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 3: Historically informed health care system analysis

This chapter describes the first part of the iterative process of identifying and unravelling persistent problems in the Dutch health care system, and thus the first step of the UPP framework. As argued in chapter two, this comprises a historically informed system analysis. The aim of such a system analysis is to identify regime elements that underlie the production and reproduction of problems by current practices, in order to iteratively combine those regime elements, as sensitising concepts, with subsequent case studies. This chapter first gives a short overview of the historical development of the current Dutch health care system, intertwined with the wider development of Western medical science, and as such describes the process of co-evolution that led to the current system. The Dutch health care system, as most modern health care systems, may attract many critiques, but for a long time has done what it was meant to do. As a result of the ever increasing medical knowledge acting as the base on which new care techniques and practices are built, medicine made enormous progress over the last two centuries. In combination with the emergence of Western state-based care systems, a smooth and well-operating health care system emerged that was able to prolong life expectancy considerably and ban out many deadly diseases (Grin, 2004a).

This description of the process of co-evolution gives insight in relevant regime actors, who act through institutionally and culturally paved pathways, and the rules and resources on which they base their actions. Rules and resources that are elements of the regime in which they function. The institutionalised way these rules and resources structure the actions of agents can then be seen as mechanisms. Some of these regime elements, however, are a subject for discussion. Actors constantly disagree about whether the system solves the problems it should be solving, and critical debates between actors in the system thus indicate where the system might have defects. Contested regime elements are thus brought forward in debates in the (scientific) literature about problems in the system. In this chapter, intertwined with the description of the co-evolution of the current system, a set of relevant debates are described. These debates cannot be considered to be all encompassing. Relevant debates are highlighted in iteration with the subsequent case studies. In health care, the rising costs and a set of quality concerns have been discussed repeatedly. Within these critical debates, analysts point out underlying reasons of those enduring problems. Underlying reasons that some define as the core problem, but others explicitly do not. Evidence-based medicine as research methodology is a good example of such
an underlying factor, or regime element, that is both valued and criticised for the effects it has on for instance the quality of care.

The concluding section of this chapter lists and explains relevant regime elements said to be tied to enduring problems: success factors with negative side effects. These negative side effects, manifesting themselves as enduring problems, might be reproduced. The identified regime elements are taken as sensitising concepts in chapters four and five to see if and how they manifest themselves in and how they add to the construction of new practices dealing with enduring problems.

3.1 Co-evolution of the Dutch health care system, and its critiques

The modern Western welfare state — described as the aggregate of arrangements for protections against social risks (Trommel & Van der Veen, 2004: 13) — is rooted in the great social problems in the nineteenth century. These problems came into existence together with the emergence of the industrial society: exploitive factory work, bad hygiene, grinding poverty, the resulting health problems, and uncertain livelihood. In reaction to this, a wide range of collective care arrangements were constructed. Gradually social support provisions emerged, and during the twentieth century, governments increasingly took control of both development and governance of these arrangements (Trommel & Van der Veen, 2004: 7).

The (normative) idea that the health status of the population should be improved, as propagated by many actors, could not have been voiced without the scientific developments that made improvement possible. Foucault (2003) described how modern discourse of medicine developed around the end of the eighteenth and the beginning of the nineteenth century. Until then, diseases were classified in terms of symptoms, and combating symptoms was at the centre of medical action. Around that time the medical gaze turned inwards, revealing the inner workings of human bodies, and as a result, diseases became classified in terms of bodily abnormalities. The central focus of diagnosing diseases thus changed from symptoms to physically discernible deviations. Around this knowledge base, a strong medical profession emerged.

The central actors in the regime became the central government with its agencies, financial institutions like health insurers, and the medical profession. The medical practice arrangements as organised by these actors have become very successful in fighting diseases and prolonging average life expectancy. Together with the ever increasing success of the health care system, however, a set of enduring critiques emerged. On a policy level, the debates focussed for the larger parts on upholding to the principles of availability, accessibility, acceptability, and quality. The modern system and the welfare providing position of the government emerged in years of
economic success. Soon communal costs put the system under pressure, leading to increasing pressure on to upholding the principles and balancing between those principles became central to policy developments. The role of the government has gradually changed over the twentieth century from a purely supportive, distant to a strongly intervening and managing role, mostly aimed at controlling the growth the government itself helped bring about. The medical profession with its autonomy reacted strongly on bureaucratic interventions. Alongside these institutional issues, the medical way of perceiving the world spread into society, creating a strong cultural force. Nowadays, the intertwined health care system elements are perceived as growing in costs, without the quality improvements that some expected.

This section, first, describes more in-depth relevant actors and regime elements that are related to the success of the system and its problems of diminished returns. Intertwined with this are the main problems discussed that dominated the agenda in specific episodes, how multiple actors responded with initiatives, and how these co-evolved with structural change. In addition, this chapter pays attention to critical debates in the scientific literature about those issues. This leads to the description of a set of success factors with alleged negative side effects.

3.1.1 The birth of modern welfare and health care

In the Middle Ages, religious institutions or hospitals (in the original sense of providing hospitality), provided shelter and care for the needy. One did not have to be ill to be taken in, and medical science did not play a major role. Around the sixteenth century, more or less specialised care facilities came into existence, like a specialised facility for care for the elderly, or ‘mad houses’ (dolhuizen) for mentally ill, and the like. Despite these differences, most houses provided the same kind of care, with the focus on care, not on cure (Boot & Knapen, 2005: 49-50). More general health promotion began in the eighteenth century as more or less charitable activities of advocate groups for clean drinking water, good aspiratory facilities, and public hospitals. These groups focussed on the relation between social injustice and health.

In the Netherlands, the connection between these problems obtained even more emphasis in the course of the nineteenth century, when they were collectively labelled as ‘the social issue’. It comprised a wide variety of problems, including poor housing, disastrous private and public hygiene, quantitatively and qualitatively failing nutrition, poverty, and recurring epidemics. Many of those who were politically active around these issues, adhered to the ‘hygienist’ idea that, first, most health problems are related to unhealthy environmental circumstances; second, that collective interventions were the best way forward; and third, that statistical and scientific methods are most suitable to research and attack public health problems (Mackenbach
& Van der Maas, 2008: 20-4). These actors, however, needed changes in the regime of the time to support their cause.

There were allies of different backgrounds. Even though the system emerged in reaction to social problems, it has never had a purely humanitarian goal, as political and economic motives have also been prevalent. One of these motives is that a sizable and healthy population was seen as a prerequisite for a strong nation state (Mackenbach & Van der Maas, 2008). Furthermore, health care facilities have been seen as an instrument to promote employment. Not only by supporting a healthy, strong, and more productive workforce, but also by creating jobs (Van Heffen & Kerkhoff, 2004).26

The efforts of these combined advocate groups to increase public health status and attack other social issues were increasingly successful over the course of the nineteenth century. As a result, a whole range of new regime elements came into existence. These include both material elements, like sewers and clean drinking water, and non-material, like medical knowledge, education, and a professional health care regime. Around 1850, the inspection of the medical schooling greatly improved. Until then, doctors were not professionals of distinction, and their social status was low. Around 1900, more and more doctors became specialised, because medical knowledge became more precise and diversified. The local physician as health-craftsman transformed slowly into the modern general practitioner — a state-certified professional with an undisputed role as gate keeper of the health care system, being at the centre of primary care service providers, and managing the medical record of the patient (Boot & Knapen, 2005: 55). Hospitals changed from crisis centres, or shelters, into curative institutions, following the transformation of medical science into applied medical science that included new technologies, like narcosis, that made hospitalisation necessary (Boot & Knapen, 2005: 49-50). The new practices and structures that thus emerged as a response to social issues in turn would have ‘epidemiological effects’. Around 1900, when most of the cities had water pipes and a sewer system, the focus thus shifted towards attacking infectious diseases based on the scientific developments in bacteriology. This focus remained central until 1950 when infectious diseases were diminished.

