

# ***A valued General Practitioner: priced, not praised***

*Exploring the effects of economization on the professional identity of Dutch GPs*

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# Chapter 1

## *Introduction*

*'General Practitioners are drugged by money' (Tonkens, 2011 [translated from Dutch])*

Healthcare in the Netherlands is booming. Over the next decade, the demand for care will increase sharply due to a variety of reasons, ranging from demographic changes like the aging of the population to medical technical developments. The costs are expected to rise accordingly from 3,920 Euros per person in 2007 up to 6,300 Euros in 2020, which is an increase of 63 percent (VWS, 2007: 39). It may not come as a surprise that many aspects of the Dutch healthcare system are subject of heated political and societal debate. As Hilhorst puts it, '[i]t barely seems possible to talk about healthcare without talking about costs' (2004: 20). One of these aspects is the care provision by General Practitioners (GPs), the 'gatekeepers' of our healthcare system. The number of consultation moments between patients and their GPs is expected to rise from 114 million in 2007 up to 170 million in 2020 (VWS, 2007: 38). For GP care – and for society in general – it is a tough undertaking to face the organizational and economical challenges that come along. Many politicians, GPs, scholars and citizens support the debate on these challenges by expressing their opinions and thoughts on how GP care should (not) be organized. The quotation above offers one example that strikingly touches upon the theme of this thesis. It is the title of a column, which 'brightened up' the opinion page of the Dutch newspaper the Volkskrant on 11 May 2011. The author addressed the highly debated issue of GP employment by health insurance companies (cf. Marselis, 2011).<sup>1</sup> The underlying theme is the possible tension between money and healthcare; between an economic and a medical professional logic.

## 1.1 Where logics collide

Ever since the sixties, many scholars have written about professions and professionals (e.g. Freidson, 2001). One of the reasons that make them an interesting object of study is the fact that they play an important role in our society, whereas 'normal' citizens depend upon them for specific service delivery. Medicine is generally regarded as the profession par excellence (Trappenburg, 2011). In this thesis, I focus on GPs. These medical professionals take on a special role within our healthcare system, because they can be regarded as the 'gatekeepers'. After all, citizens in the Netherlands are obliged to be listed with a GP. Moreover, as soon as a person has health complaints, he can visit his GP.<sup>2</sup> GPs can treat people for a wide range of relatively small problems and they can write referrals for patients that need secondary care (i.e. hospital care) (Boot & Knapen, 2005: 102; Schäfer et al., 2010: 23; Van den Berg, 2010: 11; Van Dijk, 2012: 10, 13). Overall, GPs fulfil a pivotal role in our society whereas they are patients' 'first contact' when it comes to healthcare.

Over the past few decades, the environment in which medical professionals – like GPs – have to carry out their day-to-day responsibilities has changed. These changes have received comprehensive academic attention and are often described in terms of societal and managerial 'pressures' (e.g. Jansen, Kole, and Van den Brink, 2009). The complex interplay of these pressures is partly induced by an economic logic that has become more dominant in our society. In turn, the same interplay of pressures seems to strengthen the economic spirit of the age itself, creating a vicious circle. In this

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<sup>1</sup> Evelien Tonkens, a Dutch sociologist and professor in participatory citizenship at the University of Amsterdam.

<sup>2</sup> For consistency and stylistic purposes, I will refer to finite forms with 'he' and 'his' throughout this thesis.

thesis, the increased dominance of an economic orientation is called ‘economization’, which is explained as an increase in both a managerial and a consumer logic.

Although it is not the only development within healthcare that show clear signs of economization, the most prominent example is the introduction of *managed competition*.<sup>3</sup> After two decades of political debate, the Dutch healthcare system was transformed radically in 2006. The system reform implied a shift from an emphasis on regulating the supply side to a focus on the demand side of healthcare; from provider to client. Under the banner of liberalization, the government has withdrawn partly and both healthcare providers and health insurance companies are to compete as if they operate on a free market (Van Heurck, 2003: 147). I deliberately use ‘as if’ whereas the government has not fully retracted from the market. On the contrary, in order to offset market failures the government has set preconditions, creating a system of managed competition. A comprehensive set of laws came into force, forming the legislative framework that underpins the regulation of the healthcare markets. Chapter 2 will pay more attention to the healthcare system but the essence is clear: an economic logic underpins the system of managed competition.

This seems to provide an interesting tension: GPs as medical professionals having a ‘professional logic’ working in an economized environment characterized by an ‘economic logic’. According to Freidson, these are exactly the two logics that are often at odds with each other (2001; see also Kuhlmann & Saks, 2008: 4-5). What does working in such an environment do with a GP? This thesis aims to examine whether and how economization affects the professional identity of GPs.

## 1.2 Problem statement

Focussing on the possible tension mentioned above, the central question of this thesis can be phrased as:<sup>4</sup>

*What are the effects of economization on the professional identity of GPs and how can we understand these possible effects?*

This study has a theoretical part and an empirical part. Both sections are mainly descriptive in nature because the key aim of this thesis is to explore. The value of such an exploration will be discussed in the next paragraph. In the first section, I will pay considerable attention to the central concepts of *economization* and *professional identity of GPs*. After all, both concepts are very abstract in nature. Moreover, I will focus on describing what possible reactions GPs can have on economization: do they adapt, do they alienate or do they resist? This first section forms the fundament for the second, which is the empirical part of this study. In this part, I will pay detailed attention to the professional

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<sup>3</sup> In this thesis, I will follow Dwarswaard et al. who use the English concept of ‘managed competition’ as translation for the Dutch concept of ‘gereguleerde marktwerking’. It refers to the system of market elements that has been introduced in Dutch healthcare especially with the major system reform of 2006 (2011; see also Van de Ven, Schut, Hermans, De Jong, Van der Maat, Coppen, Groenewegen & Friele, 2009: 30).

<sup>4</sup> In order to formulate the main question, I have made use of the guideline offered by Booth in order to compose a line of reasoning ranging from ‘general question to meaning’ (2008, ¶ 3.4).

identity of GPs based on the experience of twenty-two Dutch GPs and to the way they deal with economization.

In order to answer the main question of this study, I have formulated a number of subquestions that together structure this thesis. The first three of these questions are answered in the theoretical part of this thesis. The remaining ones are answered via the empirical section.

- 1) *What is economization and what has it implied for Dutch GP care?*
- 2) *How can we conceptualize the professional identity of GPs?*
- 3) *How can GPs theoretically react to economization?*
- 4) *How do Dutch GPs experience economization in terms of their professional identity?*
- 5) *How do Dutch GPs deal with economization in their daily practice?*

### 1.3 Relevance

Providing an answer to the research question is relevant because in all discussions – both societal and academic – two key values for the functioning of our healthcare system are put at stake by economization: ‘trust’ and ‘professional standard’ (i.e. quality) (Hilhorst, 2004: 11). This study can contribute to this ‘market and moral’-debate (see also WRR, 2012: 59 ff.) by focussing on these values from the side of the professionals – the GPs – themselves. Many discussions on this theme underestimate the complexity of the market society and are fuelled by normative ideals about the relation between market, society and government (WRR, 2012: 12). This thesis does not focus on the political side by paying attention to what the healthcare system should actually look like. Instead, it focuses on the practical side by looking at how the system is being experienced by people on the ‘shop floor’.

First, from a societal point of view, this study can contribute to the debate on the trustworthiness of GPs. As follows from the column quoted at the beginning of this chapter, the question is openly asked whether the money incentives that nowadays characterize their work environment have corrupted GPs. This study can provide insight into how GPs experience a possible perverse effect of these incentives. Moreover, over the past few years the quality of (GP) care has become subject of debate. Our current healthcare system with its market elements is among others explicitly aimed at improving quality. Health insurers play an active part in trying to come to grips with quality.<sup>5</sup> This study can contribute to the societal debate on GP care quality by offering a professional perspective on quality in times of economization.

Second, from an academic perspective, this study can contribute to the debate on the professional ethics of GPs. Dwarswaard has conducted a study specifically aimed at the professional ethics of GPs (and medical specialists) under influence of the spirit of the age. She among others concludes that market incentives have led to a change in professional ethics in the sense that they have become less reluctant in providing care (2011: 227 ff.). Van Dijk on the other hand, comes to a different conclusion. She has studied the effects of the change in the remuneration system using longitudinal

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<sup>5</sup> Although it was not about GP care, an example is health insurer CZ that made the headlines in 2010 with its initiative to develop a list ranking the quality of breast cancer research in different hospitals.

data from patient files and she concludes that financial incentives do not matter (2012: 173 ff.). This mismatch makes it worthwhile to take another look at this theme. Both studies are Ph.D. theses so some modesty is appropriate. Compared to Dwarswaard, this study aims specifically at professional identity using the Good Work framework, which offers structure and which is slightly more comprehensive than professional ethics. Moreover, it looks specifically at one societal development, economization, which offers a more structured approach than taking an open-ended look at ethics. Compared to Van Dijk, this study does not focus specifically at the remuneration system. Economization is broader than that.

Furthermore, the discussion on quality (professional standard) does not only take place on societal level. Scholars have also tried to come to grips with quality in GP care via developing all sorts of indicators (e.g. Westert, Van den Berg, Zwakhals, Heijink, De Jong, & Verkleij, 2010). This study offers insight into how GPs themselves experience the use of these indicators. Moreover, the literature on professional identity remains quite vague on what how this concept can be studied. This thesis offers an operationalization of professional identity by understanding it as a core of Good Work and several preconditions that underline the contextual nature of the professional identity concept.

## 1.4 Thesis structure

As the WRR puts it, ‘the market society is a complex system’ (2012: 12). This definitely counts for the Dutch healthcare system with its many involved organizations ranging from care providers, to interest groups, to health insurers, to supervisory bodies et cetera. In order to have a more thorough understanding of the healthcare system in general and the position of the Dutch GP in particular, *chapter two* offers background information on both topics.

In the *third chapter*, I will pay attention to the managerial and societal pressures on professionals and I will look into the concept of economization that is connected to these pressures. Subsequently, I will focus on economization in a GP context and I will operationalize it by looking at five developments within GP care that show clear tendencies of economization. These five developments are in this thesis labelled as ‘tokens of economization’.

*Chapter four* focuses on the second concept of this study, professional identity of GPs. In this chapter, I focus on the academic literature on professions and professionals and on identity. Via adopting a functionalist perspective on professionals, we can speak of a social contract between medicine and society that brings along mutual expectations. For GPs, these expectations are about their professional identity, which is subsequently defined in terms of Good Work (excellence, ethics and engagement) and four preconditions.

In the *chapter five*, economization and professional identity of GPs are brought together. Basically, there are two options: GPs have adapted their professional identity, or they did not. However, reality is not always as it should be. Doing and thinking are two different dimensions. What if they did not change their understanding of their professional identity but did change their actions? Accordingly, I will pay attention to a small continuum with three possible stances: adaptation, alienation and resistance.

After this theoretical part of the study, it is time to dive into the empirical side of the story. First, this requires attention being paid to the methodological considerations that founds this part. *Chapter six* focuses on the research design.

The *seventh chapter* offers the lion's share of the empirical part: the reporting of the results. Based on the conceptualizations of professional identity of GPs and of economization in GP care, it is being examined whether the latter has affected the former.

