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Continuity and Change: Comparative Case Study of Hospital and Home Care Governance in The Netherlands

Rosanne Oomkens[1], Marcel Hoogenboom[1], and Trudie Knijn[1]

Abstract

This article aims to understand the evolution of health care governance in the Dutch hospital and home care sector. We pay particular attention to how institutionalized governance structures shape policy reform. Professionally-dominated governance structures are likely to continue to exist to some degree, even when new policy measures seek to introduce hierarchical control or market mechanisms in order to restrict professional autonomy. In contrast to the home care profession, the dominance of the medical profession with its high corporate power has been institutionalized into the governance structure, constraining actors' choices in ways that only permit incremental changes in hospital care.

Keywords

health care governance,professions, path-dependency, New Public Management, the Netherlands

Introduction

Responding to increasing health care costs, financing deficits and population aging, in the past two decades many OECD countries have been exploring

[1]Utrecht University, The Netherlands

Corresponding Author:
Rosanne Oomkens, Utrecht University, Heidelberglaan 1, Utrecht, 3584 CS, The Netherlands.
Email: r.f.oomkens@uu.nl

new models of health care governance that operate more effectively and efficiently (OECD, 2010). In many countries, attempts have been made to shift toward a market-oriented and New Public Management-based system (NPM). NPM is a broad set of management approaches and techniques, borrowed from the private sector, that are applied in the public sector (Hood, 1991). The basic hypothesis of NPM holds that market-oriented forms and private-sector styles of management in the public sector will lead to greater cost-efficiency for governments and better quality care. In most definitions, NPM is described as decentralizing large (public) bureaucracies into smaller agencies that compete with other public or private agencies. Contracting agencies based on provider performance is an important means to realize mechanisms of regulated competition that will subsequently lead to more transparent, consumer-oriented, and efficient forms of service provision (Hood, 1991; Newman, 2001). NPM has become increasingly prevalent in public services since the 1980s. Recent literature shows a wide interest in changes in the health care sector due to attempts to introduce NPM-based reforms (e.g., Ackroyd, Kirkpatrick, & Walker, 2007; Burau, Wilsford, & France, 2009).

A first stream of literature shows specific interest in the consequences of NPM-based reforms for health care *professionals*. Here, it is claimed that the features of NPM tend to strengthen the position of managers and market agents at the cost of the autonomy and discretionary space of professionals such as medical specialists and home nurses (e.g., Tonkens, 2008). A second strand of literature focuses on the consequences of NPM-based reforms for health care *governance structures*, stressing the far-reaching shifts in the balance of power in a country's health care system from professionals to patients—now organized as health care consumers—and managers (e.g., Burau et al., 2009). We claim that both streams of literature on recent NPM reforms tend to oversimplify its consequences as a result of two interconnected misconceptions.

First, existing literature tends to overemphasize homogeneity of *national* institutional settings in which NPM-based reforms take place. Various authors explain continuity and change in health care by exploring NPM reforms in the context of *national* governance systems (cf. Helderman, Schut, van Grinten, & van de Ven, 2005). Although the NPM literature stresses that the governing instruments used due to the arrival of NPM take various forms in different national institutional settings, it also assumes similarities within national political contexts. By doing so, this approach overlooks *cross-sectoral* differences in governance reforms *within* a country (cf. Ackroyd et al., 2007). This article will show that in the Dutch health care system, the hospital and home care sectors are two almost entirely separate worlds in terms of historical development, the professions involved

and types of services provided. In the past two decades, similar NPM-based reform plans promulgated by Dutch governments have thus had very dissimilar outcomes per sector.

Second, and in connection with the first point, we claim that existing literature neglects the potential discrepancy between NPM *measures* and their *implementation*, for two reasons: Institutionalized governance structures fuel the reproduction of existing policy paths and in some cases merely allow incremental policy changes, and professions potentially derive power from these governance structures used to mediate the route from measure to implementation. In our view, existing literature tends to oversimplify the role of and the consequences for health care *professions* in the NPM-based reforms by assuming their position—before and after the reforms have taken place—to be similar across the sector. Yet to assess attempts to reform health care governance properly, a profession's position in specific institutional settings must be considered. Political support for and social status of professions and their organizations vary across health care sectors. Within corporatist welfare states political power is connected to corporatist decision-making structures where professions are a key element in social policy reforms, such as introducing NPM principles into the health care sectors. Top–down reforms can be implemented directly in a state-based health care system like in the United Kingdom, but demand major deliberations in private-based (nonprofit) health care systems such as the German or Dutch (WRR, 2004). Through their specific role in corporatist decision-making structures, professions have the ability to co-produce, amend, and negotiate social policy reforms, albeit to a different degree. We argue that the nature of Dutch health care reforms largely depends on the ability of health care professions to mobilize their veto powers and to mediate policies. It is subsequently reasoned that the discretionary space of individual professionals (their "autonomy") is inextricably linked to the institutional setting in which the collective group of professionals (the profession) operates.

This study seeks to understand the evolution of health care governance in the Netherlands and the extent to which NPM components have been incorporated into reforms over the last few decades. We will demonstrate how the evolution of health care governance in hospital care and home care is co-produced by the relative position of health care professions toward other actors in the sector—including the state and health care purchasers (insurance companies acting on behalf of their enrollees)—and by the extent to which existing policy patterns are institutionalized. It is important to recognize that existing governance structures partly frame future ones. So when changes in governance are studied—the core dependent variable of this article—characteristics of the existing governance

structure simultaneously function as an independent variable, shaping reforms. The two sectors selected share a coercive nature of reforms, in that the government initiated change and made use of legislation and executive powers to set new policy routes and similar imperatives for change. However, before the reforms were introduced the two professions considered here, medicine and home care work, varied systematically in the organization of their professional cadres and in the degree of individual autonomy of their professionals.

The article is structured as follows. Section 2 introduces the theoretical framework. Section 3 discusses developments in governance structures in two Dutch health care sectors by analyzing changes in the relationships between the sectors' key actors and by studying the extent to which professional dominance is institutionalized. In Section 4, we return to the central issues of continuity and change in health care governance and how this relates to the role of professions.

Understanding Continuity and Change in Health Care Governance Reforms

In the past two decades, welfare state research has focused on how continuity in social policies in various Western countries can be explained despite attempts to thoroughly change these policies. The dominant answer is that continuity of policies results from the path-dependent nature of institutions (Esping-Andersen, 1990; Mahoney & Thelen, 2010; Streeck & Thelen, 2005). Institutions can be defined as "well-established and structured patterns of behavior, usually structured around continuing relationships, [which] are always characterized by formal and informal rules and procedures" (Burau et al., 2009, p. 268). Once created, institutions tend to reinforce and reproduce themselves, as well as follow a specific "path" of development—so-called self-reinforcing sequences—to a certain degree despite attempts to change them (Mahoney, 2000). In time, a governance structure of a (social) policy field and the practices produced by it will turn into an institution. Once the institution is created, actors accumulate knowledge about its functioning and get used to "repeated patterns of behaviour that evoke shared meaning among the participants," producing path-dependent development (Scott, 2008, p. 60). According to historical institutionalists (e.g., Mahoney, 2000), path dependency stems from feedback mechanisms of resistance toward change through which actors in a sector gain returns for acting in ways that are consistent with how they behaved in the past, therefore encouraging them to act similarly in the future (Pierson, 2000).