Simultaneous with the construction of sewers and hospitals, modern medicine emerged. According to Foucault (2003), modern medicine has fixed

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26 This still is a relevant issue. In 2007, about 1.2 million people worked in the health care sector in the Netherlands (CBS, 2010), making up fourteen per cent of the total employment (Mackenbach & Van der Maas, 2008). Governance and (re)structuring of health care thus cuts multiple ways: more production in health care creates jobs in the sector itself, and stimulates the economy, while on the other hand the money has to be brought up by the economy itself. The collective costs thus put a limit on health care spending, while on the other hand a healthy population can make the economy grow, making an increase in spending possible, and so forth (Van Heffen & Kerkhoff, 2004: 186).
its own date of birth in the last years of the eighteenth century. In medical science diseases had been perceived as a kind of autonomous organism in itself, existing outside the body. (You did not get a disease, a disease got you.) Linnaeus, in his *Genera morborum* (1763) classified 325 diseases based on their manifestations and symptoms. He took the same approach as in his famous *Systema naturae*, in which he classified plants based on number of pistils and stamen of the flowers. In the nineteenth century, pathologist Rudolf Virchow was one of the people who changed this position, declaring that diseases have no autonomous or isolated existence. Diseases are manifestations of life processes under changing circumstances. Nowadays, diseases are seen as conditions of an organism (Mackenbach, 2010: 12). The work of Virchow was embedded in a wider movement that took place around the end of the eighteenth century, which claimed that illness existed in the form of localised pathological lesions inside the body (Foucault, 2003). Building on this, clinical practice could no longer monitor the illness as it entered and moved through the body, but had to devise techniques for physically investigating the organs and tissues where the disease was located. Post mortem analyses became common to identify precisely the disease that had caused death (Armstrong, 2003: 1).

This development marked the start for impressive medical achievements based on the meticulous descriptions of the inner workings of bodies and the resulting standardised health care interventions based on this knowledge. The history of modern medicine shows that the medical profession benefited greatly from the uniformity generated by recruitment, selection, and performance standards. Standards have been explicitly used to rid medicine of quacks, impostors, and alternative forms of healing, and to put the human body under the jurisdiction of physicians, nurses, and other officially sanctioned medical groups (Timmermans & Berg, 2003).

Because of the technology and knowledge that was now needed to treat patients, hospitals turned into places for patients to receive treatment. Treatment aimed at cure, instead of the traditional focus on care. This new model of disease, called biomedicine, reduced illness to a physiological abnormality and led to enormous resources being invested in the examination of anatomical and physiological processes. The more recent co-evolving pharmacological revolution of the last 50 years has given doctors a wide range of methods to attack pathological abnormalities (Armstrong, 2003).

This however would not have been possible without supporting institutions. Medical science, and especially care facilities where applied medical science could be performed, initially emerged from private initiatives, as niches in an incumbent regime. At the beginning of the twentieth century, care provisions and its financial arrangements were scattered. Around five hundred small health insurance funds existed, both private and public ones (Van Heffen & Kerkhoff, 2004). The actors behind these care initiatives could not make headway without political support. Besides the more structural
interventions like clean drinking water provisions, they thus lobbied for governmental financial support. These efforts turned out to be rather successful, and as recognition grew, private care initiatives started to rely more and more on a wide range of collective arrangements, from sewer systems to a certified medical training school (Van Heffen & Kerkhoff, 2004).

3.1.2 Fast-paced growth of care provisions and institutions

Mid twentieth century, the Dutch government became more and more involved, but not by substituting the existing private initiatives. At first, the government stayed at a distance, limiting itself to creating the context in which health care arrangements could grow by increasingly subsidising the care facilities that used to rely on private donations and contributions (Van Heffen & Kerkhoff, 2004: 188). This was however not the initial setup. During the Second World War, the Dutch government in exile learned about the “Report of the Inter-Departmental Committee on Social Insurance and Allied Services” (most commonly known as the Beveridge Report) that served as the basis for the post-World War II welfare state in Great Britain and aimed at setting up a similar system in the Netherlands after the war. The hallmarks of the British National Health Service (NHS), put in place in 1948, were nationalised health care provisions paid out of the public funds. Care was arranged in regions, governed by a vast network of civil service institutions. The then Dutch government aimed at organising accessible health care facilities of high quality and initially followed the NHS model. It was however not integrally adopted, partly because the confessional parties, directly after the war, did not want all-encompassing state interventions (Van Heffen & Kerkhoff, 2004: 187). The ambition to give a boost to public health care services, however, was widely supported. The government thus followed the strategy of stimulating health care provisions and facilities by giving space to private initiatives, like confessional, or union based; each pillar in the Dutch society (see: Lijphart, 1975) had its own provisions.

To provide a wide range of public health care services, existing partnerships between government and non-governmental parties were further developed. In the Netherlands, health care required, and requires, cooperation. A hallmark of Dutch health care became the interwovenness of public and private domains. Governing health care thus emerged as governing by deliberation. Civil society co-develops and co-implements health care policies. This process of deliberation preceding all policy interventions implies the willingness of all parties to take common interest into account. A collective responsibility has therefore existed during most of the development. Logically, entrepreneurship in health care has always been loaded with societal goals. In constructing health care provisions, or when attacking problems of availability, accessibility, acceptability, or quality, the public and private domains have to work it out together, even though the manifestation of this public-private
interdependency is constantly changing (Van der Grinten & Kasdorp, 1999: 5). In the first years after the war, the earlier private initiatives and the growing governmental role co-evolved together with medical scientific and practical progress in a fairly harmonious way. This was closely related to the economic progress and the widely shared strong focus on building care provisions for the population.

An important prerequisite for further cooperation was the Health Act (Gezondheidswet) of 1956, which arranged for official consultation between the representatives of civil society parties and the government. This law created the foundation of the organisation of the health care system, as it still is today, and can be seen as the result of a series of political compromises laid down in separate agreements and regulations — separate in time, place, and considerations. Ten years of gradual development after the Second World War, this compromise entailed: first, equality in accessibility; second, private insurance for all citizens above a certain income; third, social insurance for all below this threshold; fourth, social insurance for everyone for uninsurable risks; and last, a system of privately-run health care facilities, with an encouraging as well as restricting government (Van der Grinten & Kasdorp, 1999: 7).

Besides the government, the public insurers had also become an important power because of their know-how, their high level of organisation (also on the national level), and their formal position as executors of the law on public health care insurance (Ziekenfondswet; ZFW) and the exceptional medical expenses act (AWBZ). The third important power was the group of highly organised medical professional interest groups (Van der Grinten & Kasdorp, 1999: 11-3). These three parties together built, through a deliberative process, an immensely successful system.

By that time, however, the kind of life threatening diseases that had been the driving force for these developments were replaced by chronic illness, like cardiovascular diseases and cancer (Mackenbach & Van der Maas, 2008: 20-6). The demographical and epidemiological transition, exemplified by an increase in chronic diseases and an aging population in general, led to a series of regime reactions. For instance, in reaction to overflowing hospitals, specialised nursing homes arose after the Second World War (Boot & Knapen, 2005: 49-50). Furthermore, a social insurance for uninsurable risks was constructed in 1967: the exceptional medical expenses act (Algemene Wet Bijzondere Ziektekosten; AWBZ). This financial arrangement became most of all responsible for the enormous growth of health care provisions at that time. It, for instance, further stimulated the construction of nursing homes and facilities for mentally challenged (Van Heffen & Kerkhoff, 2004: 188).

Parallel to this enormous growth in provisions, the government slowly became concerned with the associated increase in costs. Minister Veldkamp warned about growing costs in 1966 with his memorandum on public health (Volksgezondheidsnota). Around that time, costs grew from 3.3 per cent of
the gross national product in 1956 to 5.4 per cent in 1968 (Van Heffen & Kerkhoff, 2004: 189). The subsequent administrations at the time, however, did not intervene because there was no real financial need (Van Heffen & Kerkhoff, 2004: 189). The AWBZ itself was, for instance, built on the favourable economic circumstances in the sixties. All in all, care provisions grew rapidly, but were not following a preconceived strategy or blueprint (Van Heffen & Kerkhoff, 2004: 186, 204). And because of the continuing economic growth, enabling the government to continually grant requests from the field, few conflicts arose (Van der Grinten & Kasdorp, 1999: 11-3). This would however not last long.