*Chapter eight* presents the conclusion of this study by answering the main question. Moreover, it offers a discussion section in which I will place the results in a wider perspective.

The *appendix* offers the introductory letter that served to 'recruit' respondents, the topic list for the interviews (in Dutch), and a list of respondents (GPs & experts) who were interviewed for this study. Figure 1.1 visualizes the structure of this thesis.

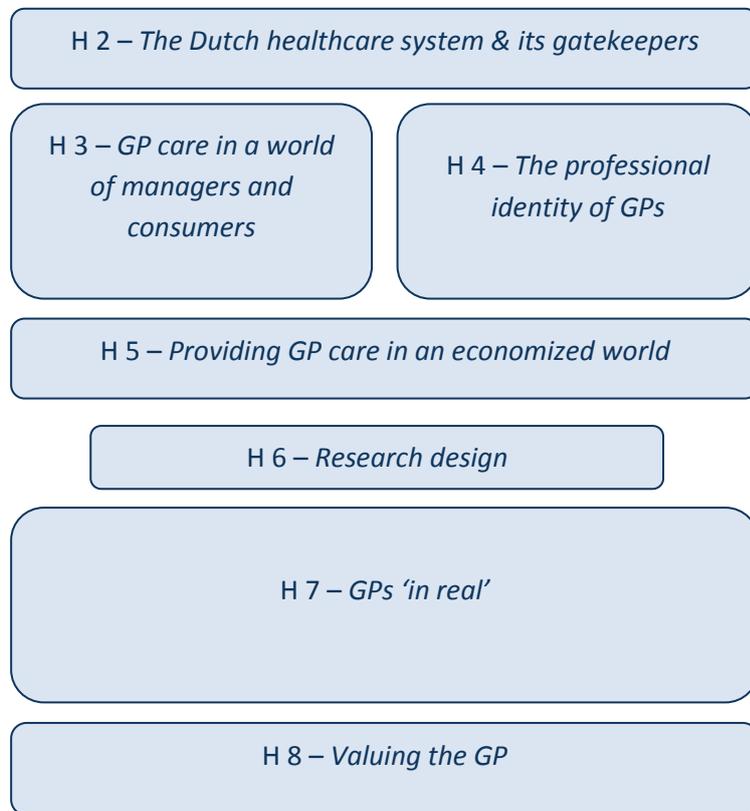


Figure 1.1 – Schematic overview of the thesis outline

# Chapter 2

## *The Dutch healthcare system & its gatekeepers*

Healthcare is about the people and their health and illness that is determinant for the way in which facilities are being shaped to meet the peoples' needs. This happens via all kinds of laws and regulations. Ultimately, the peoples' values, norms and standards about well-being and illness shape the healthcare system which consists out of a system of supply and demand (Boot & Knapen, 2005: 1). Before turning to the central concepts of this thesis (economization and professional identity of GPs) it is important to have a clear understanding of the Dutch healthcare system as we know it nowadays. In this chapter, I will pay attention to this system and I will focus especially on one medical professional in particular: the general practitioner (GP) who fulfils a central role in the Dutch healthcare system. The position of the Dutch GP is the result of an historical process. What does contemporary GP care actually look like?

## 2.1 Healthcare: towards a system with market dynamics

The Dutch healthcare system can be placed in the 'Bismarckian' social insurance tradition. During the second World War, a social health insurance system was introduced that covered the part of the population with low incomes which was around two-thirds of the entire population (Schäfer, Kroneman, Boerma, Van den Berg, Westert, Devillé & Van Ginneken, 2010: 13). Especially in the sixties, the healthcare system was broadened which led to an increase in costs: in 1950 the public expenditure on healthcare was 0.9 percent of the GDP, whereas in 1975 it was 3.8 percent (CPB, 2006 in Laeven, 2008: 26). Government policy became more aimed at getting the costs under control (Schäfer et al., 2010: 20). Despite the introduction of some market elements, this system remained more or less unchanged until in 2006 a major healthcare reform was processed by changing the entire insurance system (Schäfer et al., 2010: 13; see also Dwarswaard, Hilhorst & Trappenburg, 2011: 390). This change was not out of the blue: it was the result of twenty years of political and societal debate.

In 1987 the commission Structuring and Financing Healthcare under the management of Wisse Dekker published an advisory report called Willingness to Change ('Bereidheid tot verandering') (Commissie Dekker, 1987; Enthoven & Van de Ven, 2007: 2421 ff.). In this report radical recommendations were done to reform the Dutch healthcare system (Helderman, Schut, Van der Grinten, & Van de Ven, 2005). The commission argued that more free-choice options, competition and entrepreneurship in healthcare were absolutely necessary for the healthcare system to be 'future-proof' (Van der Grinten, 2007: 227). This report marked the starting point for a reorientation of healthcare policy towards a different content (i.e. health instead of care content) and governance (i.e. markets instead of decentralization) (Boot & Knapen, 2005: 213-216). According to the commission Dekker a coherent set of measures on three domains was needed: the financing, the insurance package, and the management of healthcare. The concept of 'managed competition' was being used.

Competition as a steering mechanism finds its basis in economic science. Traditional economic theory assumes a market of independent and rational subjects who have complete knowledge of the market and who are able to express their preferences perfectly. We can speak of true competition when insured/patients have a real 'exit-option', meaning that they should have the ability to transfer to a different health insurer or provider, and health insurer and provider really feel the 'pain' of this

transfer. The same goes for health insurers and providers who should have the ability to turn to a different healthcare provider or insurer because of quality or efficiency reasons (Putters, 2002: 6-7). Furthermore, these parties should also have a real 'exit-option', meaning that they should be allowed to refuse clients for example because they have too many health risks. However, reality does not meet this ideal type. There are elements like uncertainty due to a lack of transparency that undermine this efficiency, which cause market failures to occur. Besides, a free market would have highly undesirable consequences within healthcare, for example because patients with major health risks would be unable to insure themselves at all leading to huge issues of inequality. That is why we speak of *managed* competition because governmental regulation serves to counter these market failures (Van der Grinten, 2007: 227). In Dutch this is called '(gereguleerde) marktwerking'.

Already in the nineties, state secretary Simons tried to implement important reforms to meet the ideas of the commission Dekker. However, this implied a radical change of the healthcare system. The societal support turned out to be very low and a sense of urgency was lacking (Van der Grinten, 2007: 228; Schäfer et al., 2010: 21; Scheerder, 2002: 207). The proposed reform was too radical and too many barriers were in place. During the nineties, an incremental approach was adopted and gradually the (technical-organizational) barriers were removed. Although at the time of Scheerder's writing it was not yet clear whether the debate on the national healthcare system would actually result in new legislation, he already mentioned several trends: 'more responsibility of the insurers for the costs of healthcare provisions, less legislation and regulations on building and tariffs, and a government that tries to reduce its interventions in the system' (Scheerder, 2002: 207).

In 2003 minister Hoogervorst started to complement the already existing technical and organizational matters and brought everything together. Eventually, a window of opportunity opened: the societal acceptance for paying premiums increased, a sense of urgency was felt for controlling the healthcare costs at macro level, and a great number of people holding key positions were in favour of a revision of the healthcare system. For example some key figures within the European Commission and the association for medical specialists (Orde van Medisch Specialisten) were in favour of a system reform (Van der Grinten, 2007: 228-230). Eventually, a new healthcare system that introduced managed competition as we still have it nowadays was implemented on January 1, 2006.

In the domain of healthcare the introduction of this managed competition is a theme not to be missed. 'Patients' have become 'clients' and 'health insurance companies' and 'physicians' have become 'agents' (Groenewegen & Hansen, 2007: 62). Although it seems a straightforward concept, managed competition has become a diffuse concept. In general, it comes down to the liberalization of aspects of the healthcare policy. The national government withdraws partly and stops with regulating the supply side of healthcare. Healthcare providers and health insurance companies are to compete as if they operate on a free market (Van Heurck, 2003: 147). Several acts were passed in parliament that together form the legislative framework for managed competition in healthcare. The most important acts are the Health Insurance Act (Zorgverzekeringswet), the Healthcare Market Regulation Act (Wet Marktordening Gezondheidszorg), and the Healthcare Allowance Act (Wet op de

Zorgtoeslag) (Van de Ven, Schut, Hermans, De Jong, Van der Maat, Coppens, Groenewegen & Friele, 2009).<sup>6</sup>

The modern healthcare system aims at securing the public interest, which is divided into three elements: quality, accessibility and affordability. The provided care has to be of sufficient *quality*, that is, it must be safe, effective, timely and customer focussed. *Accessibility* means that care must be both physically and financially reachable for citizens. The former means that citizens must be able to receive the right care without having to travel across the country, while the latter means that people must be able to afford the premiums and deductibles for the care they require. *Affordability* focuses on another level. Namely, it means that care must be affordable on a societal scale (macro level) (Van de Ven et al., 2009: 26). In order to reach these aims, three markets have been formed to establish competition (figure 2.1). A supervisory body, the NZa, has been established to safeguard the proper functioning of the three markets (Schäfer et al., 2010: 23). The system of managed competition can be regarded both as a consequence and a cause of economization in care. The system reform would never have occurred in the first place without managerial and societal pressures pushing towards a more economically oriented healthcare system, making it a consequence. In turn, managed competition itself forms a strong managerial pressure for medical professionals and in that sense, it is also an important cause.

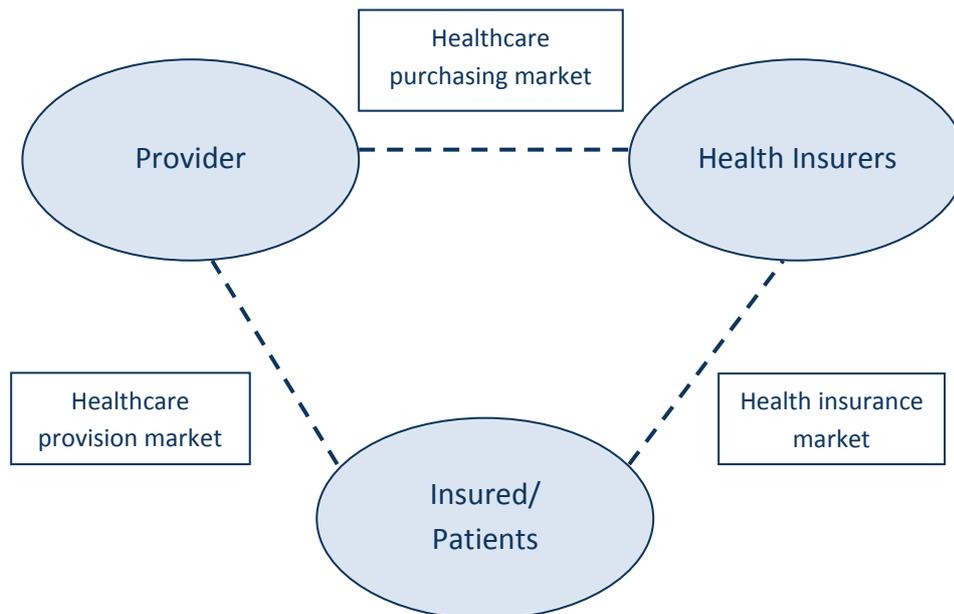


Figure 2.1 – The three markets in the system of managed competition (based on Westert, Van den Berg, Koolman, & Verkleij, 2008: 189; Westert, Van den Berg, Zwakhals, Heijink, De Jong, & Verkleij, 2010: 203; Van de Ven et al, 2009: 31, 45; Van Ginneken, Schäfer & Kroneman, 2010)

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<sup>6</sup> Other acts are among others the Dutch Competition Act (Mededingingswet), the Healthcare Institutions Admission Act (Wet Toelating Zorginstellingen), the Quality of Health Facilities Act (Kwaliteitswet zorginstellingen), and the Individual Healthcare Professions Act (Wet op Beroepen in de Individuele Gezondheidszorg) (see Van de Ven et al., 2009:29; Schäfer et al., 2010: xi).