Table 1. Models of Health Care Governance Structures.

Professionalism/self-governance	**Network/corporatism**
Based on expert authority (specialized knowledge and qualifications)	Based on interdependent flows of power in network
Core actor: profession	Core actor: interdependent actors
Examples: codes of practice and clinical guidelines set by professional agencies, monitoring through peer review	Example: negotiations among actors
Professional control over practice	*Adaptation and flexibility*
Hierarchy	**Market**
Based on formal authority	Based on the exchange of demand and supply
Core actor: legislative state (agencies)	Core actors: purchasers and providers
Examples: centralized system of standardization and auditing, earmarked funding, professional regulation as part of bureaucracy	Examples: performance-related payment, competition for contracts, public ranking based on benchmarking
Control, standardization and accountability	*Maximizing cost-efficiency and effectiveness*

Note. Based on Burau, Wilsford, and France (2009); Knijn (2000); and Newman (2001).

Health care governance structure refers to the way health care services are organized, regulated, and controlled. A health care governance structure is defined by the relationships between actors in health care, including the professions, purchasers of care (patients/consumers and health insurers acting as agents on behalf of their insured clients), and the state, which can get institutionalized over time. The dependency of organizational actors on the resources of another actor leads to a dominant position of one or more specific actors possessing high levels of corporate power. Power can be defined as "the chance of a man or a number of men to realize their own will in communal action even against the resistance of others who are participating in the action" (Weber, 1958, p. 180). Corporate power is the capacity of a corporate actor to get decisions and actions taken as well as situations created which concord with and support the interests of the actor. In the governance structure it is decided which actors are granted autonomy. Decisions on who is granted autonomy are thus *not* part of the autonomy: professions enjoying high corporate power create a governance structure with the profession as core actor, most likely resulting in high levels of autonomy.

Applying an approach toward governance that combines analytical frameworks of Burau et al. (2009), Knijn (2000) and Newman (2001), four ideal

typical models[1] of health care governance structures can be distinguished: the hierarchical model, the market model, the corporatist model, and the professionalism/self-governance model. The main characteristics of the four models are listed in Table 1, which in this article serves as a heuristic device that guides us when investigating health care governance reforms. The hierarchical model is based on formal authority with the legislative state being the core actor in the organization, regulation, and supervision of health care provision. The market model includes a range of NPM components and is based on the exchange of demand and supply of health care, making providers (health care professions and the organizations in which they work) and purchasers (health care consumers and/or insurers representing insured consumers) the most powerful actors. The professionalism/self-governance model is based on the dominance of expert authority. Here, the profession constitutes the basis for the regulation of health care work and care provision (Freidson, 2001). The corporatist model is based on flows of power between interdependent actors. For example, professional associations and collective associations of insurers engage in collective negotiation processes in which partners aim at stable relations and interact on equal footing.

Professions share particular characteristics, including knowledge and qualifications as core traits that provide them with opportunities to exert corporate power. Some studies have already found that professions leave their mark on health care governance changes. In their role as mediator between the state and clients or patients, they "influence the kind, pace and structure of provision" (Perkin, 1989, p. 344), can adapt "institutions to their orientations and practices" (Ackroyd et al., 2007, p. 12), and can use mechanisms that steer actors in the sector toward a particular policy path (Pierson, 2000). In line with these findings, we argue that the ability of professions to mediate changes depends on their position in the governance structure (cf. Kuhlmann, 2006; Muzio, Ackroyd, & Chanlat, 2008).

In the present study, we focus on the actions and interactions of professions with other organizational actors. Based on Larson's (1977) theory of professions, MacDonald (1995) distinguishes four features of professions that might explain their relative power in co-constructing policy changes. It is precisely because not all professions are equally able to actually *realize* these features when confronted with reform attempts that varying governance structures result across different parts of the same sector.

The *first* feature according to MacDonald (1995) is that professions derive opportunities for control and power from their knowledge and qualifications. This emphasis on knowledge as a core-generating trait of professionalism (Halliday, 1987) is found in all sociological theories on professions (e.g., A. Abbott, 1988; Larson, 1977). Every occupation has a body of knowledge that

is mastered by its members. The distinction lies in the *type* of knowledge professions master—"esoteric" versus "common" knowledge. Whereas esoteric knowledge is considered highly important for the well-being of groups or individuals and is only commanded by a few, common knowledge is usually known by many people and is seen as less important. The value of knowledge fluctuates across societies and throughout history, which in turn implies, as Freidson (1970) notes, that the characteristics of professional groups are neither fixed nor stable. This suggests that control derived from knowledge is not automatically self-reproducing. In most Western societies, the professions considered in this study—medicine and home care—are acknowledged to be characterized by a different status of the knowledge they represent. Whereas home care is defined as simple, daily and routine care work, hospital care refers to complex, unique, and specialized care work including diagnosis, treatment (also surgery), and disease prevention. P. Abbott and Wallace (1990) refer to (home) nursing as a "caring profession": "While practice is an essential part of any profession and its training, in the caring professions there is a considerable body of opinion that holds that practice is actually the more important aspect. This is particularly true for nursing" (MacDonald, 1995, p. 136). This notion of nursing influences the professional standing of home care work importantly, as it "devaluates the knowledge aspect of the occupation" (MacDonald, 1995, p. 136). Home care work is further devalued because the "caring" aspect of the profession is emphasized and caring is highly gendered and familiarized:

> One of the main areas in which women were able to enter the market, and indeed to professionalize, was that of health, caring and childbirth, but only into residual activities left by the male professions with their claims to a scientific or esoteric knowledge base. These tasks were already socially defined as appropriate for women and it was really only by an elaboration of the feminine qualities of the work that women could achieve the first steps to social closure. (MacDonald, 1995, p. 137)

Home care has long been associated with femininity, familialism, and common knowledge. Knowledge was acquired on the basis of "probationership." This contrasts with the medical profession, where abstract knowledge is acquired through academic training (ibid).

A *second* characteristic mentioned by MacDonald (1995), related to the first feature, is that "professions are interest groups that are in conflict with other groups in society" (p. 30). Professions try to defend, uphold, and improve their position through a "professionalization" process. One of the main goals of professions—"one of the privileges they pursue—is a measure

of work autonomy" (Larson, 1977, p. 219). According to Freidson (1970), autonomy is a means to control work and employment. Professions *interact* with other societal actors to legitimize their position. For that reason, the *third* feature mentioned by MacDonald (1995) is that collective actions of professions can be conceptualized as a strategy of control for access to the profession and therefore closure of it. "Social closure has always been the means by which dominant—originally conquering—groups have achieved and maintained their position" (MacDonald, 1995, p. 52). The *fourth* feature that professions share is that although they might pursue economic interests, their "raison d'être" is providing services of general interest and doing good work of high quality; they provide services that are of crucial importance to their clients, patients, and society at large (Freidson, 2001; Halliday, 1987; MacDonald, 1995).