3.1.3 Emerging concerns on financial tenability

The harmonious partnership dedicated to making high quality care available and accessible started to change around the time of the first oil crisis. This crisis caused a sharp rise in public-sector spending (Van Heffen & Kerkhoff, 2004), when the cabinet Den Uyl met with a globalising economy. The negative spiral the economy was in, forced the government to control the cost development. Alongside these financial concerns, however, the organisation of care arrangements was a cause of concern for all actors. A patchwork of care provisions existed, meaning there was no balance in availability of provisions per region. Furthermore, there was a risk that the intramural, curative, specialists care would repress other provisions. Especially cheaper primary health care, as well as prevention, appeared neglected. This raised the question as to whether people received the appropriate care. In addition, this would result in even more people being guided directly to the, more expensive, specialist care (Van Heffen & Kerkhoff, 2004: 190).

As a response to concerns about costs and organisation, deputy minister Hendriks proposed in 1974 (Structuurnota Gezondheidszorg) to centralise the care provisions per region and take them away from civil society. He pointed out the need for cost control and guided development, and formulated policies aimed at reorganising facilities into the creation of a coordinated region-based system with a central role for local (provincial and municipal) government (Van der Grinten & Kasdorp, 1999: 11-3; Van Heffen & Kerkhoff, 2004: 190). Part of this was his plea for transforming the municipal health care and health services into a national network of preventive services for the promotion of ‘public health’ (still managed on a regional level). His policy document contains the elements belonging to a structure of a supply-regulated care system. The care should be financed by a mandatory national insurance and organised and controlled via a uniform tariff and payment system (Hendriks, 1974). These plans — indeed — resemble the structure of the NHS.

Another part of the plans involved a restructuring of how health care professionals worked and which professionals were trained. The ideas
underlying this part were: firstly, that for high quality care professionals should cooperate more, and secondly, that care would be more expensive but not of higher quality when the ratio of specialists per inhabitant was high. Overall, a shift from intramural to extramural care and from solo care to health care in a team was proposed. Thus, the number and kinds of professionals should change. And to make this possible, the structure of the medical education institutes should be changed to reflect the number of specialists (less) and general practitioners (more) needed (Hendriks, 1974).

The plans of Hendriks shocked the medical profession, because the withdrawn, supportive role of government was replaced by a very active and intervening one (Van Heffen & Kerkhoff, 2004: 191), and it ran into a great deal of resistance (Beek et al., 1975). This lack of acceptance, however, was not due to the content of the report. The reasoning behind the desired improvements of care provision structures was well received. Hendriks thus noted that ‘the time has come, that workers in health care will accept radical changes’, because, according to him, society itself was asking for these changes and would accept and incorporate them (Hendriks, 1974). However, when the policy proposals were further developed and the practical implications of the restructuring dawned on the field, professionals turned against the intervention, claiming it was an attack on their professional autonomy. Furthermore, the critique was that, in the process of implementation, cost control measures became more and more prominent, where other changes received less and less attention (Boot & Knapen, 2005). This professional autonomy was embedded in the evolution of the care system. The medical profession had very successfully organised itself and is supported by a strong scientific knowledge base. This scientific knowledge base excludes laypeople to have influence on medical decisions. That the government wanted to intervene in this was thus considered to be unacceptable.

The resistance in the end led to the situation that most of the initial plans were not implemented. On top of the resistance from the field, political parties and administrative bodies re-entered the debate. The mandatory national insurance (volksverzekering), for instance, was blocked because it threatened the balance between left wing and right wing views on the nature and content of the public health care insurance system. Furthermore, provinces and municipalities fought over the power over newly proposed regions (Beek et al., 1975; Van der Grinten & Kasdorp, 1999: 13). The existing power positions of various actors impeded the reorganisation of health care.

Hendriks and his successor did, however, in the end succeed more or less in reorganising care provisions in regions, leading to a more equal distribution. Part of this was the introduction of a coherent ambulance system, which ensured that each citizen, wherever in the country, could be taken to a hospital within fifteen minutes. Furthermore, provisions like the GGD were installed to support preventive measures (Van Heffen & Kerkhoff, 2004: 192).
But even though this policy document structured the developments for over ten years, the decentralisation of policy development and implementation were not adopted and executed as far reaching as proposed. Also, the field stayed less at a distance and the government obtained a less central role then aimed for (Van der Grinten & Kasdorp, 1999: 11-3). Interestingly, besides a stronger division between secondary care and primary care, with an emphasis on the latter, Hendriks proposed to add to these two levels a 'level zero' to give room to preventive health care. The aim was to push a volume of care delivery to the 'lower' levels, thus lowering the volume of expensive secondary care (Beek et al., 1975; Van Heffen & Kerkhoff, 2004: 191).

The second oil crisis in the late seventies put further pressure on the welfare state, and against the backdrop of a global trend of neo-liberalisation helped induce monetarist policies (Van der Grinten & Kasdorp, 1999: 14; Van Heffen & Kerkhoff, 2004: 193). The core objective of health care policy in the 1980s thus increasingly became cost control. One of the first measures was a patient contribution on medicines of f 2.50 (€ 1.13) per prescription, with an annual maximum of f 125.- (€ 56.72), which was introduced in 1983. The idea was that patients would be inclined to use fewer medicines. One effect however was that many doctors would prescribe large amounts of medicines at once. Besides this financial setback, the Dutch national health insurance funds were confronted with a huge administrative burden when executing the law. In 1984, a more radical measure was taken: hospitals became bound to a fixed budget. Any cost increases, for instance because of an ageing population, had to be dealt with by increasing efficiency. In terms of cost control, these measures were successful (Van Heffen & Kerkhoff, 2004: 194). The policy instrument of supply regulation was by this time matured and applied with full force. Accessibility however became under pressure, as waiting lists in health care were one of the results (Van der Grinten & Kasdorp, 1999: 14). The focus on cost control is signified by the new emphasis on the yearly financial report, which used to have a more informative than guiding function. The focus thus shifted away from quality and acceptability towards getting governmental costs under control. Related to that, a shift in the relation between government and public-private parties occurred. The focus on cooperation and consensus changed into strategic behaviour and interest advocacy. New alliances were formed and relations became more formal. These developments happened in a context of a more general discussion about what tasks are governmental and what should be left to the field (Van der Grinten & Kasdorp, 1999: 15). The relation between government and civil society that had started to deteriorate after the Structuurnota of Hendriks reached an all-time low. In that light it was remarkable that the medical field cooperated with the cost cuts (Van Heffen & Kerkhoff, 2004: 194).

These disputes about costs and organisation of care intertwined with more general concerns about the reach of the expanded health care arrangements. Medical science, and the accompanying institutions, had
proven to be very successful over the last 150 years. But around the time of
the first oil crisis, new enemies, such as cancer and heart and cardiovascular
diseases, appeared more difficult to defeat than expected. In addition, when
the life of a patient was saved, this did not necessarily mean the subsequent
years were of high quality (Van Heffen & Kerkhoff, 2004: 190). These
concerns, or disappointments so to say, would increase over coming decades.

3.1.4 Struggles about the nature and quality of health care

A number of critiques emerged just when established medicine had gloriously
fulfilled its mission, alongside the praise of the success regarding, for instance,
accessible educational and health care provisions. These critiques attacked
exactly the core of the system that had come into being. These critiques were
the result, first, of the disappointment that the new enemies, cancer and
heart and cardiovascular diseases, appeared more difficult to defeat than
expected, and second, that treatments itself had negative side effects. The
debates around those issues, present in most modern ‘Western’ health care
systems, that became more and more prevalent in the seventies and eighties,
contained three elements. The first element is directly related to the
realisation that the new health care problems could not be solved by the
biomedical model alone. These critiques focussed on the reductionist view on
health as a purely biomedical issue. The second element entails the idea that
this biomedical knowledge base together with the health care arrangements
building on this was overreaching, which led to a medicalisation of life in
general. A process of medicalisation that is, third, supported and pushed
forward by the large care bureaucracies that had come into existence
following the successful building of health care provisions by governmental
and non-governmental parties.