## 2.2 The General Practitioner

### 2.2.1 From quack to family doctor

At the start of the nineteenth century, there were around fifteen different kinds of physicians in the Netherlands. They had different authorities and skills in different field of healthcare. Nevertheless, there was no real control for quality. Some kinds of physicians were under the supervision of their guilds but with the decay of the guild system also this kind of control disappeared. In general, physicians did not really have a positive reputation. They were met with suspicion instead of trust. Especially on the countryside, the societal position of the physician was poor (Boot & Knapen, 2005: 55; Goudsmit, 1978: 18). In itself, it was not illogical that physicians were approached in a reserved way whereas the diversity among physicians themselves was huge. Although there were province based commissions that had to register everyone that called himself (or herself) anything like a doctor, a midwife, a pharmacist et cetera. Furthermore, they had the authority to judge the quality of these doctors. The control by these commissions was highly deficient. Moreover, the majority of people was barely able to make a living, let alone that they could afford to go to a doctor. If a worker was to see a doctor at all, he was forced to visit a cheap one that was quite commonly a quack. As soon as a doctor made some name as being good, they ended up working solely for the wealthy who could afford to pay for their services (Goudsmit, 1978: 16).

Together the bad social conditions of the Dutch population, the lack of government action, the poor societal position of most physicians and the huge differences in quality between them strengthened the cry for change (Boot & Knapen, 2005: 55; Goudsmit, 1978: 19-24). Halfway the nineteenth century the monitoring and education of physicians improved drastically and the predecessor of the The Royal Dutch Medical Association (KNMG) was founded. During the second half of the nineteenth century, medical training became concentrated on universities by legislation of 1865. This choice was made after more than a decade of political debate and turbulence, and fierce discussions amongst physicians. Already in 1849 a governmental advisory commission stated that it was necessary to strive for more unity among physicians in order to offset the enormous differences in quality, competence and financial and societal position between them (Goudsmit, 1978: 28-30). Moreover, scientific developments made universities the designated place for medical education and the length of the medical education was extended which caused a considerable decrease in the number of practicing physicians. (Boot & Knapen, 2005: 55).

At the start of the twentieth century, the material position of workers was dramatic. Labour movement's effort to improve the situation of workers proved successful by the realization of social legislation. Together with modern scientific insights the fight against illness and death caused by infectious diseases became much more successful. Whereas major progress was being made in all fields of healthcare, a number of physicians started to specialize themselves (Boot & Knapen, 2005: 55). Already in the early days of the twentieth century, this division between physicians raised numerous questions about the future of the 'normal practitioner' which refers to what we now call the general practitioner (Dwarswaard, 2011: 43). In 1930 an act was passed in parliament that formally divided powers between specialists and general physicians. Because of this legislation, specialists were able to create a difference between them and their generalist colleagues (Boot & Knapen, 2005: 55). In 1946 the professional association of GPs (LHV) was founded, but nevertheless,

many GPs felt subordinate to their specialized colleagues. The lack of clarity about the tasks and position of the GP was reason for several progressive GPs to found the Dutch College of General Practitioners (NHG) in 1956 (Dwarswaard, 2009: 43). This organization was aimed at developing the general practice by research and teaching (NHG, 2012a).

The founding of the NHG is sometimes regarded as the 'awakening of the GP' (Huygen, 1961 in Dwarswaard, 2011: 44). An important marking point for the identity of GPs was the Woudschoter-conference in 1959 which can be regarded as the start of the Dutch GP care. During this conference twelve subtasks were formulated as well as a description of the function of GPs which in general is still recognizable in the role of GPs nowadays. The function of GPs was formulated as follows:

'Accepting the responsibility of a continuous, integral and personal concern for the healthcare of the individual people and families to him entrusted. It considers this healthcare as the neutralization, limitation and if possible prevention of disorders in the individual or family healthcare (curative, rehabilitative, preventive)' (Vroege, 1966 in Van den Berg, De Bakker, Van Roosmalen & Braspenning, 2005: 18).

This idea must be regarded as an ideal type because it was understood that in reality this would never be fully feasible. The 'continuous' element from the function description refers to the long lasting relationship between GPs and their patients. 'Integral' means that it is not just about care from a medical-technical perspective, but also about the social context of a person. That is why use is being made of the term healthcare instead of medicine. The term 'personal' emphasizes that especially the relationship between GP and patient is regarded as an important added value. In other words, not just the disease is central but the person itself (Van den Berg et al., 2005: 18-19).

In the sixties, the generalist expertise of the GP was widely acknowledged and the GP truly fulfilled the role of the family doctor (Boot & Knapen, 2005: 56). The GP had acquired the position of mediator between society and medicine (Dwarswaard, 2011: 45-46). Much attention is being paid to end the subordinate position of the GP. The NHG among others focuses on the medical education which is regarded as being too much in the hands of specialists. Eventually, in 1973 a one-year post medicine education is introduced. In 1978 this education became a precondition for the registration in the GP register. Without this one-year education, it was no longer able to become a GP (Dwarswaard, 2011: 44). Around 1980 there were many unemployed GPs, among others due to a raise of practising GPs by 20 percent in the seventies. In the eighties, the increase in the number of GPs was flattened due to a new settling policy which was enacted at municipal level. Moreover, in order to meet the unemployment problems, a new policy regarding the transfer costs of practices came into being (Boot & Knapen, 2005: 100). It is also in this period that the length of the GP education is extended up to two years instead of one (Boot & Knapen, 2005: 56). Nowadays, the modern GP education takes three years, including compulsory internships.

GPs are of pivotal importance to the Dutch healthcare system since they can be regarded as gatekeepers. First of all, all citizens are obliged to be listed with a GP. As soon as a citizen has an (expected) health issue which is not immediately life threatening, he can visit his GP. GPs are there to treat patients for a wide range of relatively small problems. As soon as more hospital and specialist care is required, patients first require a referral by a GP who will judge the necessity of this kind of

care (Boot & Knapen, 2005: 102; Schäfer et al., 2010: 23; Van den Berg, 2010: 11; Van Dijk, 2012: 10, 13). Consequently, GPs are the first persons patients will turn to when they suffer from health issues. Of all contacts between GPs and patients, approximately 96 percent is handled within the general practice, and only the remaining 4 percent is referred to secondary/other care (Van den Berg et al., 2005: 133; Van den Berg, 2010: 12). All in all, GPs are an extremely important spindle in our system and therefore it is of great importance to keep an eye on possible changes of this spindle.

### 2.2.2 GPs: facts and figures

On January 1, 2011 there were 11.306 reregistered GPs in the Netherlands. In total, 7,866 GPs were self-employed and 1,018 GPs were on the payroll of a self-employed GP (HIDHA).<sup>7</sup> Of all self-employed GPs and HIDHA's, 41 percent is female. Especially within the HIDHA category, we see that women form the majority namely 85 percent of all HIDHA's. Of the self-employed GPs only 35 percent is female. In general, the number of female self-employed GPs and female HIDHA's has grown tremendously from 1,960 in 2000 up to 3,628 in 2011, which is an increase of 85 percent. On the other hand, the number of male self-employed GPs and male HIDHA's has decreased from 5.809 in 2000 to 5,256 in 2011, a decrease of nearly 10 percent (see table 2.1). There is one important category of GPs left that partly overlaps with HIDHA's: the GPs that hired themselves out to sit in for other GPs. At least 1,007 GPs belong to that category (NIVEL, 2011: 8 ff.; NIVEL, 2012a). According to NIVEL, this means that in total there are at least 9,891 active Dutch GPs. This leaves a gap of 1,415 GPs who are registered, but of whom it is unclear whether they still practice their vocation for example by hiring themselves out. Research by NIVEL shows that an estimated 707 (50 percent) of them to some extent do (NIVEL, 2011: 9).

	Self-employed			On the payroll			Total		Total
	Male	Female	Total	Male	Female	Total	Male	Female	
<b>1980</b>	5,036	219	5,255	110	158	268	5,146	377	5,523
<b>1985</b>	5,427	481	5,908	123	182	305	5,550	663	6,213
<b>1990</b>	5,611	782	6,393	168	239	407	5,779	1,021	6,800
<b>1995</b>	5,637	1,103	6,740	105	279	384	5,742	1,382	7,124
<b>2000</b>	5,690	1,531	7,221	119	429	548	5,809	1,960	7,769
<b>2005</b>	5,514	2,032	7,546	170	769	939	5,684	2,801	8,485
<b>2006</b>	5,464	2,154	7,618	179	810	989	5,643	2,964	8,607
<b>2007</b>	5,419	2,265	7,684	189	853	1,042	5,608	3,118	8,726
<b>2008</b>	5,348	2,403	7,751	182	900	1,082	5,530	3,303	8,833
<b>2009</b>	5,270	2,513	7,783	178	921	1,099	5,448	3,434	8,882
<b>2010</b>	5,202	2,638	7,840	189	947	1,136	5,391	3,585	8,976
<b>2011</b>	5,107	2,759	7,866	149	869	1,018	5,256	3,628	8,884

Table 2.1 – Number of GPs based on function and gender on January 1, 2011 (Nivel, 2011: 8 ff.; Nivel 2012)

<sup>7</sup> In Dutch this is called 'huisarts in dienst van een huisarts', which is a GP who is employed for at least half a year by a self-employed GP.

From table 2.1 we learn that in the last three decades the number of female GPs has increased strongly. In the literature, this development is often being referred to by speaking of a ‘feminization’ of the GP profession. Sometimes the term feminization is being used to indicate a change in professional culture: more women lead to more feminine values within the profession (Van Zalinge, 2008: 9 ff.). A notable observation is that especially within the younger age categories, women seem to outnumber their male colleagues (see table 2.2). It is beyond the scope of this thesis to pay elaborate attention to this development. Nevertheless, it is commonly hypothesized that this development might have speeded up important developments within the GP profession like the possibility to work part-time (Van Zalinge, 2008: 196 ff.; e.g. Wiegers, Hopman, Kringos, De Bakker, 2011: 27).

