a different quadrant than this physical-cure quadrant. A couple of previously deadly diseases are shifting from cure to care. Many cancers can be treated, but usually not swift and clean; a patient enters a trajectory of at least five years. A period in which treatment like radiation- or chemo-therapy is spread out over months, accompanied by follow-up consultations and several treatments aimed at mitigating the side effects, like nausea or loss of hair. After years of treatment, the patient might be declared ‘cancer free’, based on a statistical probability, or the cancer is winning, and palliative treatment, which is purely an issue of care, becomes central. Another example is aids, or actually HIV-infection. It still cannot be cured, but by taking medication daily, it is possible to suppress the virus. HIV went from being deadly to being chronic.

A disease like diabetes was turned into a chronic disease by the discovery of insulin in 1921 (Dedding, 2009). The cure has not been found, but in the subsequent decades the care interventions for the body steadily improved because of, for instance, the development of new needles, more knowledge about appropriate dosage, and more recent electronic blood sugar meters and implanted insulin pumps. During this process, it became increasingly clear that it is also a social disease; a disease in which the physical interacts with the environment in a complex way, and thus care for the ‘mind’ became increasingly important. It appeared that adhering to the medical regime, for instance, not eating whenever you want or planning your

insulin intake, means hard work for the patient. Even worse, it became clear that lifestyle and, therefore, behaviour, may be co-responsible for getting diabetes mellitus two (an enduring high intake of sugars can overburden the bodily system of blood sugar regulation). In modern medicine, where treatment is developed based on meticulous knowledge of how the body works, diabetes shifted from aiming to cure the body to aiming to care for the body, to the idea that care for the, inherently social, mind is indispensable.

A related but even more poignant shift is the shift for a particularly special group of patients. It is estimated that currently half a million people have ‘vague complaints’  — that is, physical complaints for which doctors can find no physical cause. As worked out in chapter four, the (social) mind is not only relevant in terms of receiving support for integrating the disease in daily life, but bad care for the ‘mind’ can even result in more bodily complaints. If medical practitioners are trained in the paradigm of treating bodily abnormalities, these shifts in quadrants may pose a problem.

Medical science emerged from the biomedical model, in a time where morbidity existed out of acute illness from which patients recovered, or they died. In this model, medical diagnosis is central. It is the task of the doctor to discover the aetiology of the symptoms of a patient and decide on the best treatment based on that. This also means that a patient cannot have a disease if a doctor is unable to interpret the symptoms — as is by definition the case with people with medically unexplained symptoms. As a result, problems in communication between patient and practitioner occur, leading to frustrated patients and professionals. Furthermore, for chronically ill patients, the meaning of a diagnosis has changed. The diagnosis is no longer a relief because the disease is known, and treatment can commence, but a sign that life has changed forever. The diagnosis signifies a life of pain, fear, gradual loss of mobility, and maybe loss of independence. Care and relief of suffering has become more important than cure, and ‘quality of life’ becomes the most important yardstick for effectiveness of treatment. Also, the doctor cannot do much anymore and care becomes the patient’s own responsibility, turning the role of the professional more into that of a coach or mentor. This is something that has not been central in their medical education (Mackenbach & Van der Maas, 2008; Mackenbach, 2010). Because the social aspects of the patient have become relevant not only in diagnosis, but also in treatment, in some professions, the practitioners felt a new model for their medical practice was needed. A model that is less narrow than the regular one.

Already in 1954, an attempt was undertaken to expand the biomedical model. Professor and psychiatrist Engel believed that the definition of health in terms of somatic parameters is not sufficiently addressing the complexity of health. In his vision, the biomedical model was no longer relevant for scientific tasks and social responsibilities of either medicine or psychiatry. The

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16 Vermeulen, M., "Kerngezond', maar wel in een rolstoel', de Volkskrant, 10-01-2008, Amsterdam: PCM Uitgevers BV.
biochemical defect is necessary, but not a sufficient condition for the occurrence of disease according to the human experience. Within this bio-psycho-social model, health would be defined as a state of complete physical, mental, and social well-being, and not merely as the absence of disease or infirmity (Engel, 1977). More than fifty years later, this bio-psycho-social model has not become the dominant model, and problems in terms of acceptability and quality of care remain for certain groups of patients.

1.1.3 Problematic policy interventions in health care

Problems in the domains of availability, accessibility, acceptability, and quality are not unrecognised, and on a policy level a set of interventions has been tried. Those interventions were usually aimed at the system level, not on support of specific practices. Such intervention thus took shape as system reforms. Recent system reforms that have been introduced consist of cost-control measures by targeting the delivery and financing model of health care. Internationally, most popular interventions are forms of ‘managed care’. By this concept Thai et al. (2001) try to bind together a range of cost-containment strategies developed in the United States, which are exported abroad. These strategies are used by governments of different countries to pursue some form of rationing, revamping, or restructuring of their health care systems. As these ‘managed care’ strategies are implemented, however, issues of quality, access, and costs appear to become only more urgent, as the newspaper articles above suggest.