3.1.4.1 Critique on a reductionist view on health

The critiques that had to do with the reductionist view on health as a purely
biomedical issue depart from the question as to what kind of health it is that
health care professionals provide, and for which they must provide. Before
discussing such critiques, the question is how health can be defined. It
appears that no univocal definition exists. An often used description is ‘the
absence of disease, injury, or deficiency’, but this leaves out variations in
functioning and well-being that exists even in the absence of disease
(Mackenbach & Van der Maas, 2008). The World Health Organisation focussed
on the positive aspects of health with their well-known 1946 definition:
‘Health is a state of complete physical, mental and social well-being and not
merely the absence of disease or infirmity’ (WHO, 1946). Even though this
view on health is criticised as unobtainable, it signifies that health does not
have to be a goal in itself, but a condition for functioning in society
From that point of view, being ill can be subdivided into three parts. First, experienced illness, as the subjective, difficult to measure way of how a disease is experienced in terms of complaints and well-being. Second, being ill as a diagnosable condition based on medical and physiological classifications. This condition usually can be measured by scientific methods, which are perceived as being objective, and can be classified as disease regardless of whether the patient actually feels ill. Last, illness behaviour, or sickness, refers to how the patient reacts to the condition: does he or she stay at home, go to a doctor, or go to work (Armstrong, 2003).

Critiques entail that medical practice generally values the second form, disease, the most, and classifies the other two as belonging to psychology and sociology (Engel, 1977; Armstrong, 2003; Mackenbach, 2010). For specialised health care professionals being focussed on diagnosable diseases implies that the goal of the intervention is not set unless there is a fair amount of confidence that the means are there to reach it. In the context of health care interventions, specialists then do not define a certain problem unless they are confident that the methods, techniques, and theoretical knowledge exist to actually solve the problem (Van der Wilt, 1995). A diagnosable condition, thus, is a prerequisite for treatment, but also for the idea that the problem is a medical problem, as well as whether a person objectively has a disease. When a diagnosis is made, other determinants for health or well-being than purely biomedical are made irrelevant in specialised medical practice.

This reduction of health can be seen as the result of the change towards a ‘clinical gaze’ as described by one of the most prominent critics of modern health care, Michel Foucault (2003). The clinical gaze is a different way of viewing diseases, in which the focus shifts from ‘fantasy’ to ‘constant visibility’. Fantasy refers to talking about diseases in cause and effect while lacking any perceptual base. With the anatomical study, abnormalities were traced to alterations in physical structures, thus changing the gaze inwards into the physical body. Disease then manifests itself in physical abnormalities. According to Foucault, this does not mean that a simultaneous shift occurs from fantasy to truth. Even though the aim of medical science is objectively true knowledge, the only thing that really changed was the focus and the language used to describe disease. The link between pain, discomfort, and the underlying disease remains a matter of interpretation. The reductive, positivistic, discourse of doctors is just a new form of interpretation, in which disease is no longer outside, but inside the body, based on what is visible and expressible.

Building on this, according to Foucault (2003), a far reaching shift occurred in how patients are perceived; in objectifying disease, also the individual becomes objectified. The new way of perceiving and talking about disease allowed people to be seen as objects with similar features through which the disease travelled, instead of individuals that are all different in both
social as well as physical ways. Because of the new ‘gaze’, it became possible to hold a scientifically structured discourse about an individual. In order to know the truth of the pathological fact, the doctors must abstract the patient. Thus, paradoxically, in relation to that which he is suffering from, the patient becomes only an external fact. As a result of this clinical gaze, knowledge about the disease becomes leading. Based on this aggregate knowledge, the patient is told how the disease will progress. The 'time' of the body does not affect, and still less determines, the 'time' of the disease (Foucault, 2003).

Thus, following Foucault, even though the language, images, and ways to perceive disease fundamentally changed, the idea that ‘you did not get a disease, but a disease got you’, was still valid. To get a grip on this disease, medicine then starts by diagnosing, which means attempting to ascribe the symptoms to one specific disease. A disease is then a typical combination of phenomena, meaning disruptions on organic, cellular, sub-cellular, or molecular level, with a common cause. The medical professional knows what is wrong only if the specific pattern is recognised, or, even better, certain measurements of the patient’s physicality have revealed the underlying cause. Illness or sickness are of minor importance. But whether illness or sickness can be ascribed to a definable disease has great implications for the individual. The diagnosis determines the treatment, the prognosis, but also whether the patient receives reimbursed health care at all, or benefits when job loss occurs (Mackenbach, 2010: 14). The debate is whether the current health care system, through its medical and financial structure is not too much focussed on the second form of illness, the allegedly open to objectification disease, thereby ignoring the also relevant other two sections, both in searching for the cause and searching for the appropriate treatment.

Another, related, critique refers to the assumption about causality underlying the medical gaze of thinking: social factors are not important, only physical, whereas diseases might be the result of a complex interaction between the human physiological being and the environment. Exogenous determinants (physical environment, life-style, and social environment) interact with personal attributes (genetic predisposition, and somatic as well as psychological features). The continuous interaction between all these features determines the health status of a person (Mackenbach & Van der Maas, 2008: 69). The bio-psycho-social model as described in section 1.1.2 was developed as alternative to the purely biomedical approach.

The rise of this clinical gaze, and its dominance in medical practice, co-evolved with medical technologies that embody this gaze with its focus on the physical. These technologies can be found in hospital wards, emergency departments, rehabilitation centres, and general practitioners’ consultation rooms, but also outside these controlled environments in daily practice. Various critics have taken up these issues. For instance, Vos and Willems (2000) show how an insulin pump meant to aid in controlling insulin levels, or
a cochlear implant meant to restore hearing, travel with a patient and shape the daily life with a focus on the physical. Mol (2006) shows that these technologies are not just neutral aids, but that they promise control and health, while reducing health to the purely biomedical issue of a ‘correct’ blood glucose level. Care, implying actions that address the problems a diabetes patient experiences in daily life and are also of a social nature, is reduced to measure-and-inject mechanic treatments.

As a final example, Mackenbach has pointed out that the assumed objectivity on which specialised medical practice is built is less absolute than might be expected based its institutional embedment. Institutionalised classifications of disease depart from the same focus on disease as a biomedical issue. They are, however, not mutually consistent. The ICD-10 (International Classification of Diseases, revision ten) comprises about eighteen hundred units, each subdivided into separate categories. This attempt to systemically describe the abundant amount of diseases is not build on one ordering principle. The ICD is a compromise: some diseases are categorised based on cause (like infectious diseases, or external injury), others based on mechanisms (like malicious neoplasm, or endocrine abnormalities), and others based on anatomy (like heart and coronary diseases, or respirational diseases) (Mackenbach, 2010: 17).

3.1.4.2 Criticising medicalisation

For Illich (1976), the philosopher of medicalisation, the preoccupation of society with health is one of the ill-effects of modern medical science and its institutions. He labelled this social iatrogenesis: the creation of ill-health by getting people to become worried about their health while decreasing the tolerance for pain and discomfort. Besides social, he also introduced the concepts of clinical and cultural iatrogenesis. The first referring to the harmful side effects of medical treatment itself, the second to the ever growing dependence on health care professionals (Illich, 1976). Hans Achterhuis (1983), building on the work of Illich, raised a series of paradoxes while talking about the ‘utopia of health’. These paradoxes include the discrepancy between the relatively high quality care in the Netherlands and the nonetheless high numbers of people visiting their general practitioner. Furthermore, he claimed that education and early detection are meant to prevent diseases, but leads to more illness. Lastly, he stated that the population wants to be independent and healthy while exhibiting dependent and unhealthy behaviour.

Achterhuis (2004) notes that his analysis of these paradoxes led to the conclusion that the increase in health care facilities and professionals leads to insecure and dependent people, which actually undermines their health, pushing them towards the medical circuit for every minor complaint. Therefore, Achterhuis argues, personal health has become extremely
important, and suffering is hardly accepted. Care is demanded by all instead of asked for by the sick. Health care has become more or less an exclusive field of government, insurance companies and medical specialists — instead of something that people do for themselves or each other — leaving the responsibility for good health in the hands of care professionals.