Age	Male		Female		Total	
	Abs	%	Abs	%	Abs	%
< 30	9	0.2	15	0.4	24	0.3
30-34	156	3.0	412	11.4	568	6.4
35-39	398	7.6	818	22.7	1,216	13.7
40-44	562	10.7	759	21.1	1,321	14.9
45-49	748	14.3	635	17.6	1,383	15.6
50-54	1,129	21.5	486	13.5	1,615	18.2
55-59	1,352	25.8	365	10.1	1,717	19.4
60-64	836	15.9	113	3.1	949	10.7
> 64	56	1.1	2	0.1	58	0.7
<b>Total</b>	<b>5,246</b>	<b>100.0</b>	<b>3,605</b>	<b>100.0</b>	<b>8,851</b>	<b>100.0</b>

Table 2.2 – Number of employed GPs based on age and gender on January 1, 2011 (NIVEL, 2012a).<sup>8</sup>

Traditionally, the Dutch GP was self-employed and worked in a solo-practice (Van den Berg, 2010: 11). Nowadays however, the majority of GPs is still self-employed but work in a duo-practice or group-practice and especially this last one has become a popular organizational format. In 2001, 33 percent of all Dutch GPs worked in a solo-practice. By 2011 their number had dropped to 18 percent. The percentage of GPs working in a group-practice (which is a practice with three or more GPs) on the other hand has risen from 31 percent in 2001 to 54 percent in 2011. The number of duo-practice-GPs has shown a small decrease from 36 percent in 2001 to 28 percent in 2011. This is also visible in the given that of all 400 GPs who are looking for a practice only 12 are looking for a solo-practice to take over. The majority, namely 217, is looking for a group-practice (NIVEL, 2012a).

Although each practice is different, in the past the NZa used in its analysis of the costs and returns of GP practices some units of account that describe the ideal typical standard practice. The most important of these is the measure that each full-time employed GP has approximately 2,350 registered insured which is called the size of the ‘norm practice’ (Karssen, Schipper & Jurling, 2009: 41). The most important services that a GP offers are the consultation, the visit, the telephonic consultation and the vaccination. The weighting factors of these are respectively 1; 1.5; 0.5; and 0.5

<sup>8</sup> Of 33 GPs, the NIVEL had no age-data available.

meaning mainly that for each visit one-and-a-half consultation and for each telephonic consultation and vaccination half a consultation will be reimbursed. One consultation is set to last from ten up to twenty minutes (Karszen et al., 2009: 44). The tariffs for practically all GP services are fixed by the NZa. For one consultation the tariff is 8,78 Euros (NZa, 2011). Some GPs are active in a GP-service-structure (in Dutch: Huisartsen Diensten Structuur, HDS) and fulfil after hours services (in Dutch, Avond, Nacht en Weekend diensten, ANW). The hour tariff for these services is 67.41 euro (NZa, 2011).

## **2.3 To conclude**

Basic knowledge about the Dutch healthcare sector and the role of Dutch GPs within this system is required to fully understand this study. This chapter aims to provide this basic knowledge. It makes clear that the Dutch healthcare sector is not static. Instead, it is a very dynamic domain that has been confronted with important changes over the past few decades. As a whole, the system has been radically reformed in 2006 with the introduction of managed competition. Also in this current system, GPs fulfil a pivotal role and can be regarded as 'gatekeepers'. Nevertheless, the GP of fifty years ago is not the same GP as the modern one. Nowadays, more women have come to work as GP leading to a 'feminization' of the profession and most GPs seem to prefer to work in a group- instead of solo-practice.

# Chapter 3

## *GP care in a world of managers and consumers*

Whereas society constantly changes – mostly gradually, sometimes radically –healthcare changes along. In this chapter I will pay attention to the way in which our society has changed by focussing on the pressures on professions and its professionals. Subsequently, I will focus on economization, whereas in our contemporary society economic logic plays an increasingly prominent role. Economization is the result of a complex interplay of pressures. This is also true for our healthcare system (Hilhorst, 2004: 15). But what exactly is economization? And how can we relate it to GP care?

### **3.1 Pressures on professionals**

Over the past few decades the role of the professional in Dutch society has changed considerably. Ever since the 1980s and 1990s scholars have studied the changes of professional services at length (Noordegraaf, 2011a: 1349). In the academic debate, the image of the professional being trapped by these changes has become popular (Van Montfort, 2008: 47). Noordegraaf exemplifies this by mentioning examples of publications that among others have explored ‘political attacks on professionalism’, ‘the managerialization of professional work and standards’ and ‘the marketization of professional products’ (2011a: 1350). These examples come close to several of the developments mentioned by Jansen et al. in their explanation of why professionals have a feeling of maltreatment; a feeling of ‘professional pain’: the pressure on professionals for ‘doing more with less’ due to constant cutbacks; an ever decreasing trust in people working at the shop floor due to incidents that have led to more regulation, sanctions and loss of face; and a declining discretionary space for professional due to an increase in surveillance and control (2009: 18-19).

We can distinguish several pressures on professional work (cf. Noordegraaf, 2011b; see also Tummers, 2012: 16). Some are exogenous which means that their origin is external to the professions and some are endogenous indicating a change of the professions and professionals themselves. There is discussion about whether or not these pressures have changed the peculiarities of professional practice completely (e.g. Faulconbridge & Muzio, 2008; Van Montfort, 2008: 47). Nevertheless, they undisputedly have had an effect on professional work.

#### ***3.1.1 Exogenous pressures***

A first exogenous pressure is administrative in nature and is commonly referred to as managerialism. This refers to the development that over the past few decades the management in the (semi-)public sector was highly inspired by the ideals of the New Public Management (NPM) (Mulgan, 2003: 151 ff.). Since NPM has become an umbrella term that catches many different nuances, it is difficult to give a conclusive description (Noordegraaf, 2004: 87). Basically, the NPM ideals were derived from the ‘conceptual framework of administration in the private sector’ (Farrell & Morris, 2003: 136; see also, De Bruijn, 2006: 11). According to Hood there are several overlapping precepts that come forward in most NPM discussions (Hood, 1991: 4-5).

One of the most important ones is the doctrine that management should have the room to control the organization. The autonomous position of the professional was challenged by the resulting enhanced managerial prerogatives (Waring & Currie, 2009: 755). Secondly, standardization and performance measurement became more and more important (De Bruijn, 2006: 11-17; Groenewegen & Hansen, 2007: 61; Pollit & Bouckaert, 2004: 90). Goals had to be defined and (quantitative) indicators determined for efficiency and accountability purposes (see also WRR, 2012:

49). In many organizations 'knowledge management' was introduced to standardize professional practices and to enable managers to come to grips with the knowledge of employees (Waring & Currie, 2009: 758). Thirdly, there came a greater emphasis on output controls (with strong focus on the financial aspects). Results instead of procedures became centre of attention (De Bruijn, 2006: 16). For example in healthcare deviation from guidelines (standardization) was more and more being regarded as undesirable – disregarding the reasons for deviation – and more supervision was introduced (Groenewegen & Hansen, 2007: 66). Finally, competition and commercialization became core themes with 'do more with less' as the credo (Bureau & Vrangbæk, 2008: 29; Groenewegen & Hansen, 2007: 61-64; Jansen et al., 2009: 19). In many countries market mechanisms were introduced usually implying that in sectors that used to be steered by government direct steering was replaced by indirect steering via large scale liberalization and privatization operation (WRR, 2012: 21, 44 ff.; see also Pollit & Bouckaert, 2004: 66 ff.).

Managerialism is generally seen as *the* most important pressure and usually it is regarded as a top-down development that stems from governmental policies (e.g. Noordegraaf, 2011a; WRR, 2012: 21).<sup>9</sup> Nevertheless, the managerialism pressures are not the only ones that affect professional work. There are other external pressures as well that are more bottom-up. A rich body of literature is available on the developments that have changed our society considerably. Within sociology, these developments are often linked to the 'baby boom' starting in forties and the increase in wealth (see also Spangenberg & Lampert, 2010). Schnabel has articulated five processes – all starting with an 'i' – to describe them (SCP, 2004: 51-65): individualization, informatization, internationalization, informalization and intensification.

Individualization refers to the growing autonomy of the individual that is less reluctant in expressing his opinions and preferences (see Schnabel, 2004; SCP, 2011). Scholars often point at a tendency to consumerism. Citizens have become much more demanding when it comes to service delivery: they show more strategic behaviour, do not hesitate to stand up for themselves and demand tailored services (Noordegraaf, 2004: 56-57; WRR, 2012: 51 ff.). Informatization refers to the increased access to information, among others due to technological developments and educational attainment, leading to better informed citizens/clients (see Groenewegen & Hansen, 2007: 28-29). Many scholars have come to speak of the *information* or *knowledge society* (Bovens, 2003: 30 ff.). Internationalization refers to the fading of national (cultural, social and economical) borders (see Hirst & Thompson, 1999: 1; Versluis, Kleistra & Termeer, 2008: 2). Informalization refers to the loosening of the mores between people and the decreasing differences in status (see also Groenewegen & Hansen, 2007: 71). Finally, intensification refers to the trend that on average people nowadays seem to have a desire for deep emotional experiences and have become more extravert instead of reserved (see SCP, 2011; Spangenberg & Lampert, 2009: 80). These societal developments

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<sup>9</sup> In many cases the (scientific) debate on managerialism comes down to the professional being positioned opposite the management, often arguing that the former is being overshadowed by the latter (see Trappenburg, 2011). Among others the Dutch government seems to adhere to this stance as well: 'The regulatory pressure, especially for *professionals* and citizens, and the inter-administrative burdens are being reduced' and 'In healthcare it is not the management but the execution – and thus the shop floor – that should be central' (Regeerakkoord, 2010 [emphasis added]).

have increased the complexity of professional service delivery and require professionals to adapt and to attain new skills.

### **3.1.2 Endogenous pressures**

The endogenous pressures are the 'changes from within'. Specialization is one of them (e.g. Dwarswaard, 2011: 44). The use of technocratic principles causes tasks to be further divided into separate parts constantly. The sheer existence of the impressive diversity of educational directions illustrates this division (Groenewegen & Hansen, 2007: 59). In the future, the labour market will show an even more differentiated picture (SCP, 2004: 269 ff.). Simultaneously, there is a certain necessity for professionals to have general competencies as well due to the increasing need for multidisciplinary cooperation (Groenewegen & Hansen, 2007: 59). Nevertheless, especially in the domain of healthcare, the development of different specializations has resulted in the establishment of different professional associations (Groenewegen & Hansen, 2007: 38-39).

Another internal pressure on the way professionals work is their work preference. Traditionally, professions were strongly uniform, meaning that professionals had a shared understanding and a shared point of view about their profession. However, it turns out that this traditional uniformity no longer matches reality completely (e.g. Dwarswaard, 2011: 91-106). Medicine is a good example of the present-day differences in work preferences. Organized medicine has a very strong position in regulating itself. For a long time, traditional professionalism was predominant: medical specialists were to act altruistic and should be very autonomous in order to be able to fulfil their profession properly. This can be termed *nostalgic professionalism* (Hafferty & Castellani, 2010). Over the past few decades, this has changed. New types of professionalism have emerged. Especially *entrepreneurial* and *lifestyle professionalism* have come to compete with nostalgic professionalism (Castellani & Hafferty, 2006). The first is focussed on commercialism, and the second on work-life balance. An important factor that has contributed to this is the emancipation of women whereas the percentage of female professionals has increased drastically in all different professions over the past few decades (Groenewegen & Hansen, 2007: 53-55).