In line with this ‘managed care’ philosophy, the Dutch government intervened by the introduction of controlled competition in the health care sector, with the aim to let ‘the market’ organise higher quality, patient-centred care and lower costs. The underlying assumption is that insurance companies will only buy the most cost-effective, high-quality care for their clients, and that patients thereupon will choose the best performing insurance companies. Like in other countries around the world, this introduction has however engendered much critique, because this policy intervention is said to lead to higher costs, de-personification of care, more bureaucracy and possibly fraud.17,18,19,20,21,22 One of the reasons, according to the Social and

17 Bruinsma, J., 'Komst commercie is de pest voor de gezondheidszorg', de Volkskrant, 05-09-2006, Amsterdam: PCM Uitgevers BV.
18 Peeperkorn, M., 'Declaraties specialisten zijn niet te controleren', de Volkskrant, 17-10-2006, Amsterdam: PCM Uitgevers BV.
19 Damen, E. and Hokken, R., 'Door nieuwe marktwerking daalt kwaliteit in zorg', de Volkskrant, 08-12-2006, Amsterdam: PCM Uitgevers BV.
20 Kant, A. and Palm, I., 'Marktwerking is funest voor kwaliteit thuiszorg', de Volkskrant, 08-03-2007, Amsterdam: PCM Uitgevers BV.
21 Vos, C., 'Het CIZ als paarse krokodil in de zorg', de Volkskrant, 30-03-2007, Amsterdam: PCM Uitgevers BV.
Cultural Planning Office (*Sociaal Cultureel Planbureau*; SCP), is due to a fundamental tension between the goal of cost reduction and the market-driven goal of increasing turnover and profit. If the margins on delivered care become lower because of competition, then companies might strive to increase care delivery in order to retain profit (Van Bottenburg et al., 1999). Insurance companies might not be inclined to facilitate sensible and economical care, but simply any care their clients might feel is of high quality. An even higher health care utilisation may be the adverse effect. This could be relevant, but by itself will not fully explain why this latest policy intervention, so far, appears to be inadequate to solve enduring problems.

Because revamping the financial system has so far not proven to be effective, health care providers, committees, and other actors started to argue from the 1980s on that, although restructuring the system at a macro level might be helpful, ultimately choices have to be made at a micro level. Nowadays this notion is widely supported and is propagated, for instance, by both CVZ and RVZ. Both are relative autonomous parts of the Dutch governance structure to regulate the health care system. CVZ states that, primarily, political decisions have to determine what has to be reimbursed by insurance companies and what not (Strikker et al., 2006). To aid such decision-making processes, the RVZ, amongst others, tries to formulate criteria for deciding what care products are allowed to burden general expenses.

Cost control via restricting the contents of the basic insurance package was worked out by, for instance, the commission Dunning in 1991, which formulated the so-called ‘Dunning’s funnel’ (*trechter van Dunning*). The idea of this model, in short, is that any care product will be subjected to four criteria before becoming part of the standard reimbursement package. This means the care has to be: (1) necessary; (2) effective; (3) efficient; and (4) cannot be left to a patient’s own (financial) responsibility. What is called necessary care is defined via three lines of argumentation, which are all based on the idea that health is the ability of a person to function in society in a normal way. The second criterion, if a care product is effective, is a testable concept based on medical, evidence-based medicine, methods. Efficiency of a care product is measurable with cost-effectiveness analyses. The last criterion is anchored in the solidarity principles of the Dutch health care system; it is not possible to decide on the application of a care product based on age, lifestyle, or other private individual features. The only possible limit is when the costs are high and the effects are low (Commissie-Dunning, 1991).

This decision model is twenty years old and widely supported. However, the implementation and application of these rather extensively worked out criteria seem to be posing severe problems. This may be partly due to the difficulty of assigning hard figures to terms as necessity, equity, justice, or even effectiveness, while qualitative norms seem to be too difficult to generalise and lead to inequality and randomness (RVZ, 2006). For
instance, when CVZ on March 28th 2007 proposed to take the rollator out of the basic health insurance package, based on arguments of necessity, effectivity, costs and feasibility, several political parties reacted strongly. The socialist party (SP) argued CVZ did not take social solidarity into account, whereas the liberal party (VVD) stated that everybody is able to buy a rollator for approximately 100 Euros.23

The continuous struggle of the Dutch Government to preserve availability and accessibility of care thus appears to be enduringly difficult. Policy interventions appear difficult to design or implement, and if implemented, have unexpected effects. The problems in health care might have underlying, systemic issues.