To understand the consequences of NPM-based policies for professionals' individual autonomy, it is necessary not to confuse this with the corporate autonomy of professions, as is the case in many studies on the topic (e.g., Tonkens, 2008). Coburn (1999) distinguishes *corporate autonomy* of the professions from *individual autonomy* of professionals. The degree of corporate autonomy of professions subsequently influences the degree of individual professional autonomy in daily work. Individual professional autonomy exists as freedom from organizational constraints in decision-making in the work context based on internalized professional norms and (expert) knowledge, although it does not exclude interprofessional training, supervision, and skills development. Corporate autonomy refers to control of the profession over admission into it, work standards and quality criteria for professionals' work (Batey & Lewis, 1982). It also refers to the status-related organizational position of a profession to other nonprofessional actors in the sector, such as the state, purchasers, and organizations' managements. Finally, the individual autonomy of professionals relates to the organizational structure in which they work, including the formal allocation of work roles and the administrative mechanisms to control and integrate work activities (Child, 1972), and the relative corporate autonomy of their own profession as against other professions. Work settings of professions vary in terms of their subordination to other professions and the dependence or independence of other professions with a higher hierarchical status (Freidson, 1970; van der Boom, 2008). Absence of interference and supervision of organizational control and of other professions can provide professionals with more work autonomy.

To summarize, we will study continuity and change in health care governance in Dutch hospital care and home care. Our level of analysis is the macro environment of health care governance structures and the corporate autonomy of professions. As is demonstrated in the conceptual model (Figure 1), health

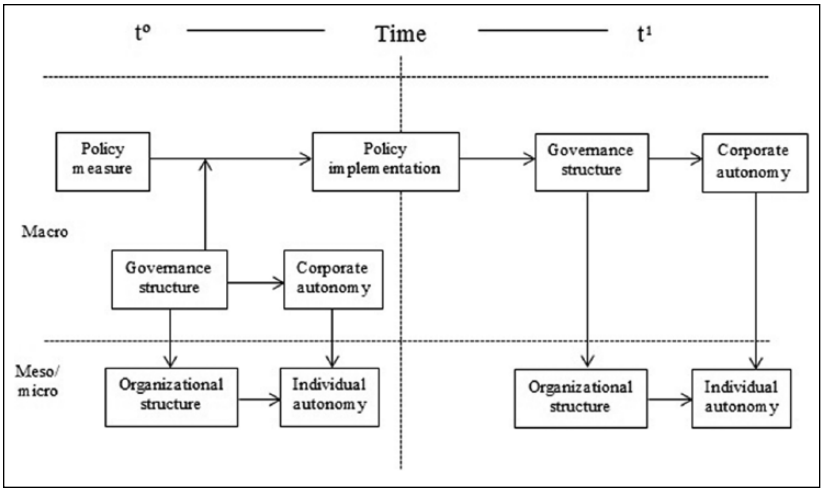

Figure 1. Conceptual model.

care governance structures are the link between social policies, organizational structures, and corporate and individual autonomy. In our search to understand the evolution of health care governance structures and why institutional arrangements evolve along singular policy paths in different health care sectors, we assume it crucial to focus on existing governance structures, more specifically the role of professions in relation to other actors in the sector and their ability to mediate changes.

Health Care Governance in Hospital Care and Home Care

In this section, we will present a comparative case study of waves of NPM and other health care reform attempts in Dutch hospital care and home care starting in the 1970s. The effects of reform attempts in the historically divergent development of the two health care sectors distinguished will be analyzed from the perspective of the theoretical framework outlined in the earlier paragraphs. In the present study, we focus on nursing and home help duties of home care, excluding housekeeping activities. Home *nursing* services include rehabilitative, supportive, promotive or preventive, and technical nursing care. Home *help* is defined as caring services including personal care (bathing/dressing) and social activities. The contrast-oriented, "most different cases approach" (Skocpol & Somers, 1980) analysis is based on the contrast

in knowledge domain, corporate power and sources of autonomy of the two health care sectors in the pre-reform period, and enables us to challenge traditional overly generalized theories on governance reforms and to accentuate the mediating role of professions in reforms. The reform attempts were analyzed based on secondary sources, including white papers and historic research. To analyze the attempts to reform after 2000 we also used data of 40 interviews that were conducted with insurance companies ($n = 7$), the Dutch Hospitals Association (NVZ), the Organization of Care Entrepreneurs (Actiz) and Dutch Nurses' Association (V&VN; $n = 3$), medical specialists and home nurses ($n = 8$), and managers of hospitals ($n = 8$), and home care organizations ($n = 14$). The interviews were conducted in 2009 and early 2010, and focused on the phenomenon of performance-based contracting. In the comparative case analysis, we first describe general developments in health care in the Netherlands for each period, followed by an exploration of the developments in hospital care and home care.

Professionalism and Corporatism in Dutch Health Care (Until 1970: Pre-Reform Period)

The provision of health care in the Netherlands exemplified the "pillarization" of Dutch society, that is, the process that between 1900 and 1970 compartmentalized Dutch population into several smaller segments or "pillars" according to different religions or ideologies, each with their own social institutions—political parties, labor unions, employers' associations, schools, periodicals, universities, charities, housing associations, athletic clubs, and so on (Lijphart, 1968). Each of those pillars also secured provision of health care to their members through religious-based hospitals and home care associations that were governed by autonomous boards. State regulations were limited and only concerned the licensing of medical professions, criteria for subsidies and, later on, regulation of the sickness funds. The dominant confessional (Catholic as well as Protestant) political parties, which together held an absolute majority in Dutch Parliament until the 1970s, supported the self-governance of these confessional private, not-for-profit organizations. The absence of a *national health care system*—and therefore the absence of *direct* government influence—also increased self-governance in the health care sector (WRR, 2004). Consequently, the Dutch health care system was "built upon corporatist arrangements whereby the state has delegated public regulatory authority to the various associations of providers, insurers, trade unions and employers" (Helderman et al., 2005, p. 194). In hospital care and home care, organized professions as well as individual professionals had

strong ties to the joint self-administration of medical specialists/home care organizations, and the pillarized sickness funds, which during the period 1880-1940 had been established in the Netherlands by the hundreds. As of 1941, these sickness funds functioned as the operating body of the Sickness Fund Act (Zfw), which obliged all Dutch employees to insure themselves (and their families) for medical costs with a sickness fund and lay the foundations for the growth of a corporatist health care governance system during the postwar decades (van Elteren, Kunneman, & Rozing, 2006).

Developments in hospital care. Though the pillars had a strong hold on large parts of the Dutch health care system, the medical profession as such has never been fragmented along religious lines (van Doorn & Schuyt, 1982). This is because the professionalization of medical specialists had taken place mainly *before* the period of pillarization. Hence, and unlike home care workers, the position of physicians had never been derived from its relation to confessional groups. From the mid-19th century onward (e.g., with the development of the Royal Dutch Medical Association [*Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst; KNMG*]) in 1849, the establishment of the medical profession had evolved around the development of medical science and gradually brought medical professions to a dominant position within the sector of health care.