Specialization and diversifying work preferences have also increased the pressures deinstitutionalization and fragmentation which are both exogenous and endogenous. The former refers to professionals being more individually oriented, leading to a decline in might and influence of professional associations (Groenewegen & Hansen, 2007: 38). Moreover, it refers to the equality ideal that caused professionals to descend from their ivory tower. For example, the GP no longer wore a white lab coat (see also Aulbers, 2002). Simultaneously, the organizations in which professionals work have gained importance over them as well (Groenewegen & Hansen 2007: 15-16). Fragmentation points at the increase in (paradigm) conflicts between professionals practising the same profession and between professionals of different professions (e.g. Hafferty & Castellani, 2010). Figure 3.1 visualizes the exogenous, the endogenous and the mixed pressures on professionals and professional work.

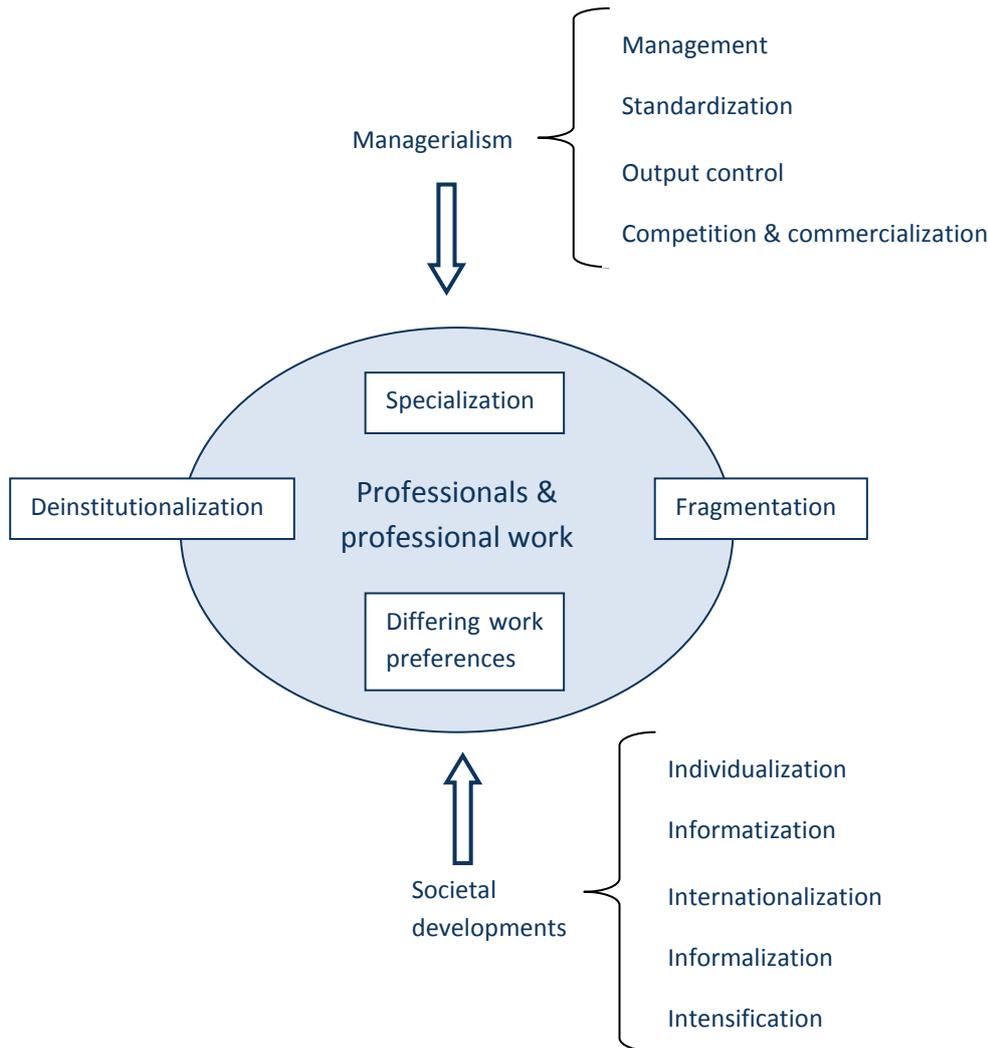


Figure 3.1 – Exogenous, endogenous and mixed pressures on professionals and professional work (partly based on Noordegraaf (2011b) and SCP (2004))

### 3.1.3 Economization

In reality, the discussed pressures that influence professionals and the way they work form a complex interplay. The managerial pressures, the societal developments and the endogenous pressures are not to be regarded as completely separate. For example, individualization is not something solely reserved for ‘normal’ citizens. Professionals like any other person are part of society as well and they have also become less reluctant in expressing their opinions resulting among others in discussion amongst professionals about differences in work preferences (e.g. Hafferty & Castellani, 2010). Consequently, it becomes difficult, or probably even impossible, to isolate one pressure and to study its effects on whatever subject. This understanding is very relevant for this thesis, because it is the main reason why I focus on *economization* as a generic concept. As the WRR states, establishing causal links between governmental policies that introduce market dynamics and (societal) developments is impossible because of numerous external factors like changes in consumer preferences (Ministry of Economic Affairs, 2008 in WRR, 2012: 118).

Economization is not just about one or two pressures. It refers to the complex interplay of many pressures that together simultaneously lead to a more economic orientation within societal relations. In line with Reagan and Thatcher, in the eighties the Dutch cabinet Lubbers made cost awareness the core of governmental policy and ever since cost considerations have played a key role in all kinds of policy discussions (Van Damme, 2006: 9). The managerial pressures set by government, and especially the fostering of competition and commercialization, have pressured citizens and companies to adopt a consumer role (Dwarswaard, Hilhorst & Trappenburg, 2011: 389; WRR, 2012:21). On the other hand, demanding, internationally oriented and well-informed citizens force government to strive for making professional services become more effective, affordable and high in quality, leading to more managerial pressures (Noordegraaf, 2004: 57). In other words, whereas the managerial pressures cause society to change, the other side of the coin is also relevant: societal developments have formed the breeding ground that allowed managerialism to flourish. And in our individualized society this breeding ground has been neo-liberal in nature, meaning a withdrawal of, and cutbacks by, the government, with a strong belief in the market as coordination mechanism (see Noordegraaf, 2004: 85; Mulgan, 2003: 151 ff.).

Economization refers to the increasing role of markets as coordination mechanisms. Contracts and financial incentives have gained importance at the expense of values and norms that seem to play less meaning within economic interactions (De Waele, 1999: vii). This trend is everywhere to be found in our contemporary society, leading the WRR to characterize it as the 'market civilization' (2012: 21). In the healthcare context, Van Hout and Putters mention that economization is about the 'ever increasing dominance of financial-economic reasoning in healthcare' (2004: 130 [translated from Dutch]; see also RVZ, 2004: 153 ff.). Characteristics of economization are a management approach, quantification, a market oriented way of working, an entrepreneurial attitude, productivity as norm, steering from a distance, maturing of organizational management by marketization and a profit orientation (Grit, 2000, Van Hout & Putters, 2004, Engelen, 2004 in RVZ: 2004: 154). For medical professionals working in the healthcare sector, this implies that besides medical also economic considerations are to be kept in mind (RVZ, 2004: 153). Van Hout & Putters follow Grit who argues that the term economization is being used from three perspectives: the growth of managerialism, the rise of the market and the spread of neo-liberalism (2000: 4 ff.). All perspectives show clear links with the pressures I have discussed before.

Firstly, Grit uses managerialism in a comparable way as I do when he emphasizes the increased importance of business-like management in the public sector. He quotes Van Gunsteren according to whom we live in an era in which management is being regarded as the way to improvement, not just in the private sector but also in public organizations (Grit, 2004: 6). Secondly, by speaking of a 'rise of the market', Grit emphasizes that supply and demand as coordination mechanism has become more dominant in practically all sectors. He refers to the idea that 'everything is for sale' and mentions that all actors involved act accordingly (2000: 8). Those that can offer goods and services only do so when they are being paid for it, and those who pay expect goods and services that are worth their money. In other words, people have adopted the roles of suppliers and consumers and it strengthens the trend of consumerism discussed earlier. Finally, Grit refers to the spread of neo-liberalism which is not just about political preference, but more about a wider societal climate that is positive towards markets as mechanisms of coordination and towards individual responsibility (2000: 9). This stresses

the important observation discussed earlier that we can speak of a complex interplay between both managerial pressures by government and pressures due to societal developments.

The three interpretations of economization try to come to grips with the way our society has changed from different angles. Managerialism focuses on *professions*, the rise of markets on *systems* and the spread of neo-liberalism on *ideology*. From all three angles we can see that our healthcare system has changed. According to Van Hout and Putters (2004: 130), on the one hand management has been on the rise in healthcare and this management has professionalized greatly, which is being highlighted from a managerial perspective. On the other hand, they mention that the autonomy of patients has become more central, leading among others to more commercialization and more efficient organizational structures. This shows clear signs of economization from a 'rise of the markets' point of view. Van Hout and Putters stress that all of this occurred against a background of an increasingly strong belief in markets, which is emphasized by the neo-liberal perspective. Looking at healthcare from these three perspectives, Van Hout and Putters conclude that economization puts two logics in the limelight: the logic of consumerism (bottom-up) and that of managerialism (top-down) (2004: 130; see also Dwarswaard et al., 2011: 389). In this thesis, it are exactly these two logics that together constitute economization. But what does our current healthcare system actually look like?

### 3.2 Economization in GP care

Economization did not leave GP care in the Netherlands untouched. On the contrary, we can distinguish several developments within GP care that show clear signs of managerial logic or consumer logic. These developments are partly caused by economization and/or strengthen the tendency towards it. 'Partly' because it is important to note in advance that none of these developments can be regarded as *purely due to economization*. They are not just the result of economization pressures but also have to do with other pressures like scientific developments and work-preferences of GPs themselves. Below, are mentioned. Nevertheless, in this thesis, I focus on five developments within GP care, that I consider to be *tokens of economization* in order to come to grips with the economization concept. These developments have irrefutably strengthened consumerism and managerialism. The ones mentioned are the revision of the remuneration system, standardization via guidelines, task rearrangement, more cooperation and after hours clinics, and healthcare groups and multi-disciplinary care. I do not claim that these developments are the only ones within GP care, not do I claim that they are completely coordinate. Instead, they (mutually) influence each other. Nevertheless, from the interviews with experts (and from the interviews with GPs) it follows that these are the most prominent when it comes to increased managerialism and consumerism.

#### 3.2.1 Remuneration system

The revision of the remuneration system is the most prominent token of economization. Before the introduction of market principles in the healthcare system, the sector was financed via a mixture of public and private insurances (Boot & Knapen, 2005: 181). How a patient was insured depended on income. In 2005 a person whose gross annual income was above 33.000 euro had to take private insurance. In 2001, approximately 60 percent of the Dutch population was publicly insured and the

remaining 40 percent had private insurance. The remuneration of GPs depended upon the insurance of his patients. GPs were paid 'a capitation payment for publicly insured patients and a fixed amount of money per year for every listed (publicly insured) patient' (Van den Berg, 2010: 12). For elderly people (65+) and for people living in deprived areas the amount of money GPs received was slightly higher. Every GP had listed a mixture of both publicly and privately insured patients. Because of the link with income, GPs in wealthy areas had more patients with private insurance than those in more deprived areas (Van den Berg, 2010: 12). For privately insured patients, there was a fee-for-service system. The remuneration difference between publicly and privately insured was more and more regarded as undesirable, whereas it was said to lead to differences in the provision of GP care between these categories (Van Dijk, 2012: 10).