According to De Swaan (1996), these developments are, amongst other things, the result of diffusion of the medical professional way of thinking of health care professionals to laypeople, a process he framed with the term protoprofessionalisation. According to Novas (2006), this diffusion of medical knowledge, intertwined with health care-seeking behaviour, is a self-fortifying process. Developments in medical research, and the ever growing medical technology, stir up the hope that a cure is near or at least a better treatment is in sight. This goes not only for high-impact diseases like cancer, but also for general fatigue. As long as hope for success in the near future exists, financial investments, and thus new developments, will continue. This is a self-fortifying process, as long as there are actors who benefit from the research economy.

The process of medicalisation is said to not only turn citizens into needy patients, the diffusion of medical knowledge in other domains also influences what society sees as ‘normal’. In the past two centuries, a broad range of behaviours from homosexuality to alcoholism has been medicalised. The focus on locating the genetic precursors or the neurobiological basis of illness, diseases, disabilities, and behaviours, implies that the knowledge base of scientific medicine is more and more used to define the limits of ‘normality’ and the proper functioning, deportment, and control of the human body (Williams & Calnan, 1996).

3.1.4.3 Institutional critiques

The third fundamental critique attacks the institutions that grew simultaneous with the medical knowledgebase and its practice. Ivan Illich (1976) criticised the large care bureaucracies, who would rob individual citizens from their capacity to take care of themselves, while making those citizens increasingly dependent on anonymous institutions. In the Netherlands, Hans Achterhuis (1983) attacked the expansiveness of care professionals and their attempt to turn independent citizens into needy clients (Trommel & Van der Veen, 2004: 7). Not only patients would become subjected to growing bureaucracies, but also professionals and their professional autonomy became increasingly under pressure, as argued in section 3.1.5.

These three critiques were echoed in the memorandum 2000 published in 1986. It contained a plea for a shift in focus from (even) more curative care to influencing medical and social determinants underlying health. This policy document drew on (scientific) discussions stating that the influence of (curative) health care on disease and health is relatively limited and that
environmental and social factors have a far bigger effect on health status. This memorandum is aligned with the international discussion regarding the feasibility of health care that is more focussed on primary health care and prevention than on specialist’s interventions in high-tech hospitals (Van Heffen & Kerkhoff, 2004: 195). Yet, in the course of the 1980s, the existing critiques became less social and more business-like. As a result of the economic crisis and the rise in unemployment, the affordability of the welfare state became a concern. The issue of independence was again raised, but this time not as an issue of morality, but of financial independence from the state (Trommel & Van der Veen, 2004: 7-8). Authors like Illich and Achterhuis contend that institutionalised care thus has its own dynamics, creating more care facilities and more needy patients. Whether the debates are more philosophical or economical by nature, both appear to pose questions about the growing influence of medical profession and way of thinking, bureaucracy as menace to both professionals and patients, the position and relative strength of the demand side, and questions about what limits exist to health care provisions and how these should be determined.

3.1.5 Demand-driven care and professional autonomy

What the critiques regarding the reduction of health to merely a biomedical issue, the medicalisation of life, and large care bureaucracies had in common is that they all comprise components of availability, accessibility, acceptability, and quality of care. In the context of the institutionalised reduction of health to a biomedical issue, an overly reliance of the public on medical professionals, large care bureaucracies, and ever rising costs, the report of the commission 'structure and financing health care' (1987) was drawn up. The focus was on strengthening the demand side based on the idea that well-informed citizens would become equals to professionals, thus liberating themselves from paternalistic interventions. This could improve the quality of care while making the process more cost-efficient.

The commission, also called commission Dekker after its chair, Philips CEO Wisse Dekker, developed policy proposals based on market principles. Based on the argument that a supply-regulated system leads to too much bureaucracy and lack of efficiency, a demand-driven system of controlled competition was proposed. At the core was the idea that insurance companies and care suppliers get more freedom in organising (more differentiated) care within boundaries set by the government (Van der Grinten & Kasdorp, 1999: 15; Van Heffen & Kerkhoff, 2004: 195). To make this possible, the commission proposed three changes. First, insurance companies have to compete for customers. Second, restricting regulations need to be removed. Third, a number of advisory boards, as well as the idea of regionalised care, need to disappear (Van Heffen & Kerkhoff, 2004: 199). The commission Dekker stated that quality control and promotion should become the
responsibility of the health care professionals instead of the responsibility of the government. The underlying notion was that competing care providers ultimately have a financial stake in providing high quality care (Van der Grinten & Kasdorp, 1999: 39).

In contrast to the policy impact of the memorandum of Hendriks in 1974, many proposals of the commission Dekker in 1987 were more or less adopted, diffusing in the policies developed in the decades that followed. A notable change was the transformation of the national health insurance funds into care insurers that were no longer bound to their own region (Van Heffen & Kerkhoff, 2004: 199). Furthermore, in terms of efficiency and customer-oriented care, the government saw much improvement, and the growth of health care costs in terms of percentage of the GDP significantly slowed down. From 1980 until 2005, it only increased from eight to nine per cent (Mackenbach & Van der Maas, 2008: 419) — much less thus than the increase from three to eight per cent of the GDP in the twenty-five years preceding 1980 (Van Heffen & Kerkhoff, 2004: 189).

However, (especially) the medical profession protested loudly against the changed structure, preventing a full-scale transition to a market driven system (Van Heffen & Kerkhoff, 2004). A series of severe shortcomings of the result of the policies were voiced. Firstly, the enduring supply-restrictions resulted in waiting lists and bleaker care provisions. The accessibility declined, threatening the legitimacy of governmental policies. Relatedly, because the money flows followed the laws based on the idea of supply-regulation, accessible, acceptable, and high quality care practices that do not comply with the system receive little or only temporary financial support. Lastly, patients, or patient organisations, remain a weak party. Even though demand-driven care implies that care providers depart from the needs of patients, the climate of cost control keeps the focus on care organisations that implement policy decisions on the regional or national level (Van der Grinten & Kasdorp, 1999: 18).

In the 1990s, no large changes were proposed or implemented. A series of incremental changes occurred, slowly moving towards the model Commission Dekker had proposed, but with an increasingly unclear control structure (Van Heffen & Kerkhoff, 2004: 201). Because the transition into a market driven system did not carry through, in 1993 insurance companies also started to protest loudly. Their main concern was that they did not want to bear the financial risks, without the room to change the policies they implemented. During that time, the government implemented more legislation to keep costs under control: the law on hospital provisions (Wet Ziekenhuisvoorzieningen) and the law on tariffs in health care (Wet Tarieven Gezondheidszorg; WTG) (Van der Grinten & Kasdorp, 1999: 29). The governmental pressure to improve efficiency increasingly began to produce

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side effects. One effect was the declining interest in becoming a nurse, as a result of low wages and high work pace. Relatedly, there was less time to spend on a patient, to have human interaction, which threatened quality of care and the primal reason for nurses to become a nurse. Furthermore, the quality of care over all is perceived as getting less, especially for chronically ill people and elderly. On top of this, there were, at least in the 1990s, many complaints about waiting lists. Also, as a result of budgeting of the hospitals, patients were taken in later in the process and discharged earlier, thereby increasing the workload of general practitioners as well as the demand of home care. Lastly, to lower costs, less qualified personnel was hired (Van Heffen & Kerkhoff, 2004: 209).

Tonkens (2008), amongst others, argues that the logic of the market, with its supply-driven structure, did not solve the problems of too paternalistic professionals, as pointed at by Illich (see section 3.1.4). The rationality of professionals had been replaced by a suffocating bureaucratic rationality, even though a market-driven system aims for the opposite. In her analysis, the new market logic changed the patient into a client. A consumer who almost has the moral responsibility to obtain the best possible care. As result, for instance, general practitioners prescribe more medication than needed because articulate consumers feel they paid for it. Furthermore, the logic of the market dictates that professionals have to justify their interventions and have to provide institutionally-accepted proof that the intervention is working. Their work has to become evidence based. This in itself leads to more administrative tasks and thus less actual work.