In the second half of the 19th century, medical training programs and licensing became anchored in state legislation. The existence of professional codes of ethics and professional standards provided doctors with jurisdiction over budgets and quality assessment. The expert knowledge monopoly of doctors granted them societal trust and status, and legitimized a strong degree of individual professional autonomy. Other hospital care staff (nurses, care workers) adapted to the practices and orientations of doctors.

In 1946, the National Association of Specialists (*Landelijke Specialisten Vereniging* [LSV]), a professional organization representing the interests of medical specialists, was founded, setting the basis for a strong degree of corporate power. Soon it became the one and only corporate actor negotiating with the sickness funds and the national government, which via all sorts of subsidies became increasingly involved in health care governance after World War II. In addition, in the 1950s groups of specialists formalized their relationship with hospitals through private partnerships, which have ever since provided them with economic and professional countervailing power offsetting hospitals and sickness funds (Klazinga, 1996). Within hospital care negotiation emerged as an important form of mediation between specialists, hospitals, sickness funds and the state, creating a corporatist decision-making structure where medical specialists predominated. Like in most of the Western

world, while medical consumption was rapidly growing in the Netherlands during the 1950s and 1960s, thanks to technical advances and growing prosperity, the financing system in hospital care retained its open-ended character: The hospital organization granted all the initiatives of specialists while sickness funds and the state increased hospital revenues. All in all, medical specialists had acquired a dominant position in the field of hospital care. However, starting in the 1970s, in an austerity period due to the economic crisis specialists' autonomy was increasingly seen in political circles as the main culprit of strongly risen health care costs. Specialists were accused of overtreating patients and of filing inaccurate expenses claims (Nicolai, 2003).

Developments in home care. The development of the home care sector in the Netherlands started in the late 19th century with the founding of pillarized local and regional Home Nursing Associations (cross associations—*Kruisverenigingen*), which from the 1910s onwards fell under national pillar umbrella organizations. These associations were financed by membership subscription fees and voluntary contributions and gifts (Adriaansen & van der Laan, 1996; van der Boom, 2008). Until World War II state regulation was limited to the legal recognition of nursing professions, but in the postwar years state influence gradually increased through stricter criteria for subsidies, such as inclusion of nonmember clients and number of clients per home nurse (Wijnen-Sponselee, 1997). For a long time the professional training and surveillance of home care was largely embedded in the context of a pillarized Dutch society, as confessional home care schools educated nurses not only according to required professional skills but also to religious principles about family life and femininity.

Just as it did with hospital care, after World War II the state got increasingly involved in the financing of the home care sector. On top of the membership subscription fees pillarized home care associations received various subsidies from the state, which steadily increased as in the 1950s and 1960s medical consumption grew and prevention (e.g., vaccinations) became an important task of home nursing organizations (Wijnen-Sponselee, 1997). Via its co-financing of home nursing budgets the government also cautiously increased its interference in quality matters, by making subsidization ever more dependent on quality criteria that included professional training and education of home nurses employed by the associations. Halfway through the 1950s a registration system was introduced to find out if home care workers performed the most important activities and did so in an efficient manner; home nursing started to become a nonreligious semi-medical profession (Verhagen, 2005). And yet, while the budgets for home care increased the accountability of home nursing associations remained minimal.

Conclusion. Both sectors were characterized by a nested governance structure of corporatism and self-regulation of the providers (hospitals and home nursing associations), though the basis for individual autonomy of the respective professionals differed significantly between medicine and home care. Medical specialists' professional individual autonomy was guaranteed by way of private partnerships which also strengthened corporate power, and their status rose in tune with the technical advances and growing medical knowledge they mastered. Despite their weak status and embedding in the ideologically based home care organizations, home nurses also developed individual professional autonomy. Precisely because they represented their pillars in the members' homes, they worked according to the "internalized" criteria of their denominational training and conviction. At the same time, they were almost free of organizational control and thus experienced a large degree of individual autonomy.

The structuring of hospital organizations evolved along denominational pillars while medical practices developed through knowledge expansion, consolidation, and specialization controlled by a medical profession organized in and represented by an official, ideologically neutral professional organization. By the 1960s, the medical profession was already well-established and strongly organized, resulting in a governance structure that allowed high levels of corporate and individual autonomy. In home care, by contrast, professionals occupied skills partly embedded in gendered and religious principles, worked on the basis of a strong normative confessional foundation, and lacked a strong professional organization.

Reform Attempts Phase 1: State-Oriented Reforms "(1970-2000)

General developments in health care. In the 1960s, the process of de-pillarization set in, and identification with the denominational pillars slowly started to fade away. When in the second half of the 1960s, the denominationally based corporatist governance structure in both health care sectors deteriorated, professional identity became the most important frame of reference for these services, their workers, and care-providing organizations (WRR, 2004). Just a few years later, in the 1970s, comments on public services gained ground, also directed at both health care sectors. In addition to right-wing critics emphasizing the overspending welfare state, social movements (e.g., psychiatric, and medical patient organizations, youth movements, the women's rights movement) pointed to the paternalistic attitude of professionals and their authoritarian power in the public domain (Knijn & Verhagen, 2007). In addition to subsidizing "alternative" services such as women's health care

centers and self-help programs, the main structural response of the government consisted in curbing health care costs and increasing accountability of health care expenditures (Schut, 1995). By introducing the Health Services Act (*Wet Voorzieningen Gezondheidszorg*; 1982-1996) the government tried to regulate the health care supply in both sectors. The national government further tried to control health costs by introducing the Health Care Tariffs Act (*Wet Tarieven Gezondheidszorg*; WTG; 1983-2006) that set maximum tariffs for health care services. Skepticism over these centralized planning and pricing policies kept growing. In 1987, a special government advisory group, the Dekker Committee, released a far-reaching plan—introducing the NPM discourse in the policy domain—aimed at improving the efficiency and equity of the system, enhancing consumer orientation and deregulating governmental interference through the introduction of regulated competition (Helderman et al., 2005). The Dekker Committee considered that professionals should be responsible for quality assurance, while proposing to certify care organizations and physicians as was common practice in the private sector. The Dekker plans immediately found broad political and societal support, because they provided a simultaneous solution to problems of inefficiency and paternalism. Yet, it would take until the second half of the 1990s for many of the Committee's recommendations to be implemented. Meanwhile, the growing political support for supply regulation and regulated competition caused the position of health care professions to gradually weaken in favor of the state, insurance companies, sickness funds, managers, and consumers, albeit to a different degree and in a different manner in each sector.

Developments in hospital care. In the 1970s, to reduce costs in hospital care the national government sought to limit the income of medical specialists: "the revenues of specialists were portrayed as the symbol of uncontrolled and unacceptable growth" (Lieverdink & Maarse, 1995, p. 83). In the end, all government plans to restrict medical specialists' incomes turned out unsuccessful, according to Nicolai (2003), largely due to the delaying tactics of the medical profession, which still held a strong position in national negotiations. Nonetheless, plans for income restriction remained. In 1983, global budgeting systems substituted the open-end reimbursement system for hospital costs, not including costs of medical specialists (Nicolai, 2003).