1.2 Failing optimisation of health care practices

The problems in the Dutch health care system can be seen as optimisation problems. When costs go up, one would expect that quality would go up as well. This, however, appears not to be the case. It might be that the current system has reached the end of its existence, since it appears to be ill-equipped to deal with the changed circumstances — for which the system itself is for the larger part responsible — and attempts to restructure the system have been unsuccessful. Even novel practices, sometimes seen as innovative practices that have the aim to overcome the problems described above, encounter resistance and inertia. According to ‘De Denktank’ (2006), innovative care practices are regularly discontinued after their trial period even after being (scientifically) evaluated as effective, because no permanent funding could be realised.

While the Dutch government has responded to these problems through a variety of system-level interventions, like the managed care philosophy introduced above, it has also attempted to optimise practices to make the system more sustainable. However, these governmental interventions are oftentimes unsuccessful. In this section, a recent study into an optimisation problem is used to explore how and why it is so difficult to optimise health care, both from a policy and a practitioners’ perspective. This optimisation study does acknowledge that the current system is ill-equipped to deal with the changed circumstances, but surprisingly still fails in its goal. In this case, a new and expensive medicine, mebeverine, was subjected to Dunning’s funnel (see section 1.1.3) as part of the ambition of optimisation of health care.

The mission of the earlier mentioned CVZ is to make good health care accessible by appropriate insurance and funding. To do so, CVZ performs policy analyses on optimisation problems. The interventions as part of these policy analyses do not restructure the system on a macro level, but try to

intervene at the micro level in which doctor-patient interactions take place. The optimisation attempt described below — based on a draft article by John Grin (2006), later published in a revised version with the focus on structuring ill-structured problems (Moret-Hartman et al., 2007) — shows that this is not a straightforward task. The underlying policy problem for CVZ was the failure of the then minister of Health, Welfare, and Sport, Borst-Eilers, to delete mebeverine from the reimbursement package. Mebeverine, a spasmolyticum that is believed to affect smooth muscle cells in the gut and reduce gastrointestinal spasms, is used to treat Irritable Bowel Syndrome (IBS). The medicine proved to be clinically effective in controlled tests by the manufacturer (i.e. its efficacy was sufficient), after which it was admitted to the reimbursement package. In practice however, the effectiveness was conceived disappointing and the therapeutic value appeared to be extremely limited. According to the National Health Service Council (Ziekenfondsraad, ZFR) supportive measures concerning diet and comfort were preferred, but since the complaints imply a burden for patients and a good medical alternative is lacking, the medicine should stay part of the reimbursement package. The minister, however, thought it made no sense to let doctors prescribe a medicine that does not work in practice, so she ignored the ZRF advice and decided to remove the medicine from the insurance package. In a final attempt to win the debate, the manufacturer challenged the decision and took it to administrative court, which then decided in favour of the manufacturer. The reasoning of the court was, since it could not be proven that the product was effective, and no medicinal alternative existed, the medicine should remain part of the reimbursed treatment options.

It appeared that the focus on effectiveness, as part of the decision model based on Dunning’s funnel, did not lead to the prescribed action of removing the medicine from the package, although it seemed clear the effectiveness was disappointing. Therefore, a second research round was set up, with the aim to put the focus on therapeutic value instead. This second (policy driven) intervention also did not lead to changes in the care for IBS. However, it did lead to some surprising research results. It showed that the placebo effect concerning mebeverine was particularly high (up to 70 per cent). Furthermore, maybe as a result, general practitioners appeared to consider satisfaction amongst their patients the most important standard for success in the case of IBS. Since no effective cure is available and the compliance to dietary advice is mostly low, doctors usually just aim at

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24 Efficacy of a care product: its pharmacological action results in a therapeutic effect in clinical research (therapeutic potential). Effectiveness: its use in clinical practice results in the aimed goal of the treatment. Therapeutic value: the sum of the relevant characteristics (like effectiveness, toxicity, or user-friendliness) qualify for its position relative to alternative therapeutic interventions. Efficiency: a medicine is effective and the balance between therapeutic value and costs is favourable in comparison to other treatments. (Taken from: Table 2. Reimbursement Criteria, in (Moret-Hartman et al., 2007).)
reassuring the patient. Part of this reassurance is to prescribe something. By providing the medicine, the patients feel taken seriously, which is both beneficial to the relationship between doctor and patient and the patient’s feeling of wellbeing, although it does not lead to a cure.