Intertwined with this is the problem that the increasing technological possibilities do not lead to better interventions, but to a further erosion of the quality of the interventions. New technologies are usually very expensive, and to keep costs under control, professionals have to work more efficiently. But the quest for more efficiency in practice was translated in an increasing accountability burden, thus more bureaucracy, and, again, less time to spend on the primary process. Tonkens (2008) refers to the mechanisms of market-driven care that lead to bureaucracy as institutionalised distrust. She argues that this is the most important cause of waste of money. Time-consuming, (often) computer based registration and accounting systems offer an illusion of overview, insight, and efficiency, but in practice create a misbalance between the actual work and the registration of it.

Against the logic of the market that demands speed and efficiency and the logic of bureaucracy that demands thoroughness, Tonkens (2008) places the logic of the professional. According to her, the main goal of a professional is to become as skilled as possible in his profession. Part of that is to help a client in the best manner possible, not to treat as many clients as possible. This means that professionals do want to work demand-driven, in the sense that professionals try to see all patients as individuals. Even though they might have seen a hundred patients with the same underlying pathology
belonging to a set of symptoms, every new patient might be the exception. Because of institutionalised distrust, however, protocols have to be followed. The protocols that are enforced by bureaucracy deprive professionals of the trust and the methods to provide high quality care.

### 3.1.6 Evidence-based medicine and bureaucracy

In the 1990s, a new *regime element* came into being from within the medical profession. This by now systemically embedded feature, called evidence-based medicine, is aimed at improving quality of care, and was built on the medical rationality as described in section 3.1.1. The new formalisation of medical knowledge turned out to be very compatible with the logic of the market, because of the accountability possibilities it offers. The medical rationality behind this new regime element however preceded this logic. As argued in section 3.1.4, current treatment of disease is the result of the medical way of perceiving disease and the accompanying focus on the physical. If one wants to interfere in a disease, as defined in these terms, one needs a methodology that tests the effects of interventions on these physical abnormalities. In 1992, the term *evidence-based medicine* (EBM) was introduced to practice medicine in a more efficient and rational manner (Sehon & Stanley, 2003). Besides the efficiency and providing a rational basis for making policy decisions, a benefit of working with EBM is that it improves the ability to create a shared conceptual framework for the evaluation of scientific evidence. Evidence-based then refers to the aggregate of scientific knowledge based on meta-studies of a series of randomised controlled trials (RCTs) that can inform medical practice.

Probably the oldest recorded controlled study, although not randomised, is the one in which six different diets were given to twelve patients with scurvy. Ship doctor James Lind published his findings in 1753, stating that a diet of two oranges and one lime a day works best (Mackenbach & Van der Maas, 2008). At the core of the evaluation of a new curative intervention is whether the new treatment works better than the current standard treatment. (Or whether a new, less burdening or cheaper, treatment works just as well.) Step one of the evidence-based medicine philosophy is to determine what the primary goal of the intervention is. This provides a basis for step two, determine how the outcome is measured and compared (Mackenbach & Van der Maas, 2008: 318). The goal could be, for instance, the complete removal of a tumour, or the complete removal while preserving limbs, or prolonging life expectancy, or improving quality of life over the remaining life span. In other words, the goal set determines how the intervention is carried out, as well as how the success of the outcome is perceived. Furthermore, the goals are supposed to be *measurable*. Improving quality of life as the set goal is therefore considered less suitable than the goal of complete removal of a tumour. Step three is characterising for which
patient group the intervention is meant. Patients might be excluded from the trial because of interfering co-morbidity, being too old, or having a problematic health status. Step four focuses on describing the experimental intervention in coherence with a relevant reference or control intervention. Both interventions, the control usually being some sort of placebo, are to be measured and thus be *measurable* in the same way. It is preferred that both groups do not know in which group they are placed. Step five is assigning patients to one of the two groups. This can be done by drawing lots or some other way to ensure randomisation — hence the name randomised controlled trial (RCT). Step six consists of analysing the results, and step seven of interpretation, generalisation, and implementation of results. The problem here is that a gap exists between the effects as obtained in controlled situations (the efficacy of an intervention) and the effects in real clinical practice (the effectiveness of an intervention) (Mackenbach & Van der Maas, 2008: 318).

The original definition of EBM encompasses three aspects that need to be taken into account when deciding about a medical intervention: 1) using the best available scientific evidence for an effective and save intervention in health care; 2) the preferences of the patient; and 3) the clinical expertise of the professional. In a critical review, Sehon and Stanly (2003), however, argue that what separates EBM from other approaches, is the priority it gives in practice to certain forms of evidence. EBM then actually refers to the practice of taking randomised controlled trials (RCTs) as the strongly preferred form of medical evidence, making preferences of patients and professional knowledge subordinate. The critique is that the original meaning of EBM has become narrower than intended. Generally, EBM is nowadays defined as “paying attention to the best findings from health care research, that are both valid and ready for clinical application.” This implies that decisions in health care should preferably be based on structured RCTs and meta-analysis and not on preference of the patient or clinical expertise of the professional. Such structured and standardised ways of deciding on interventions might align well with a market-driven bureaucratic system aimed at accounting and need for justification of medical interventions. For that reason, this originally medical way of thinking has diffused into other domains. The idea that all preventive, diagnostic, curative, but also organisational, interventions in health care have to be evaluated on their effects has become widely accepted in the last decades. The motives for these outcome measurements are diverse, including a quest for accountability of health care professionals and the role of insurance companies and government in formulating what interventions will be part of the standard package. This change in culture is symbolised by the widely influential introduction of evidence-based medicine (Mackenbach & Van der Maas, 2008: 317).
Other criticisms have been raised as well. If EBM leads to enforced standards for health care practice, the first problem is what to do with patients who do not fit the standard. It is said that an enduring problem in the Dutch health care system is lack of acknowledgement of diversity. Diversity then refers to differences in gender, genetics, metabolism as well as social environment. Furthermore, it is said that acknowledgement of diversity might improve quality of care and especially accessibility. Based on this specific notion, the Netherlands Organisation for Health Research and Development (ZonMw) commissioned an exploratory research project to examine factors that facilitate and constrain a focus on diversity in clinical research. The research was done by a collaborative of the Amsterdam School of Social science Research and the Academic Medical Centre (Wieringa et al., 2005). Based on this study, M’charek (2005) argues that since diversity is highly relevant, while at the same time most medical knowledge is produced by doing big-population studies, medical research itself should take diversity into account. Hardon and Van Haastrecht (2005) argue that RCTs have a homogenising influence on medical practice. The status of RCTs as gold standard for clinical research has led to a paradigm shift: from an individual-difference approach to a biological reductionist point of view, which entails that all humans are equal, biologically speaking, unless and until differences can be demonstrated. Even though diversity issues are known to be relevant, sub-group analysis by age, sex, or ethnicity is rarely done (Hardon & Van Haastrecht, 2005).

According to Tomes (2007), evidence-based medicine is a beautiful example of the kind of late modern rationality described by sociologists such as Anthony Giddens and Ulrich Beck: a technologically advanced approach to therapeutic choice that attempts to minimise risk by better understanding and predicting it. As such, evidence-based medicine presents both the strengths and weaknesses that social scientists have identified in late modern risk assessment.