Remarkably, while the Health Services Act (1982) and the Health Care Tariffs Law (1983) confronted hospitals with budget restrictions, it did not succeed in limiting medical specialists' fees that were still paid according to the fee-for-service model. Also, for quality assessment a context was created "in which plans for self-regulation by the medical profession through peer review [became] formalized and a national organization for the support of

peer review among medical specialists [was] founded" (Klazinga, 1996, p. 86). Hence state legislation in fact formalized the professional autonomy of medical specialists.

Since the mid-1980s the government has made new attempts to regulate and restrict medical specialists' incomes—initially with the same results of the 1970s. A first plan to introduce a so-called "reasonable income" for medical specialists was blocked by the negotiation tactics of the LSV (National Association of Specialists). "As a passionate interest group, the LSV deployed all its negotiating power to obstruct the introduction of a 'reasonable income'" (Lieverdink & Maarse, 1995, p. 88), while the minister of Health felt a continuing "interest in maintaining a good relationship with the specialist association which he felt was essential for the success of health care policy" (1995, p. 87). Yet, when the government subsequently based a new plan on the still-popular Dekker plans of 1987, the specialists could no longer use tactics of total resistance. In the new plan, the government proposed that medical specialists' budgets should become part of the hospital budget, an idea supported by the sickness funds. According to the LSV, were this plan to be implemented hospital boards and sickness funds would inevitably get a say in medical practices, limiting the individual autonomy of specialists. To avert the merger of hospital and specialists' budgets and to safeguard individual autonomy on the shop floor, the LSV was now willing to make some concessions (Lieverdink & Maarse, 1995). In 1989, a Five Party Agreement (FPA) was signed by the National Hospital Council (NZR), three representative associations of sickness funds and medical specialists (the LSV) in which they all committed to a macro budget for the next 3 years; specialists would collectively pay for any excess over the budget in this period.

The signing of the Five Party Agreement by the LSV board had far-reaching consequences for the collective organization of medical specialists. LSV members that were already dissatisfied for some years about the representation of their interests by the LSV board established their own interest groups: The Dutch Specialist Federation (*Nederlandse Specialisten Federatie;* NSF) and the Dutch Specialist Association (*Nederlands Specialisten Genootschap;* NSG) were established in 1990 and 1991, respectively (Nicolai, 2003). The professional community of medical specialists had now toppled from its pedestal in the eyes of national legislative authorities and the government finally had maneuvering room to gain more control over the hospital care sector.

In the early 1990s, more ideas from the NPM-minded Dekker Plans were realized. Crucial health insurance reforms were gradually implemented in the sickness fund system starting in 1992, including the introduction of a risk equalization scheme (to prevent risk selection) and concurrent ex-post cost-based payments, flat-rate premiums, free choice of sickness fund, the

abolition of a duty to contract all independent health care professions (such as medical specialists), and the replacement of fixed prices by maximum prices (Schut & van de Ven, 2011). Though the specialist profession was now internally divided, it still appeared difficult to move toward marketization in a sector traditionally dominated by a well-established profession. In 1995 hospitals, sickness funds and specialists, including the LSV and the NSF, agreed on a new financing system for specialists called "lump-sum remuneration." Almost all self-employed specialists working in hospital private partnerships left the fee-for-service system and entered the lump-sum system. For this system the three parties agreed on the maximum volume of services that specialists would deliver and on the total fee to be charged (Scholten & Van der Grinten, 2002). This reorientation toward the state in fact slowed down the introduction of market principles but was nonetheless another setback for the medical profession, as the goal of this expenditure cap was to restrict its corporate autonomy over the supply of hospital care. The associations of medical specialists came to realize that the internal strife had harmed their position toward the state and insurance companies. In 1997, the three associations of medical specialists (NSG, NSF, and LSV) reunited into the Order of Medical Specialists (*Orde van Medisch Specialisten;* OMS).

The cost-containment model showed its drawbacks in the 1990s, as waiting lists increased. Moreover, since the government froze the number of approved specialist positions in hospitals, a shortage of personnel was looming (Helderman et al., 2005). These developments, including the turmoil within the medical associations, opened a route toward a managerialist and market-based solution to curb costs and enhance efficiency.

Developments in home care. While since the early 1970s the position of medical professionals in hospital care was threatened by government attempts to strengthen its control on spending, in the same period the home care profession had to deal with an additional transformation: de-pillarization. Due to the gradual development of specialized training, skills, and knowledge, stimulated by government quality regulation of the sector and the disintegration of the pillars, home care work gradually lost its traditional anchor of local, denominational recognition and its moral notion of caritas (van Elteren et al., 2006; Wijnen-Sponselee, 1997). This opened up the opportunity for the government to strengthen its hold on the sector to curb growing home care spending. Hence, in the early 1970s, the government forced mergers between until-then denominational home nursing providers, resulting in large-scale regional and ideologically neutral home nursing organizations. Thus, in contrast with the hospital care sector, the consequences of the need for cost

containment were immediately palpable in the home care sector, and home care organizations increased in scale and concentration.

In 1974, the Dutch government presented an economic plan that revealed a strong belief in the manageability of home care. Policy instruments were introduced that created a system of accountability through supply regulation. From 1980 onward, home *nursing* care was entirely financed by the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*; AWBZ), a compulsory public health insurance scheme dating from 1968 that covered long-term and mental health care. At the same time, two hard-to-integrate social policy lines influenced debates and decisions in the home care and home nursing sector. First, there was plea and demand for de-institutionalization and individualization of elderly care. "Staying at home as long as possible" became a widespread and government-acknowledged social plea for which extra budgets became available. In 1989, it was decided that not only home nursing but also professional home *help* services would be funded by the AWBZ. This decision was accompanied by a wider availability of financial resources. Second, and due to the economic crisis in the early 1980s, cost containment became the central focus of government policies for home nursing (van Elteren et al., 2006), and the government increased supervision by setting new rules for home nursing organizations, such as stricter assessment rules and better accounting for services provided. Thus, home nursing that could be identified in medical terms experienced small budget increases until 1990, while services that were more difficult to assess faced budget constraints (Verhagen, 2005). During this control period, the costs of home care increased—mainly for elderly people staying longer at home—and the government kept searching for principles to cut back budgets. Finally, in 1994 the funding system changed as home care organizations and insurance companies or Health Insurance Funds had to make an agreement about funding conditions in the AWBZ. These contracts covered, among other things, standards of quality of care, method of reimbursement and insurers' control method. The contract culture in which provider performance plays an increasingly important role was combined with supply control. The government announced strict budget controls in the AWBZ and stringent capacity regulation. In combination with a growing demand for care due to a graying population, the waiting lists that had already grown in the 1980, became even more lengthy by the 1990s.