The implementation of managed competition has also affected GP care (Van Dijk, 2012: 13). The new healthcare system implied that there was no longer a distinction between public and private insurance. Instead, all Dutch citizens are nowadays privately insured and everybody is obliged to have at least a basic insurance which they are free to choose. In case of medical costs, every person has to pay a fixed amount of money at first. This is the compulsory deductible (in Dutch 'eigen bijdrage') which is 220 euro in 2012. Furthermore, everybody has the ability to 'carry more risk' via the level of their voluntary deductible ranging from 0 to 500 euro. Nevertheless, it is important to note that both the voluntary and compulsory deductible do not apply to GP care. Every consultation patients have with their GPs is still reimbursed. The change in system for GPs can be found in the remuneration system (Van Ginneken et al., 2010: 25). This system was negotiated by the professional association of GPs LHV, the Ministry of Health, Welfare and Sports and Health Insurers Netherlands. The result of these negotiations was 'a combination of capitation fees and fees-for-services' (Van Ginneken et al., 2010: 25; Van Dijk, 2012: 14).

For every patient a GP has listed, he receives a capitation fee and for every operation/service he receives a fee. For most of the GP services, these fees are fixed by the NZa via a maximum tariff. For a very small part of GP-services the fees are negotiable. These are several modules within the so-called modernization and innovation services category (M&I-services) like diabetes support and electrocardiography diagnostics (Van Dijk, 2012: 14; Karssen et al., 2008: 49). The capitation system aims to support a strong relationship between patients and GPs which is considered to be essential for GPs' role as gatekeepers (Van Dijk, 2012: 10). The fee-for-service system on the other hand aims to leave room for financial compensation for work done by GPs (Van Dijk, 2012: 14).

One important element of the healthcare system is the emphasis on substitution from the secondary to primary echelon for efficiency purposes. The primary echelon contains the extramural generic care (the primary care) and is relatively cheap compared to the second echelon which contains the intramural specialist care (secondary care) (Boot & Knapen, 2005: 66 ff.). Besides, there is also an emphasis on improving quality. The M&I-services, although relatively small, aim to encourage GPs to contribute to this substitution and quality improvement (Van Dijk, 2012: 15; see also Dwarswaard, 2012: 143). There are two kinds of M&I-services. The first kind is the predefined set of services of which the fees are negotiable. The second kind is the regional initiative that can be reimbursed by a certain fee on top of the capitation fee. The fees for both kinds of M&I-services depend upon negotiations between health insurer and GPs (see also Van Ginneken et al., 2010: 25). Nevertheless,

M&I-services only reimburse additional services. In general, financial incentives for quality improvement have never played an important role in the Dutch remuneration system of GPs. There is for example no pay-for-performance (P4P) system that focuses on patients or performance outcomes (Van Dijk, 2012: 15).

Already in the early eighties, the first GP information systems (HIS) were introduced (Van den Berg et al., 2005: 35). Nowadays, practically all GPs have digitalized their patient administration. There are at least nine different computer programmes available that serve to administer background information of patients, medical information, and financial information of the practice (NIVEL, 2012b; Peek, 2010).<sup>10</sup> The HIS plays an important role in facilitating the remuneration system explained above. Although there is some variation between the systems, most HIS are very comparable, because they are based on the HIS-reference model of the NHG which describes the functions a HIS must have (Rijnierse, Bastiaanssen & Westerhof, 2011). Consequently, each HIS records the reason for contact with a patient, the examination he has conducted, the diagnose and the planned treatment, referral, prescription or laboratory request (NIVEL, 2012b). Especially the examination, the diagnose and the planned action are important, because via the HIS specific codes can be attributed to each consultation moment for the type of consultation, the specific diagnose and the kind of treatment (see paragraph 3.2.2). Nowadays, health insurers are using this data for the reimbursement of GP care.<sup>11</sup>

Further elaboration on the reimbursement system and the HIS is beyond the scope of this thesis, but the underlying systematic is very important to understand why the remuneration system can be regarded as a token of economization. GPs nowadays receive a capitation fee and a fee for each service they deliver. This latter is 'to realise financial compensation for the performed workload' (Van Dijk, 2012: 14). According to Groenewegen and Hansen already in the old system, GPs had to balance between their professional targets and reaching a target income. However, the new system is explicitly aimed at stimulating a more commercial attitude (2007: 62-63). Furthermore, the entire process of contact between patients and their GPs has been cut into pieces (e.g. the examination, the diagnose, and the treatment) and for each piece a separate label (i.e. a code) is available. These labels make the performance of GPs more transparent and also play an important role when it comes to the reimbursement of costs by health insurers to GPs. This labelling system can be regarded as a clear expression of the managerialism described in paragraph 3.1.1.

### ***3.2.2 Standardization & performance measurement via guidelines & indicators***

At the start of the eighties, the NHG started to worry about the non-committal nature of the GP profession. There was a lot of inter-doctor variation and it was feared that ultimately this would make the profession very hollow and subject to political and financial decisions taken by others (Dwarswaard, 2011: 111). To forestall government, the NHG proactively started to work on the

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<sup>10</sup> The nine GP information systems evaluated by the LHV are Hethis, Medicom, Microhis, Mira, Scipio, Studio Promedico ASP, Promedico VDF and Zorgdossier (Peek, 2010).

<sup>11</sup> This happens via an intermediary digital portal like VECOZO (see <http://www.vecozo.nl>) for which GPs must provide an invoice file that is made conform the Vektis-standard. Vektis is an organization that among others has developed standards for electronic exchange of data within healthcare (see <http://www.vektis.nl>).

profiling of the GP profession. Several measures were taken: meeting several substantive requirements became compulsory for NHG-membership, a system of mutual scrutiny was introduced, and guidelines were developed, the so-called NHG-standards (Dwarswaard, 2011: 115 ff.). These standards are composed by experts, including GPs, and are as much as possible the result of *evidence based medicine* (see also Van den Berg et al., 2005: 33). "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996: 71). When talking about 'evidence based medicine', the evidence, which is being referred to, is practically always of scientific nature whereas it is the result of published scientific research. To the present day, these standards are not binding, however GPs are encouraged to consult and follow them as much as possible.

In itself, the NHG-guidelines are not at first sight an expression of economization. However, there are two reasons why I still mention them as a token of economization. Firstly, they serve as a kind of *knowledge management* that is explicitly aimed at standardizing the professional practices of GPs. As follows from paragraph 3.1.1 standardization in itself can be regarded as an expression of managerialism (see also De Bruijn, 2006: 11-17; Groenewegen & Hansen, 2007: 61; Pollit & Bouckaert, 2004: 90; Waring & Currie, 2009: 758). Secondly, the NHG-guidelines have come to play an ever more prominent role in the discussions about the quality of and accountability within GP care (see Dwarswaard, 2011: 115-116). Although widely acknowledged that merely following standards does not guarantee quality in GP care, many studies make use of adherence to standards as an important proxy for quality (see also Van Dijk, 2012: 127 ff.; Braspenning, 2004: 20 ff.). As mentioned in paragraph 3.1.1, in healthcare deviation from guidelines (standardization) is more and more being regarded as undesirable (Groenewegen & Hansen, 2007: 65-66).

In the last paragraph, I mentioned the codes GPs must add to every consultation moment for the type of consultation, the examination, the specific diagnose and the proposed treatment. These codes are the so-called International Classification of Primary (ICPC) codes, which have become the 'standard for coding and classifying complaints, symptoms and diseases in the GP practice' (NHG, 2012b). Via a HIS, the consultation can be labelled with these codes and they form the basis for the reimbursement by the health insurer. Each code brings along a formulary, which is an indication of what you should prescribe to a patient. In the examination phase, GPs can enter in subjective and objective information into the HIS. The patient himself provides the subjective information. Test and lab results like specific blood values are the objective information. This objective information has to be entered into the HIS in a standardized way in line with pre-defined indicators. These indicators allow GPs themselves and healthcare groups to measure their performance (see Van Doorn, Bouma & Braspenning, 2009).

The guidelines, codes and indicators all serve to increase standardization to facilitate more transparency, which is a crucial precondition for a proper function of the markets within the healthcare system (Westert et al., 2010:21-22; Wiegers et al., 2011: 27). In general, transparency and managed competition serve to increase quality and efficiency (Van Doorn et al., 2009: 3) and to strengthen accountability. In order to safeguard accountability more supervision has been introduced under the motto of 'execute or explain' (Groenewegen & Hansen, 2007: 65-66).

### **3.2.3 Internal organization: task rearrangement**

The coherence and arrangement of the Dutch primary healthcare can be studied at different levels. First of all there is the internal organization of GP practices (this paragraph). Secondly, there is the horizontal organization within the primary care echelon on district level (paragraph 3.2.4). And thirdly, there is the regionally oriented vertical organization which aims at alignment between the primary and secondary healthcare provision (paragraph 3.2.5) (cf. Wiegers et al., 2011: 24 ff.)

Due to an increasing and changing demand for healthcare, the organization of GP practices has become centre of attention. GPs are academics that are educated as generalists. Due to their academic skills and knowledge, they are capable to help people with complex problems both from a medical and a psychosocial perspective. However, most of their time they treat minor diseases that require a standard treatment (Ebbens, 2002: 463). Especially since the number of patients with chronic diseases was growing, more care capacity was required and consequently the workload of GPs increased substantially. This has led many GPs to question ‘how can my GP practice be organized optimally?’ The answer has been sought in the configuration of the tasks a GP performs, or more specifically, in task delegation (see also RVZ, 2002).

Already in the sixties, the practice assistant was introduced. In the last decades, the low-educated assistant has professionalised rapidly and nowadays all sorts of small GP tasks are delegated to assistants, varying from ear syringing to administrative tasks to telephonic triage (Van den Berg et al., 2005: 29).<sup>12</sup> Nevertheless, since the assistant is not high educated, delegation of complex medical tasks was impossible. Due to the increase in workload and due to a striving for quality improvement – including better service delivery – the function of the ‘practice seconder’ was introduced in 1999 (in Dutch ‘praktijkondersteuner’, POH) (Van den Berg et al., 2005: 30; Wiegers et al., 2011: 31).<sup>13</sup> The POH is a high-educated person who can take over certain routine tasks in order to ease the pressure on GPs (Ebbens, 2002: 463). The POHs especially focus on care for chronically ill like diabetes or COPD (Van den Berg et al., 2005: 30). In 2008, already 60 percent of all GP practices had a POH employed (Wiegers et al., 2011: 31).

Task rearrangement is a token of economization because it has a clear managerial and consumer logic: it is all about optimizing the organization of GP practices in order to improve efficiency and quality including service delivery and it requires GPs to think more in terms of management (see also RVZ, 2002; Wiegers et al., 2011: 24). Tasks are being weighted for their complexity and they are divided between GPs and their supporting staff which is basically the implementation of specialization principles (Groenewegen & Hansen, 2007: 58-59).