3.1.7 Managed care and the logic of the supply side

Overall, in the last thirty years the focus of the government was on containment of the cost development and gaining control in a multi-actor field. Furthermore, the focus was on curative care, which might be the result of a well-developed and powerful civil society. The contents of care received little attention (Van Heffen & Kerkhoff, 2004: 202). The latest major revision of the system is said to be in line with this bureaucratic-biomedical view on health care. On the first of January 2006 the law on health care insurance (Zorgverzekeringswet; Zvw) came into effect, introducing a system of care provisions steered by market forces, but regulated by the government. The underlying rationale was finding a balance between accessibility, quality, and affordability of care. The plans of commission Dekker were further executed,
and Minister Hoogervorst succeeded in implementing the basic insurance that several ministers had been trying to push for over twenty years (Mackenbach & Van der Maas, 2008: 437-8). Part of this new legislation is the introduction of the law on social support (Wet Maatschappelijke Ondersteuning; WMO), delegating the provision of medical aids for home use, home care, and care involving well-being to the municipal level (Mackenbach & Van der Maas, 2008: 438). This move towards a system of managed care, or fully market-driven care, has not been completely fulfilled. Especially the AWBZ has been reorganised into a system even more based on supply regulation. One care administration office exists that contracts care providers in the specified region. The arrangements are based on the goals laid down in the sectoral multiannual agreements. At the moment, both policy programs are at work alongside each other: the current Dutch health care system is governed both by supply-regulation and demand-driven care. The first remains important because the most important aim of the government is still cost containment. The result is a system in a split (Van der Grinten & Kasdorp, 1999: 17-20).

The system of managed competition in health care is inherently contested; recent examples are described in chapter one. One of the critiques is that the health care system in the United States, the paragon of managed health care, is even more expensive — approximately sixteen per cent of the GDP is spent on health care, compared to ten per cent in the Netherlands (WHO, 2009) — but not necessarily of higher quality (Van Heffen & Kerkhoff, 2004). Furthermore, the movement towards more demand-oriented care does not mean that the patient takes a more central position. Oftentimes the care asked for is interpreted and granted by other parties, like care professionals, insurance companies, and commercial or municipal caretakers (Van der Grinten & Kasdorp, 1999: 59-60). Besides, it appears that it is difficult for the actual clients to make an informed judgement about what insurance company is the best (Van Heffen & Kerkhoff, 2004: 214).

3.1.7.1 Position of regime actors in the new system

The question is whether this new system provides the desired incentives to the actors involved. The system for organising and providing health care facilities can be seen as existing of three main parties that co-govern, arrange, and deliver care provisions: government/policy makers, insurance companies/financers of care, and care providers/medical professionals. The current system is the result of the interaction between these domains. All these domains have their own organisational and professional autonomy and thus their own underlying rationale and culture. ‘The government’ as such does, of course, not exist. The governmental parties involved in steering and governing health care and health care provisions contain multiple bodies on state, province, and municipal level. Furthermore, both a political and a public-servant domain are involved in both development and implementation
of policies. The role of these governmental bodies changes over time and depends on the position they hold on two fictional axes: the axis of functional decentralisation and functional centralisation, and the axis of territorial decentralisation and territorial centralisation (Van der Grinten & Kasdorp, 1999: 46). Since the second half of the 1980s, the focus was on functional decentralisation: less government, more market. This principle was mainly applied to the cure facilities: acute care, specialists, and general practitioners. Simultaneously, however, a counter movement was visible for care provisions, like nursing, home care, mental health care, and care for the disabled. In this sector, making up forty per cent of the total budget, the government tightened the (financial) grip (Van der Grinten & Kasdorp, 1999: 47). Also on the axis of territorial decentralisation and centralisation, the government has been moving and shifting responsibilities to the provincial and municipal level. Decentralisation on this axis does not involve cure, but care (Van der Grinten & Kasdorp, 1999: 47). On the first of January 2007, the social support act (Wet Maatschappelijke Ondersteuning; WMO) came into force in all municipalities. Under the Act, the municipalities are responsible for setting up social support in cases of protracted illness, invalidity, or geriatric diseases. The act encloses the area of well-being or welfare policy as well.

As stated in chapter one, the government is constitutionally obliged to provide necessary care of high quality. The individual financial affordability is arranged via a compulsory insurance (Mackenbach & Van der Maas, 2008: 390). The (public) health care insurance companies that execute this system usually reimburse health care services in kind. This implies that an insurance company cannot just reimburse, but is actually responsible for the care delivered. For this purpose it concludes contracts with doctors and care institutions that deliver the specified care. This system enables insurance companies and health care providers to decide on what care will be provided, leaving out the voice of patients in the decision process. This underlies the historic system of supply-regulation, in contrast to the recently propagated and implemented idea of demand-driven care (Van der Grinten & Kasdorp, 1999: 11). The third party, care providers, consisting of care professionals and care institutions, are relatively independent and oftentimes organised in private organisations. The term ‘professional’ is based on the recognition of a unique body of knowledge obtained by theoretical and practice-based education. The occupational group is itself responsible for formulation of the standards and ethical codes to which they must adhere, although sanctioned by the governmental inspection for health care (Inspectie voor de Gezondheidszorg). Alongside this professional autonomy, an organisational autonomy also emerged in the twentieth century. These institutions and care professionals are, as a result, strongly influenced by the rationality of the medical profession and less by the rationality of the Dutch government (Van der Grinten & Kasdorp, 1999: 8). The (former) partners of the government in shaping and implementing health care policies, the care providers and
insurance companies, have over the last 50 years changed from umbrella organisations, with a societal role, into professional organisations serving the interest of the (semi-) commercial parties they represent (Van der Grinten & Kasdorp, 1999).

3.1.7.2 Dominance of the logic of the supply side

The previous sections convey that the debates that dominated the public discourse in which these actor groups positioned themselves have not led to clear resolutions. Rather it seems that all parties slowly diverted from a cooperative stance towards a position in which they increasingly serve their own goals. From that perspective, a set of critiques exists that attack the notion that a market-based system will change the dominant position of the supply side while strengthening the demand side. For instance, it is said that underlying the lack of attention for diversity in clinical trials are political and economic factors. Taking diversity into account is not in the interest of pharmaceutical companies that fund most RCTs, as findings may limit markets for their products. Besides, systematic consideration of diversity in efficacy and safety studies of medicines implies that regulators would need more time to study the dossier. Under the current fee-for-service payment structures, it is not in the interest of drug regulators to demand more complicated dossiers (Hardon & Van Haastrecht, 2005). Attempts to change this have been relatively unsuccessful. In recent research, an effort was made to explicitly incorporate the patient’s perspective and strengthen the demand side of care by letting patients participate in decision-making on biomedical research. This appeared to be a difficult task. The traditional research community, for instance, saw no surplus value of patient participation. Furthermore, the strong specialisation of the research community, with the accompanying reductionist way of thinking, minimised the room for researchers to take up other research topics than purely biomedical ones that might be relevant to patients (Caron-Flinterman, 2005).

Besides actors that changed from a co-operative stance towards serving their own goals, a hidden, but more powerful mechanism might underlie resistance to a change towards a more demand oriented system. Following Illich (1976), Achterhuis (1983), and De Swaan (1996), it might be that the demand side is governed by the rationality of the demand side. Every attempt to transform the system is thus blocked via two mechanisms: first, direct institutional impediment; and second, the demand side that works according to the logic of the supply side. Dehue (2008) elaborately describes how anti-depressants are being pushed by pharmaceutical companies. These companies have a big influence on research programmes concerning these medicines, which can lead to biased publication of results — that is, only safety-confirming research is published, while side effects and insufficient effectiveness research outcomes are ignored. More important however, Dehue
describes how ‘melancholia’ has slowly become *medicalised*: first, via a redefinition of melancholia as part of depression, and later, when depression was included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and re-defined as *disease*. After that, in concurrence with scientific unravelling of neurobiological, and neurochemical, processes, depression became a biological aberration that can be treated by chemicals.

Not only pharmaceutical companies with their advertisements, but also scientists and practitioners reproduce the idea that depression is a physical disease that should be treated. Dehue argues, however, that this pharmaco-scientific-medical complex cannot be held fully responsible for the increasing amount of prescribed anti-depressants. The widespread fight against depression is part of the process in which the ideal of the socially engineered society becomes replaced by the idea of the engineered individual. The attention is now on the brain when a setback occurs, where it used to be on general circumstances. The responsibility has become more related to the individual. And where our biology, our nature, could be identified as changeless circumstance, it has now also become our personal responsibility to control and fix.

This thus means that the demand side actually follows the logic of the supply side. The notion of *medicalisation* implies that the above-described reductionist view of health as a purely medical rationality, which is the rationality of the supply side, is also internalised by laypeople, thus the demand side of care. Via this internalisation or building of habitus, the demand for care is stimulated by the supply side. A more market-based health care system does not attack this problem, but ultimately strengthens it.