Professionals in the sector reacted to these developments. No longer bound to denominational structures, in the 1980s and 1990s they organized themselves into several professional associations for nurses and home care workers to strengthen their corporate character.[2] Since the 1990s important steps in the professionalization of home care workers have been taken by the

home care profession. In 1997, professionalization of home nursing was established through formal recognition of nurses' professional status in the Professions in Individual Health Care Act (*Beroepen Individuele Gezondheidszorg*; BIG), which provided a framework for registration and licensing. Home nurses also faced a setback in this professionalization process though, as they lost the power to assess clients to the Regional Assessment Organs (RIOS).[3] Health insurers demanded more transparent, standardized, and objective assessment methods. Traditionally, clients' needs assessment was carried out by staff members of the home care organization. In 1998, the RIOS gained control over access to care, entitlement of clients to home nursing facilities, and total amount of care that is reimbursed by the sickness fund (van der Boom, 2008).

As supply regulation policies showed their drawbacks in the 1980s and early 1990s, pressure on the government increased and NPM principles became more appealing. Commercial home care organizations were allowed onto the "market" in 1997 to deal with the waiting lists (Helderman et al., 2005). Private for-profit home care organizations were thus founded in the mid-1990s, and as a reaction the non-profit associations founded associated commercial organizations, gradually turning into market-like organizations themselves (van der Boom, 2008). As the introduction of this NPM strategy soon had questionable side effects—commercial organizations were for instance accused of cherry-picking—the government froze the entry of new home care organizations to the "market" in 1998. Moreover, standardized accessibility and quality criteria were developed for all AWBZ-financed organizations. This strongly curtailed competition.

Conclusion. For hospital care, the government appeared far more hesitant than for home care to deviate from the prevailing path and to turn to NPM principles combined with government regulation. In this phase the Dekker plans, based on NPM principles, set the preconditions for market forms of health care governance, although in general the government retained its highly regulative role. Whereas hospitals had to account for tariffs and got budget restrictions, the medical profession was able to continue its dominance over the hospital care sector until the 1990s, thus holding on to its corporate and individual autonomy. Back in the 1970s the medical profession had established a dominant position, while the normative confessional foundation of home care had ceased due to the process of de-pillarization, leaving a much more vulnerable caring profession on its own. De-pillarization opened a window of opportunity for home nurses and home care workers to professionalize on the basis of semi-medical and care work expertise.

While managerial issues within the collective association of medical specialists—the LSV—decreased corporate power of the profession and provided the state with opportunities to regulate hospital budgets in the late 1980s, it had not yet touched on the position of medical specialists. The strong corporate character of the medical profession had served as an effective blockade against changes that seriously threatened their powerful position. By contrast, home care organizations had already lost control over financial matters in the early 1970s when they became increasingly dependent on government funding, and in contrast to medical specialists home care workers had no strong corporate *professional* organizations that united and represented them. At that time they had just started on the route toward professionalization. The home care profession was unable to leave their mark on the home care governance changes in which the state holds a dominant position. After attempts to reduce costs by merging home care organizations and budget restrictions in the 1980s, home care workers lost a significant degree of individual autonomy over criteria for care work, the assessment of clients, and the daily routines of their work schedules. Health insurers and independent assessment centers gained control over home care work in the 1990s due to new government-implemented control mechanisms. Hence, in home care coercive processes changed the sector so that all actors accommodated to state-directed control mechanisms. This hierarchical governance structure also contained elements of NPM.

Reform Attempts Phase 2: NPM-Oriented Reforms (2000-2010)

General developments in health care. In 2001, the government introduced a measure that relaxed lump-sum budget caps and compensated health care organizations (including hospitals and home care organizations) for additional production. The goal of this measure was to reduce waiting lists by increasing production with financial incentives. In this phase of reform attempts to contract health care providers based on their performance altered both fields of health care. The partial failure of the hierarchical health care model paved the way for an NPM-oriented health care governance reform plan, "Focus on Demand (*Vraag aan bod*)" (Ministry of Health, 2001). In a memorandum it was argued that the existing model—which remained highly focused on supply regulation—contained limited incentives for high-quality and efficient provision of medical and home care. The model was also thought to hamper effective and efficient purchasing of care by sickness funds, lack patient orientation, have limited space for innovation, and lack transparency (Ministry of Health, 2001). After the publication of "Focus on Demand" the

government implemented several policy measures aimed at stimulating market forces. Again, the policy trajectory differed per sector.

In the 1990s, the purchasing of care by health insurers mainly involved standard contracts for hospital care and home care. Such contracts did not specify provider performance, and insurers rarely monitored it. The obligation for sickness funds to contract any willing provider was abolished in home care and hospital care in 2004 and 2005, respectively. Sickness funds were now allowed to differentiate the terms of contractual arrangements for different hospitals. This development was in line with the revision of roles of the key health care sector players as presented in the Focus on Demand reform: the government, patients, sickness funds (acting as agents on behalf of their insured clients), and professionals in the role of care provider. This revision came down to a strengthening of the position of care receivers (defined as care *consumers*) in relation to professionals and sickness funds, and of the position of sickness funds in relation to care professionals (defined as care *producers*). The role of the state in this reform was supervisory and regulatory. This created a regulated market that combined elements of the hierarchical and market governance structure.

Simultaneously, the health care sector shifted from a purchasing system whereby a predetermined budget was followed or bills were simply reimbursed retrospectively to a system of performance-based contracting. The aim was to establish regulated competition and organize control of professional work through monitoring, auditing, performance indicators, evaluation, and benchmarking. As a result, hospitals and home care organizations were more committed to accountability for their performance (costs and quality) and were monitored in greater detail and more strictly than ever before.

To regulate the new relationship between supply and demand on the curative and care "market," in 2006, the Health Care Market Regulations Act (*Wet Marktordening Gezondheidszorg*; Wmg, replacing the WTG) was introduced and the newly formed Dutch Health Care Authority (*Nederlandse Zorgautoriteit*; NZa) was made responsible for market supervision, monitoring, and market development. In 2006 too, the introduction of the Health Care Establishments Licensing Act (*Wet Toelating Zorginstellingen*; WTZi) liberalized the possibilities for new care suppliers to be admitted, aiming to ensure greater competition on the health care purchasing market and thus improve quality care and efficiency and reduce costs. It was assumed that where the state was unable to control costs, market mechanisms and managerialist principles could be an appropriate solution to deal with the perceived imperfections of the former governance structure of hierarchy and professionalism—the more because it was expected that the market would be better

able to deal with the power of professionalism (especially in hospital care) and the inefficiency of centralized planning. It was assumed that innovation and quality care could be stimulated in the process.

Developments in hospital care. Part of the "Focus on Demand" plan of 2001 was to further develop regulated competition. For proper operation of market forces hospital care, health insurers and providers needed freedom to negotiate on prices, volume, and quality. This required a deviation from the old budgeting system of regulated tariffs and fixed production ceilings. In this period, three important policy measures were implemented to realize market mechanisms in hospital care: the introduction of a new health insurance act and of a price-competitive segment based on product classifications, and the use of performance indicators in insurers' purchasing policies.

Before 2006, there was a distinction between insurance through the compulsory Sickness Fund and through private health insurance in curative care, including hospital care. In that year—almost 20 years after the initial proposals by the Dekker Committee—a new basic insurance scheme was introduced, the Health Insurance Act (*Zorgverzekeringswet*; Zvw), which dictates compulsory basic health care insurance for the entire population via an insurer of their own choice. People could opt for an additional insurance package in addition to basic insurance. Health insurers faced the legal duty to ensure care provision for their clients. From this point onwards we will refer to insurers or health insurance companies instead of sickness funds, as these would now operate in a market environment. The goal of the new role of health insurance companies is to induce price competition on premiums and competition on the quality of health care purchasing between insurers.