### **3.2.4 Horizontal organization: more cooperation & after hours clinics**

The conviction that care needs to be generalistic, accessible and available close to peoples’ homes has led government, healthcare providers and health insurers to strive for more coherent care on

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<sup>12</sup> Telephonic triage is estimating the kind and severity of a complaint when a patient calls the GP practice.

<sup>13</sup> There is no official English translation for the Dutch *praktijkondersteuner* (POH). It might be confused with *nurse practitioner*, however that is not an equivalent because a POH is more autonomous.

district level within the primary care echelon (Wiegers et al., 2011: 25). Simultaneously, GPs' work preferences have changed, among others due to the feminization of the GP profession (Rijnierse et al., 2011: 7). This has not only resulted in more part-time working GPs, it has also resulted in GPs looking for other options for their after hours services in order to have a more balanced workday (Wiegers et al., 2011: 26). Consequently, many GPs started to cooperate more structurally. As we have seen in paragraph 2.2.2, many practices merged to form duo or group practices and many started to share housing (a so-called HOED: multiple GP practices in one building, in Dutch 'Huisartsen Onder Een Dak') (Rijnierse et al., 2011: 7). This implied an expansion of scale (Groenewegen & Hansen, 2007: 57 ff.; Wiegers et al., 2011: 26-27). Moreover, GP started to cooperate more closely with other disciplines within the primary care echelon like physiotherapists and psychologists. Already in the eighties health centres started to emerge and nowadays more often professionals of multiple disciplines share housing (a so-called MOED: multiple disciplines in one building, in Dutch 'Meerdere disciplines Onder Een Dak') (Groenewegen & Hansen, 2007: 58; Wiegers et al., 34-38).

An important development in this context is the rapid rise of the after hours clinic (in Dutch 'Huisartsenpost', HAP). At the end of the nineties, the first HAP was founded. Before, it was common that the 24-hour accessibility of GP care was organized via mutual relieve of practices. The development of the HAP was an initiative of the GPs themselves because the ANW-services were more and more regarded as burdensome that often conflicted with the desired work-life balance. In the time span of a decade, HAPs have developed into full-grown institutions with a board, staff, and finance structure. In 2010, there were 131 local HAPs and nearly 98 percent of all GPs was affiliated to a HAP (Rijnierse et al., 2011: 7; Wiegers et al., 2011: 26, 34-35). In 2005, the average HAP served a population of 123,224 patients (Van den Berg et al., 2005: 28).

Cooperation within the primary care echelon, with HAPs as rapid development that especially catches the eye, is for an important part the result of changes in work preference. However, in this thesis I also regard it as token of economization particularly because it has a very strong consumer logic in it. Especially the HAPs serve to provide patients with a 24-hour service. Moreover, it also strengthens managerialism whereas more cooperation requires also more coordination, leading to the creation of management functions which are commonly outsourced (Wiegers et al., 2011: 27).

### ***3.2.5 Vertical organization: healthcare groups & multi-disciplinary care***

Compared to horizontal organization, the emphasis of vertical organization is less on cooperation between GPs themselves. Instead, it is overtly on multidisciplinary cooperation not solely within the primary care echelon, but also (to a relatively small extend) with the secondary echelon. Managed competition plays an important role in this context because although managed competition is not explicitly aimed at reorganizing primary healthcare, it does have important consequences for its organization. One of these consequences is a theme not to be missed these days: the development of multidisciplinary team care (in Dutch 'ketenzorg') (Wiegers et al., 2011: 27, 44 ff.). Basically, multidisciplinary team care is about different kinds of sequential care provided in a coordinated fashion by different healthcare providers. They together ensure a fluent care process (Wiegers et al., 2011: 40).

This cooperative way of providing care is organized via healthcare groups. A healthcare group is a regionally organized organization (consisting mostly out of primary care providers) that has legal status and that negotiates and signs contracts with health insurers. These contracts allow them to coordinate and implement the treatment of one or multiple kinds of chronic diseases in a specific region. The overarching aim is to improve quality by being more client-focussed and to provide care more efficient. There are approximately 100 healthcare groups in the Netherlands (Adviesgroep Ketenzorg, 2012).<sup>14</sup> We can distinguish between two kinds: a group in which healthcare providers remain autonomous, and a group in which the providers become part of the healthcare group (NZa, 2010: 15-17).

Even more than with horizontal organization, we can regard multidisciplinary team care organized via healthcare groups as a token of economization. Namely, this kind of care is part of the M&I-services discussed in paragraph 3.2.1, which is practically the most marketized part of GP care. Healthcare groups can negotiate with the health insurer about the way in which they set up their multidisciplinary care and about its reimbursement (see also NZa, 2010: 19 ff.). The patients (or 'clients'/'consumers') have been placed in a central position and multidisciplinary team care aims at improving quality by optimizing both care itself and service delivery. Nowadays, healthcare groups especially focus on diabetes care (cf. NMa/NZa, 2010: 7; LVG in Wiegers et al., 2011: 44).<sup>15</sup> This is directly followed by COPD and cardiovascular risk management. In all probability, elderly care and mental care will be added in the near future.

### 3.3 Conclusion

This thesis is about *economization* and the *professional identity* of GPs. In this chapter I have paid attention to the concept of economization and how it is related to GP care. As the first sub question asks:

1) *What is economization and what has it implied for Dutch GP care?*

In the literature, the pressures on professionals are well-documented. Exogenous pressures due to managerialism and societal developments and endogenous pressures coming from within professions themselves have changed the role of professionals and professional work in our society considerably. Economization takes in a special position with regard to these pressures: it is not something very tangible making it impossible to pinpoint an exact definition. Instead, it refers to the complex interplay of multiple managerial and societal pressures that put forward the logics of consumerism and managerialism.

Economization pressures also play an important role within the healthcare sector. Our current system can be characterized as a system of *managed competition*, especially since the radical

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<sup>14</sup> The supervisory bodies NMa and NZa worry that the formation of healthcare groups that cover entire regions brings along competition problems (NMa/NZa, 2010: 7; see also NZa, 2010).

<sup>15</sup> A very dynamic subtheme at the moment is the funding of multi-disciplinary team care. Especially the development of integral reimbursement evokes a lot of discussion. However, it is beyond the scope of this thesis to pay elaborate attention to the topic of multi-disciplinary team care (and its finance structure).

revision of the healthcare system in 2006 with the introduction of market dynamics. The medical professional that plays a pivotal role within our healthcare system is the GP. The GP can be regarded as the gatekeeper whose specialism is generalism. Citizens are obliged to be listed with a GP and as soon as a person has (non-emergent) health issues he can visit his GP. GPs can treat patients for all sorts of non-specialist problems and when they believe specialist care is required, they can write a referral. In essence, this role of GPs has not changed since the rise of economization. However, this does not mean that GP care remained completely unchanged. On the contrary, there have been many developments that have changed the organization of GP care considerably. In this thesis I focus on five of these developments that are prompted (partly) by a managerial and/or consumer logic or that have strengthened these logics a great deal. They do not form an exhaustive list, nor are they exclusively expressions of economization. That is why I call them *tokens of economization*.

The first is the revision of the remuneration system. Nowadays, GPs are financed via a mixed structure of capitation fees and fees for service. Moreover, the fees for treatments that are part of a certain segment – the M&I-services – are freely negotiable with health insurers. The HIS plays an important role in the reimbursement of costs. Then second is the development of a system of guidelines and indicators that serve to standardize GP care and to measure its performance. The third is the internal organization. Tasks are more often being delegated by a GP to high-educated support staff in order to optimize GP practices. The fourth is the horizontal organization. GPs are cooperating more often which has led to more group-practises and all kinds of partnerships within specific districts. The rise of the after hours clinic aimed at delivering 24-hour care is a very important development in this context. The last one is the vertical organization. Nowadays, multidisciplinary team care has become very prominent. This kind of integral care is provided via regionally formed healthcare groups consisting out of many different kinds of primary and secondary care providers.

# Chapter 4

## *The professional identity of GPs*

In this thesis, GPs are regarded as professionals that fulfil a certain role or function within our society. Both GPs themselves and society in general have expectations about the professional identity of GPs, or in other words, there are expectations about good work of GPs. In this sense, we can speak of a social contract between these two parties based on trust. We will first take a look at the scientific literature on *professions* in general in order to understand how our thinking about professionals has developed. Subsequently, I will turn to the *identity* concept followed by the more specific conception of *professional identity*. Afterwards, we will go into the *social contract* idea. *Trust* is a central notion in this context. From a social contract perspective, GPs have a certain *function within society* and we can speak of *expectations* about what the professional identity of GPs should look like. Basically, these are expectations about what good work in case of GPs is. In the last part of this chapter professional identity is being defined in terms of the literature on Good Work.

## 4.1 Professions

The roots of professions as we know them today lie in the nineteenth century. In those days the professions were important but stood outside the commercial and industrial heart of society. They were collegially organized. In the thirties these unusual occupations were first studied by Carr-Saunders and Wilson (1934, in Abbott, 1988: 3-4). In the past, the term 'professional' was only being used for a small group of high educated practitioners. Nowadays, the definition of the concept has been stretched to cover not only the traditional professional professions like physicians, or lawyers, but also to refer to nurses, teachers, policemen and others working in the (semi-)public sector (Jansen et al., 2009: 17). Already in the sixties Wilensky observed this trend resulting in his famous article 'the professionalization of everyone?' (1964). According to Wilensky there are two criteria that are distinctive for a profession. There has to be a technical base to the job, which is based on specific systematic knowledge unique to the profession acquired through long prescribed training. Secondly, the professional must adhere to certain professional norms in order to acquire the trust of the people (1964: 138-141). Wilensky states that a certain sequence of stages can be distinguished in order for a job to become a profession, ranging from doing the tasks of the job full time, to drafting an ethical code (1964: 142-146).

Wilensky's article focused on the specific features of professions. Dwarswaard classified his approach as the *characteristics approach* (2011: 21). However, ever since the sixties professions have been regarded in different ways. These different ways can be distinguished in several perspectives. Namely, the functionalist approach to regard professions, the power and control approach, and the revaluation approach (cf. Schepers, 1989 in Dwarswaard, 2011: 21 ff.). From a *functionalist* point of view, professions are being regarded as having a function within society. The professional is said to have a 'service ideal', meaning that he is assumed to act in the interest of his clients (Parsons, 1951 in Dwarswaard, 2011). The *power and control approach* regards professionals as potentially dangerous. From this perspective not the service ideal is the essential feature, but the fact that professions have the right to control their own work. According to Freidson, this places them into a dominant and autonomous position (Abbott, 1988: 5; cf. Trappenburg, 2011). More recently, the *revaluation approach* has become more popular. Again, Freidson plays an important role. He does not reject his

earlier critique on professional dominance and autonomy, but attaches greater value to the professional logic (Freidson, 2001; Dwarswaard, 2011: 27).<sup>16</sup>

In most handbooks on public administration authors embrace the idea that professionals share some distinct characteristics. First of all, they have a certain specialist knowledge. Furthermore, they have a certain ideology since they pursue a higher aim like health, justice, and intellectual development. Moreover, they are autonomous: a profession determines who may call himself a member, how the work needs to be distributed, and a profession can control and punish the professionals that do not meet the specific standards (Trappenburg, 2011). Professionals identify strongly with their profession and they share certain occupational ethics. This implies that they have occupationally bound rules to which they adhere. These rules provide guidance for how to act at a certain moment in time and what can, and what cannot, be regarded as responsible. Professionals are intensively schooled and trained. Moreover, their professional development does not simply stop after they have completed their education but continues throughout their career for example via post-educational training courses (Bovens, 't Hart, & Van Twist, 2007: 223-224; Rainey, 2009: 304-305).