### 3.2 Features and mechanisms in current health care

The aim of the first part of the iterative process of identifying and unravelling persistent problems in the Dutch health care system, comprising a historically informed system analysis, is to identify *regime elements* that might underlie the production and reproduction of problems by current practices in order to iteratively combine those structuring features, as sensitising concepts, with subsequent case studies. This section distils a limited set of those regime elements from the above described process of co-evolution and set of critiques. The description of the process of co-evolution gives insight in relevant *regime actors*, who act through institutionally and culturally paved pathways, and the *rules and resources* on which they base their actions. Rules and resources that are elements of the regime they function in. In the set of critiques, some of the *regime elements* are subject of discussion.

Emerging from the story above is that it is not so much the regime elements themselves that cause problems, these structuring features are also success factors, but the *institutionalised* version of those regime elements. In line with the conceptualisation of a persistent problem as a reproduced
negative side effect of a success factor, a system contains strongholds, which can have negative side effects in the sense that they cause a bias in solution-pathways. This bias in solution pathways implies that the features are institutionalised. It is not just a cultural, by socialisation induced oversight. Even though some people acknowledge this bias, it remains difficult to deviate from the regular institutionalised pathways. The institutionalised way rules and resources structure the actions of agents can then be seen as mechanisms of production and reproduction. The regime elements that are highlighted below are said to have contributed greatly to the progress and success of the current health care system, but their institutionalised versions, as discussed above, have also been pointed out as problematic.

**Standardisation** of health care practice has led to great successes. Standards have first and foremost been used to rid medicine of quacks and impostors, and have put the human body under the jurisdiction of physicians, nurses, and other officially sanctioned medical groups. The first question that logically follows, is whether standardisation and classification change the human body into something it is not — a standard machine. Not only do people differ in how their social context or diet influences their health, physiologically the human species knows six billion varieties. Standardisation of health care thus leads to a uniform treatment of a disease based on a statistical analysis, proving that a significant amount of people benefit significantly from a treatment in a clinical setting. Thus, by definition, this treatment is not suitable for all patients. Furthermore, if standards are formed based on what products pharmaceutical companies develop, the question is whether people benefit in a therapeutic setting and if the standard-generating supply side does create a demand or the other way around (Medawar & Hardon, 2004).

These standards have been the product of and have been supporting specialisation. In the construction of an effective and professional health care system, **specialisation** has led to enormous progress. In the decades after the war, the Dutch government was mainly interested in bringing about sufficient health services. In the period between 1955 and 1970, this led to an impressive increase in hospitals and the emergence of specialised departments in concurrence with differentiation and professionalisation (Hendrix et al., 1991). The system thus increasingly became cure oriented, specialist, knowledge and technology driven, and with a strong emphasis on the hospital as the place of medical action (Berkers, 2013, forthcoming). This specialisation also had a series of side effects. First of all, this overspecialisation might have a lesser fit with current demographics. In the Netherlands there are 27 officially recognised specialisms. In 2003, there were around sixteen thousand specialists, working in hospitals, compared to 8500 general practitioners — almost two times as much. In 1965 the ratio was one to one. Despite this shift, general practitioners are still perceived to be the central node in the care for patients: he or she is the first contact and
manages the medical file of the patient (Mackenbach & Van der Maas, 2008: 366-8). General practitioners pay much attention to more care-oriented tasks in contrast to the orientation on cure in hospitals. As described in chapter one, it appears there are, for instance, problems related to a shift on the cure-care axis, as a result of the epidemiological and demographic transition. After the impressive success that marked the beginning of the current system, nowadays, more specialist cure may lead to diminished returns. Specialists aimed at cure thus have gradually overtaken care-oriented general practitioners, both in numbers and in funding (Mackenbach & Van der Maas, 2008: 366-8), whereas the changing landscape developments ask for more and higher quality care. Related to that, in a specialist system, clients are eligible to receive the care health professionals have to offer. If the care provider cannot offer a solution, the patient is referred. In that sense, specialisation is an important force in the compartmentalisation of health care provisions. Besides that, it appears that specialised health professionals are not so much inclined to participate in multi-disciplinary care teams now requested for exactly the reason that their specialty is not easy to integrate with other specialties.

Medical rationality, with a focus on health as a biomedical issue, and its specialised professionals and medical standards is, however, not the sole domain of these professionals, as argued by Illich (1976) en Achterhuis (1983). According to De Swaan (1996), the medical professional way of thinking of health care diffused from professionals to laypeople, a process he framed with the term protoprofessionalisation. According to De Swaan, already during the early development of the modern health care system and especially the decades from after the Second World War up until now, medical discourse found its way outside the professional world. Through popular publications by medical experts, conversations by patients on what they had been told, hygienic living rules and so on, laypeople adopted the professionals’ way of talking about and dealing with their health. This process helped greatly in improving the general health. Such protoprofessionalisation, on the other hand, probably makes it easier for laypeople to gain access to professional care. This is because, first, laypeople know how to express their problems as being problems that professional care providers should be able to handle; and second, professionals may be inclined to grant these care requests because they are presented with problems they feel competent to handle. As a result, it is likely that the demand for professional health care will rise, because problems people had anyway are likely to be explained in medical terms and are thus directed at the medical system (Swaan, 1996). It is said that laypeople, although they internalised the medical stance, are nowadays less capable of utilising one’s own potential to become and stay healthy; they externalise the responsibility for, and the coordination of their care, to professionals. These professionals on their part are, because of institutional arrangements, not always capable of taking up this role.
The medical rationality and its institutionalisation present in the above described features has been further formalised by a relatively recent development: the progress of evidence-based medicine. Since the introduction of the term evidence-based medicine (EBM) by the Evidence-Based Medicine Working Group (Guyatt et al., 1992), the concept has become increasingly popular. Evidence-based medicine is the practice of medicine based upon the best scientific data available. It forms the basis for the problem-solving approach. In other words, it is a conceptual framework that professionals and students in the health care sciences use for gathering information, processing it, and attempting to utilise what is most important, relevant, and useful (Brown et al., 2005). According to the ideas of EBM, clinical practice guidelines should be based on scientific evidence, preferably a meta-analysis of randomised clinical trials offering probability estimates of each outcome. Although the original description stated this information should be integrated with the personal clinical expertise of the practitioner (Guyatt et al., 1992), proponents of EBM nowadays are wary of reasoning from basic principles or experience; they distrust claims based on expertise or pathophysiological models. They prefer to remain agnostic as to the reason why something should or should not work, rather they objectively measure whether or not it works in real-life settings (Timmermans & Berg, 2003). EBM has become a powerful discourse that has a strong structuring effect; many actors draw on this feature to inform and legitimise their actions. This includes not only health care professionals. Insurance companies tend to reimburse only EBM-validated treatments, and policymakers rely on EBM as the guardian against inefficient deployment of health care provisions. Pharmaceutical companies defend the rationale of EBM because the underlying methodology is linked to the production and accreditation cycle of their products, while it excludes health care interventions that involve treatments that are not easy to break down into single blocks with univocal cause-effect relations. EBM might thus have become more than a tool to promote sensible and cost-effective care; it has become symbolic capital, bound to institutional positions, and therefore used as a resource for other purposes than what is was developed for. The question is whether this paradigm always dictates an appropriate treatment. For instance, the regular paradigm of evidence-based medicine appears to have difficulties with two-way causality. Furthermore, the evidence is only rarely available to cover all the decision moments as laid down in medical guidelines (Timmermans & Berg, 2003). Besides, the evidence itself may have a bias because it is based on research done on an artificially composed treatment group (Hardon & Van Haastrecht, 2005). EBM, meant as a tool to support clinical decisions, has become a guiding principle supported by more parties than medical professionals, dictating particular interventions even when other solutions may be more helpful. This formalisation of medical rationality started out as a mechanism of reproduction. This logic of analysing and presenting medical
research data, however, became extremely successful over the last twenty years, to such an extent that it now can be seen as a systemic feature itself.