In 2005, a so-called "B-segment"[4] was introduced, composed of treatments for which a system was established of variable and performance-focused payments and financing based on product classifications—Diagnosis-Related Groups (DRG; *Diagnose Behandel Combinaties*; DBCs). Meanwhile medical specialists, whose honorarium was fixed, retained control over the number of treatments they performed in the price-competitive B-segment. For the remainder of hospital care (A-segment) the government set maximum prices; hospitals and insurers only negotiated about volume and quality. The DBCs were an important instrument to allow costs to be determined prospectively instead of retrospectively. As a financing body, insurers had an interest in DBCs, as it was expected to increase hospital efficiency and promote cost containment. Moreover, it was thought to enhance transparency and support hospital planning. Medical specialists were less enthusiastic about the case-mix-based funding, since they now had to bear uncertainties for cases where DBCs did not fully cover patients' financial

risks (Schmid & Götze, 2009). Already in 1994, the umbrella organizations of hospitals, medical specialists, and health insurers agreed to support the development of a case-mix approach, a form of activity-based costing in which episodes of care are classified into manageable categories. In the end, the price for support of the medical profession "was a case-mix system that was close to a fee-for-service system" (Schmid & Götze, 2009, p. 33), reflecting medical specialists' continued preponderance. The Dutch DBC system is a real "negotiated product" (van Poucke, 2007), realized between medical specialists, the state, and insurers. Under the influence of the new system, the position of insurers in relation to specialists seems to be changing slowly. Confronted with external pressures from the state, insurance companies and the increasingly state-subsidized and powerful patient organizations, specialists have gradually given ground.

In 2008, the lump-sum honorarium for medical specialists was replaced by a "pay for performance" system that remunerates according to number of DBCs produced. The specialists' honorarium component is reimbursed separately from the hospital component, meaning that separate financial circuits continue to exist. For each DBC there is a fixed time allowed per specialism. Hospitals' board of directors had the opportunity to negotiate hourly tariffs within a fixed bandwidth set by the government. The pay-for-performance mechanism reflects the government's market orientation in the funding of medical specialists.

Despite their weakened position due to the introduction of market principles, medical specialists or representatives of their partnership or specialism continue to exert control over the contracting process as well as the development of performance indicators in at least two ways. First, in the sector contracting is done on the basis of negotiations between the insurer and the hospital on volume, quality, and price of the medical treatments to be provided within the price-competitive (B) segment. This process demonstrates the continued interdependency between actors: purchasers (insurers on behalf of their enrollees), hospitals, and medical specialists. The institutional pattern of corporatism at the level of resource allocation, reflected by negotiations between insurers, hospitals, and medical specialists, and professional dominance in service provision, is institutionalized in hospital care. Second, professional associations, including scientific associations, are deeply involved in the design of instruments used, such as the development of the purchasing guide used by health insurers, the DBCs, and the performance indicators of the Dutch Health Care Transparency Program (*Zichtbare Zorg*). Insurance companies feel the need to attract medical expert knowledge for the development of meaningful indicators. In hospital care performance assessment of professionals takes place through

self-regulation, because most performance indicators are developed by professional associations. Health care still is an institutional setting in which professional consultation remains prevalent.

Health insurers are entitled to use performance indicators for selective contracting; they do not have to contract all medical treatments that a hospital offers, nor do they have to contract all health care providers. Performance measurement in hospital care is predominantly used as a mechanism of cooperation and learning: Discussing evaluation outcomes enables hospitals and specialists to improve their performance. However, since the end of 2010, insurers gradually got a grip on the sector and slowly started selective contracting, sanctioning hospitals by way of contract termination based on performance indicators. The increase of these "hard" incentives indicates that insurers have become a more dominant actor in the sector, at the expense of hospitals and medical specialists.

Developments in home care. To get grip on the large-scale and merged home care organizations as well as the new for-profit providers of home care, the government memorandum "Insight in Care" was presented in 1999. Responsibilities were reallocated and new measures introduced. In the renewed providers' market commercial health insurance companies acquired the crucial role of regional care director. The health insurer running a regional office was usually the market leader in that region. Insurers were expected to operate as judicious purchasers of home care on behalf of insured clients (van Elteren et al., 2006).

In the late 20th century, the individual autonomy home nurses had experienced during and just after the pillarization period faded away (van der Boom, 2008). While only recently their professional expertise has been based on training and context-bound experiences, it is now limited by guidelines and standardized protocols introduced to guarantee accountability of home care providers. According to van der Boom (2008), the increasing scientific and evidence-based character of home care work has diminished care workers' professional autonomy, even though such processes have led to a more powerful medical profession. Home care workers were formerly trusted on the basis of acquired skills and the confessional signature of the home care association. The new accountability rules and the related application of guidelines and protocols made their work comparable and measurable, enabling managers to monitor it. The management of home nursing organizations increasingly steered and controlled the pace and substance of home nursing.

Between 1970 and 2000, home care organizations were financed on a lump-sum basis, receiving a fixed budget related to the size and characteristics of their catchment area. In 2001, the change toward an output-based

system was completed: Regional budgets and maximum prices were determined by the central government as

> care offices and regional home care organizations have to reach a yearly agreement on the volume and prices of home care. After a period of stand-still, due to the recognition of an unequal playing field between the for profit and non-profit home care organizations, the government had again permitted commercial home care organizations to provide services covered by the AWBZ by the end of 2000. (Helderman et al., 2005)

Since 2000, there is a strong focus on accountability in home care, to prove that extra budgets are indeed warranted to offset waiting lists. Even more than before, there now is a strong relation between performance, budgets, and accountability.

The introduction of regulated competition coincided with the development of a system of "functional budgeting" to reimburse home care providers according to the functions delivered. Irrespective of the professional's qualifications and the environment in which care is provided, patients are entitled to one or more of the following "functions" or services: domestic help, personal care, nursing, supportive guidance, activating guidance, treatment, and accommodation. Since 2004, home care is reimbursed by basic tariffs and the unit of reimbursement is an hour of care provided. In that same year, a ceiling on the "production" of home care was introduced to control care budgets of regional care offices. Since 2006, maximum tariffs are set by the NZa. In contrast to hospital care, where tariffs (in the growing price-competitive B-segment) were deregulated and a system of restricted competition was created, for home care the Dutch government decided to strengthen control overspending.

Since 2005, resources in the home care sector are allocated through a process of tendering, a formal competitive bidding process where providers compete for contracts under strict rules. Gradually, the home care sector came under the dominance of insurance companies, who have a dominant and influential role in the tendering process. Insurers do not contract all care (hours) a provider offers, and only a select number of providers are offered contracts. Contract attractiveness is mostly determined by the providers' score on the insurers' performance criteria. For home care, insurers' tendering procedures clearly spell out standards of good practice, tightly monitoring, evaluating, and sanctioning professional organizations.