It appears that the attempt to provide guidance to the optimisation of a health care provision was facing the health care system it was supposed to help reform. On various levels, including the micro level of doctor-patient interaction, actors in the field worked against finding more sensible and economic cure solutions for patients with IBS. According to Grin (2006), three features appear to be especially important in this case: first, the privileged position of the supply side, expressed in the difficulty to exclude a drug once its 

**efficacy** has been proven, even if its effectiveness and therapeutic value are demonstrably low; second, the reluctance, shared by the ZFR, court, patients, and doctors, against discarding the prescription of this medicine in absence of alternatives based on evidence-based medical knowledge; and last, research meant to develop or validate alternative treatment options was discarded by actors in a series of decision rounds. Grin (2006) hypothesises that the underlying problem might be a strong reliance on medical rationality — as propagated by the relevant actors on multiple levels — which leads to a universal, biological understanding of the human body, thereby neglecting diversity amongst patients and their life circumstances. Furthermore the professionalisation of the health care system might have been accompanied by a reduction of people’s capacities to contribute to maintaining their own health. Based on this, it can be argued that failure of macro-level policy interventions in costs and problems with micro-level care interventions concerning quality are somehow interconnected by the same kind of underlying problems. Thus in this case, top-down interventions run into the same problems that come from the strong reliance on medical rationality as general practitioners who want to improve the quality of care; helping patients change dietary habits instead of prescribing an arguably ineffective medicine appears to be impeded by these problems. The question then is what these problems are comprised of.

In, for instance, the domains of agriculture, mobility, and energy, some long standing problems related to sustainability that have proven to be particularly difficult to solve, through either policy interventions or new small-scale initiatives, have been labelled ‘persistent problems’ (see e.g.: Dirven et al., 2002; Rotmans, 2005; Grin et al., 2010). One of the main features that is attributed to persistent problems and that is mentioned in current transitions literature, is that many actors with different interests are involved. This means that such problems are systemically embedded and that solving them would mean transforming the system. The actors in the system then would resist such changes, either because of their power position that is tied to the current structure, or because of the way they are currently used to deal with problems in general (Grin et al., 2010). If the enduring problems in health
care that threaten the sustainability of the system are systemically embedded, and solutions thus encounter opposition, the question is how these problems are embedded. Furthermore, because the body of literature on system innovations and transitions has not been used to analyse the health care system, the question is what this field of study can add to an analysis of persistent problems in the Dutch health care system.

1.3 Problem definition and objective of research

The Dutch health care system is facing a series of challenges that threaten the availability, accessibility, acceptability, and quality of care. These challenges appear to be related to shifts on the axes of mind-body and care-cure. The challenges, as such, do not come as a surprise, and problems related to those challenges have been acknowledged for decades. This in itself points towards the idea that these problems are systemic in nature. Furthermore, it appears that interventions in these problems seem to encounter opposition from the same system they are trying to optimise. In other fields of study such problems, which are related to sustainability, are seen as systemically embedded problems, and have been labelled persistent problems. Such persistent problems have not been identified in health care.

The main objective of this research is to identify and unravel possible persistent problems in the Dutch health care system. The central question of this research would then be: what do persistent problems look like in the Dutch health care system?

Answering this question, however, is not a straightforward task, since the concept persistent problem itself is not extensively defined, as is argued in chapter two of this dissertation. Therefore, a framework for identifying and unravelling these problems is not available either. Before formulating the final research question that structures this dissertation, this framework has to be developed. Thus, the main objective implies another objective: providing a better understanding of the nature of persistent problems and developing and evaluating an instrument for identifying and Unravelling Persistent Problems. This UPP framework is developed in chapter two. The research question and sub questions are presented in sections 2.3 and 2.4. The underlying idea is that a better understanding of the persistent nature of problems and, as such, the mechanisms underlying resistance to transitions can help novel practices, or niche-innovations (see e.g.: Grin et al., 2010), to survive or have broader impact.

1.4 Structure of this dissertation

In chapter two a method, the UPP (Unravelling Persistent Problems) framework, will be developed that can be used to diagnose sustainability problems in systems. First, persistent problems are conceptualised as
systemically reproduced negative side effects of success factors of the system in focus, building on how persistent problems are perceived in transition management and system innovation literature, and elaborated by making use of social science theory. In that chapter, the research question and sub questions that structure this dissertation are formulated. In the subsequent chapters, the conceptual framework developed in chapter two is applied and tested. Chapter three presents a historically informed analysis of debates in the Dutch health care system, distilling enduring problems and underlying success factors involved in the production and reproduction of these enduring problems. Chapter four describes the first case study: a novel practice dealing with patients with medically unexplained physical symptoms is analysed. This practice seeks to transcend the culturally and institutionally embedded dichotomy between body and mind and encounters systemic opposition. In chapter five, the conceptual framework is developed into a method for investigating optimisation problems in health care. It is further specified so it can be used to do a ‘quick scan’ of systemic problems impeding the desired optimisation. The practices analysed are trying to induce a shift on the axes body-mind and care-cure. Chapter six is the concluding chapter in which, first, the UPP framework is evaluated, and second, persistent problems in the Dutch health care system are presented.