Whereas the definition of performance indicators in hospital care is a multilateral process, the development of performance criteria for the tender in-home care is an almost solitary process of insurers. Initially, home care professionals were also consulted by insurers, for example, in the

development of the Dutch Health Care Transparency Program (*Zichtbare Zorg*). Yet, unlike in hospital care, the profession's input is not the starting point of an ongoing debate, but is used more often by insurers as a selection instrument in their purchasing policy. Hence, in-home care incentives applied by insurers are mainly designed to pursue efficiency savings in care provision and to stimulate providers to obtain national quality certificates.

In a context of increased dominance of insurers and the state over home care work, the professions of nursing and home care work experienced the need to bundle their knowledge and power to improve the organized structure of the professions and to create a strong collective standing within the health care system. In 2006, the Care Workers & Nurses Netherlands (*Verzorgenden & Verpleegkundigen Nederland;* V&VN) was established, a merger of many small professional associations. The context of NPM-based policies in fact incited the professionalization process of the home care profession.

Conclusion. Since 2005, the room for insurers to purchase health care based on provider performance has gradually increased. Still, in hospital care and home care government regulation severely limits room for negotiation on price and quality. The recent introduction of NPM principles took quite a different path for each field. In home care, the relatively weak professional standing of workers and their organizations has allowed considerable formalization of contracting arrangements and a strengthened position of insurers. Whereas before the introduction of market principles coercive change processes were taking place that were reorienting organizational actors toward state directives, now the government provided insurers with tools to reach a more dominant position. However, since home care organizations became dependent on government funding, the state's dominance became institutionalized and is reflected in its strongly regulative role when introducing competitive practices. Conversely, in hospital care, due to the still-strong position of medical specialists, some kind of interplay between hospitals, professionals, and insurers has replaced specialists' traditional dominance. Meanwhile, as in previous periods, the degree of government hierarchy in the form of budget regulation has remained stronger in the home care sector.

Conclusion and Discussion

This article aims to understand the evolution of health care governance in the past decades in two distinct health care sectors of the Netherlands, hospital care and home care, and in particular how professions shaped the implementation of NPM-oriented governance reform attempts. In line with previous research (Burau et al., 2009), our analysis of these reforms demonstrates that

continuity with past governance structures of professional self-regulation is related to the position of professions in the sector. Relative differences in pace, methods, and outcomes were found across hospital care and home care, partly due to variable institutional positions of professions in the different health care sectors.

Starting in the 1970s, the autonomous position of professional groups in both health care sectors was increasingly challenged. In *home care*, resistance of the profession against attempts to curb its autonomy was however less strong than in hospital care: The pillarization of Dutch society along denominational and ideological lines resulted in home care's association with feminine and religious principles despite the development of professional expertise in that sector. Also, the urgency for professionalization was less strong than in hospital care because home care workers' strong ties with the pillars provided them with a dominant position in the governance structure and guaranteed their individual autonomy and social status. Ideological profiling dominated over professional valuation. Yet with the disintegration of the religious pillars in the 1960s, the home care profession lost corporate power and professional status to defend state interventions aimed at fortifying control over the regulation of financial resources in times of rising health care costs. Hence, home workers' strongly positioned governance structure of self-regulation and autonomy did not prevail. This concerns the period of mergers and budget controls (1980s), and the final period when the authoritative power of purchasers (the insurers) increased relative to the devaluation of the position of workers and organizations. Government-led marketization now defines the home care sector, creating a nested governance structure of hierarchy and market.

By contrast, in *hospital care* reforms were more contested by the medical profession and changes had a strong path-dependent nature. Here, it appeared far more difficult for the Dutch government to establish a new policy trajectory due to the institutionalization of medical professional dominance in the policy path. Until the late 1980s, medical specialists' resistance against new governance structures that sought to control their work was backed up by a powerful and well-organized professional association. In the late 1980s, however, the corporate power of medical specialists was weakened by the collapse of the unity within their national association. The Dutch government took this opportunity to implement budgeting plans that had been previously blocked by resistance. Nevertheless, because the evolution of medical governance has a path-dependent nature, governance structures in which medical specialists hold a dominant position prevailed. In the recent NPM-oriented policy context, this resulted in a corporatist health care governance structure in which health insurers negotiate with hospitals and medical specialists over

budget distribution and the development and usage of performance indicators to assess quality of care. In the end, in this new structure the government and insurers still need and mostly seek specialists' consultation.

This study has shown that the extent to which a sector's governance reforms are marked by path dependency partly depend on the position of the core profession in that particular sector. Health care professions characterized by a theoretically based specialized abstract knowledge domain and high levels of corporate power are more likely to attain a dominant position in institutionalized governance structures than professions with practice-based knowledge and low levels of corporate power. Governance structures characterized by professional dominance—and subsequently high levels of corporate professional autonomy, creating structures that foster individual autonomy—are likely to continue to exist even when new policy measures seek to introduce hierarchical control or market mechanisms to limit professional autonomy. Overall, it can be concluded that the dominance of the medical profession, in contrast to the home care profession, has been institutionalized in the governance structure, constraining actors' choices in ways that only permit incremental changes in hospital care.

Notes

1. We use ideal types here in the Weberian sense: theoretical and logical constructions that are methodologically used to analyze and interpret social practices.
2. For example, Dutch Association for Nursing (*Nederlandse Maatschappij voor Verpleegkunde*; NMV, 1980), Dutch Home Care Association (*Landelijke Vereniging Thuiszorg*; LVT, 1990), trade union NU'91 (1991), and General Assembly of Nursing and Care (*Algemene Vereniging Verpleegkundigen en Verzorgenden*; AVVV, 1995).
3. In 2005, the RIOS were replaced by the Center for Care Indication (CIZ).
4. Ten percent in 2006 and 34 percent in 2009.

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Author Biographies

Rosanne Oomkens, MSc, is a PhD researcher at the Faculty of Social and Behavioral Sciences, Utrecht University, the Netherlands. For the past 5 years, she has participated in a research project on the introduction of market principles in health care. Her research interests are professionalism, New Public Management, performance-based contracting, policy implementation. She is part of the Netherlands Institute of Government (NIG), the Dutch research school for Public Administration and Political Science, and participates in a national Research Colloquium on Reframing Public Professionalism.

Marcel Hoogenboom is an assistant professor at the Faculty of Social and Behavioral Sciences, Utrecht University, the Netherlands. His research interests include the history and organization of the welfare state and theory-building concerning public and social policy. He has published in books and journals such as *Organization Studies, Business History*, and *Journal of European Social Policy.*

Trudie Knijn is a professor of interdisciplinary social science at the Faculty of Social and Behavioral Sciences, Utrecht University, the Netherlands. She is co-chair of the board of ESPAnet (European Social Policy Association), coordinator of National Associations of ESPAnet, and member of the executive committee of the EU Network of Excellence "Reconciling Work and Welfare" (RECWOWE). Her present research interests include comparative studies on work, care, and welfare and professionalism. She has published in books and journals such as *Administration & Society, Social Policy and Administration, European Journal for Social Security, Journal of European Social Policy*, and *Social Politics.*