This thesis does not only adhere to the basic characteristics approach but goes one step further by regarding professionals as having a role and function within society. The focus is on GPs and, as discussed in the second chapter, these professionals are generally regarded as the gatekeepers of our healthcare system. Consequently, they fulfil a crucial function within our social order. The relation between medical professionals like GPs and society is commonly defined in terms of a social contract between medicine and society. Therefore, this thesis fits within the functionalist approach.

## 4.2 Identity

The last twenty years, a lot of scholarly attention has been paid to the 'identity' concept. Not just sociology, but multiple disciplines like political science, economics and psychology – not to mention their individual subfields – contribute to an expanding literature on all sorts of identities, varying from ethnic, to religious identities, and from gender identity to identities in work settings (Abdelal, Herrera, Johnston & McDermott, 2009: 17; Swann Jr., Johnson, & Bosson, 2009). The dark side that comes along with all this intense interest on identity, is that it has undermined its conceptual clearness. Some even conclude that due to all this confusion, identity is a useless concept. Nevertheless, several reviews on identity provide useful ways to order research on identity. Here, one of these reviews will be considered.

Ashforth, Harrison and Corley emphasize that especially three conceptualizations of identity have been influential in the last two decades (2008: 327). The first is at micro level and is the most dominant one: the social identity theory, and the affiliated self-categorization theory (SIT/SCT). These theories define social identity as 'that *part* of an individual's self-concept which derives from his knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership' (Tajfel, 1978 in Ashforth et al., 2008: 327). Personal

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<sup>16</sup> We already came slightly across this stance in the footnotes while discussing the pressures on professionals.

identity on the other hand is 'a person's unique sense of self' (Postmes & Jetten, 2006 in Ashforth et al., 2008: 327). Social identities are about groups whose members share that identity and make distinguishing between groups possible. Personal identities on the other hand are unique and make distinguishing between individuals possible.

The second conceptualization is about roles. Identities do not so much depend on collectives, but on roles. It is called 'identity theory' and states that a person's 'identity is those parts of a self composed of the meanings that persons attach to the multiple roles they typically play in highly differentiated contemporary societies' (Stryker & Burke, 2000: Ashforth et al., 2008: 327). These roles are for example parent, worker etc. Each individual has multiple roles simultaneously. The theory focuses on the social embeddedness of roles in valued relational networks. The more valued a relationship, the more a person will consider the accompanying role identity to be of importance. Probably, the person will act in accordance with the valued identity (Burke & Reitzes, 1991 in Ashforth, et al., 2008: 327).

The final conceptualization is more on a collective level. It focuses on the identity of the organization. It is about the collective answer to the question 'Who are we as organization X?' Research has shown that there are strong linkages between organizational identity and for example strategic decision making. Moreover, it turns out that organizational identity is important for 'many key organizational variables at the individual level' (Corley et al., 2006 in Ashforth, et al. 2008: 328).

What do we learn from this overview? First of all, an important notion is that identity is simultaneously something individual and something collective. Ultimately, these two influence each other, whereas especially the perception of the collective dimension is important for the individual one (cf. Ashforth et al., 2008: 328).<sup>17</sup> The first conceptualization focuses on the individual side of identity. From this first notion it follows that it is a sense of *self*, but this sense is based on the collective to which one belongs. This collective can be a concrete group, but it is also possible that it is more an abstract notion like in the second conceptualization about roles. Apparently, the conception of one's role is vital for defining one's sense of self; one's identity. The third notion focuses not on the individual level, but on the other side of the identity coin, which is the collective level.

Ashforth et al. present these findings as three distinct notions. However, they are of course interlinked: in order for individuals to define their sense of self in terms of the collective (first conception), they first must have a clue of what the group identity actually is (third conception). And being part of this collective can bring along certain roles, which imply specific traits for their identity (second conception).<sup>18</sup> Whenever the individuals that together form a collective and fulfil roles share the same identity perceptions and articulate that identity in the same way, we can speak of a strong identity. So it is not just about the *content* of the identity as perceived by one individual, it is also

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<sup>17</sup> 'Identities are usually an amalgam of the perceived characteristics of the collective or role (e.g. values, goals beliefs) and the perceived prototypical characteristics of its members' (Ashforth et al., 2008: 328).

<sup>18</sup> Regarding the collective as determinant for the individual is within sociology often linked to Durkheim (e.g. Van Peperstraten, 2007: 188 ff.).

about *contestation* which is the degree of agreement about this content within a group (Abdelel et al., 2009: 18-19; see also Ashforth et al., 2008: 328). For this thesis, especially the group dimension is being regarded as meaningful whereas in medicine there is very little contestation about the group identity.

One final observation regarding the identity concept in general concerns its evolving nature. All scientific publications on the identity concept found, mention that identity is not something entirely fixed. Instead, *identity* is often defined in terms of *identity formation* (e.g. Anteby, 2008: 203; Beijaard et al., 2004: 107-108; Ryyänen, 2001: 24-31; Swann Jr. et al., 2009: 4). This does not mean that identity is something completely inconstant, but over time it can develop. For example, the answer a person in his twenties gives to the question 'who am I?' can differ from the one he will give when he is in his fifties (first conception). What it means to be a mother nowadays can differ from what it meant to be one a few decades ago (second conception). And organization X at time Y can regard itself differently at time Z (third conception).

### 4.3 Professional identity (of medical professionals)

The identity concept simultaneously has an individual and a collective dimension, which ultimately influence each other: individuals can define their sense of self based on the group to which they belong and the roles they fulfil, and the group consists out of individuals sharing a certain sense of sameness. We have seen that professionals share certain characteristics (see Bovens et al., 2007: 223-224; Rainey, 2009: 304-305; Trappenburg, 2011). Moreover, as we will see when discussing the social contract, professionals – like GPs – fulfil a function within our society. And whereas professionals identify strongly with their profession and professional group, they share a certain understanding of what it means to be such a professional; they share a *professional identity*. This kind of identity refers to the way in which individual professionals, professionals as a group, and society in general perceive their profession and their professional role ('who am I based on my profession?') (cf. Beijaard et al., 2004: 108). It is about 'the common 'badge' of [a] (...) particular profession' (Sims, 2011: 267). Professional identity relates to how people 'compare and differentiate themselves from other professional groups' (Adams, Hean, Sturgis & Clark, 2006: 56).

Based on Schein, Ibarra defines professional identity 'as the relatively stable and enduring constellation of attributes, beliefs, values, motives, and experiences in terms of which people define themselves in a professional role' (Ibarra, 1999: 765; Schein, 1978). This definition confirms the notion that identity is not something entirely fixed. Instead, it can develop over time. Nevertheless, it is relatively stable. The definition also appears to focus explicitly on the individual dimension but in the case of professions the group dimension is especially compelling. This refers to the earlier mentioned level of *contestation* which is the degree of agreement between members of a group about what the group identity entails (Abdelel et al., 2009: 18-19; see also Ashforth et al., 2008: 328). Together, professionals 'form a system that is more than the sum of its parts' (Hafferty & Castellani, 2011: 293).

The most ideal-typical profession is medicine (Trappenburg, 2011). Traditionally, there is very little contestation among medical professionals which makes medicine a 'strong profession'. Earlier we

spoke about characteristics shared by professionals in general. However, in the literature we can also find essentials specifically aimed at describing the medical profession (see also Trappenburg, 2011):

Medical professionalism involves 1) *specificity* (high levels of technical competence and long and intensive training), 2) *expertness* (in matters of health and disease), 3) *affective neutrality* (expectation to treat problems in objective, scientifically justifiable ways), 4) strong insistence on a *collectivity orientation* (collegiality), and 5) obligation to put *the patient's welfare above one's personal interests*. These make it possible for the physician to perform his function acceptably, to validate his professional authority, and to justify the privileges he is accorded (Parsons, 1951 in Rynänen, 2001: 33).

Especially the last sentence already shows there is some sort of social contract. Apparently, physicians – like GPs – are expected to abide by these essentials in order to be allowed to fulfil their special position.

#### 4.4 Social contract: trust in 'the other'

The relationship between medicine and society is best characterized in terms of a *social contract*. Contracts create obligations. A social contract refers to the idea that society is organized 'as if' there was a contract between citizens. Besides the law, there is no formal legal contract but it is about 'legitimate expectations', that is, the reciprocal rights and duties. In this case it is about a contract between medicine's professionalism – including GPs – and society (Cruess & Cruess, 2008; see also Caellegh, 2001; Coulehan, Williams, Van McCrary & Belling, 2003). It is based on the mutual *trust* that the other party will live up to these expectations (Davies, 1999 in Calnan & Sanford, 2004: 92; Sullivan, 2000: 673; Van der Schee, Braun, Calnan, Schnee & Groenewegen, 2007: 57). There are many definitions of trust. Despite many differences, they also share important similarities. Most of them emphasize 'the *optimistic* acceptance of a *vulnerable* situation in which the truster believes the trustee will *care* for the truster's interests' (Hall, Dugan, Zheng & Mishra, 2001: 615). The vulnerability element in this definition underlines that trust is especially necessary in contexts where there is uncertainty and risk, like in healthcare. Patients are highly reliant upon both the competence and the intentions of the practitioner (Calnan & Rowe, 2008a: 2). According to Hall et al., patients must accept this vulnerability optimistically. They must have positive expectations about their physician having the best interests at heart providing the right and best care for his patients (2001: 615-617).

Society has given medicine the possibility to have a strong autonomy, to be in a monopoly position when it comes to the use of medical knowledge, to have the freedom to regulate itself, and to make use of financial and nonfinancial rewards (Cruess & Cruess, 2008: 580). In this way, the medical profession has the 'authority to control key aspects of [the] market and working conditions [of physicians] through licensing and credentialling' (Sullivan, 2000: 673). The reciprocal nature of the social contract implies that society trusts medicine to do something in return. Before turning to these expectations, I shall first paint a more nuanced image of the social contract.

The social contract is not just between medicine and society. On medicine's side, the medical profession has both a group dimension and an individual one. The former is characterized by

medicine's institutions (e.g. professional associations) and the latter by the individual physicians. On society's side we can distinguish between the 'top down' and 'bottom-up' actors. With 'top down' I mean the government and the managers which have the legal authority to take binding decisions. With 'bottom-up' I mean the general public on group level and the patients on an individual level (cf. Calnan & Rowe, 2008a: 3). Based on Cruess and Cruess we can visualize the social contract between GPs and government and patients with figure 4.1. In line with Cruess and Cruess the managers are to be found on the society side, because in many cases they are not physicians themselves but policymakers. Nevertheless, I have placed them between brackets because in GP care there simply are not many managers.

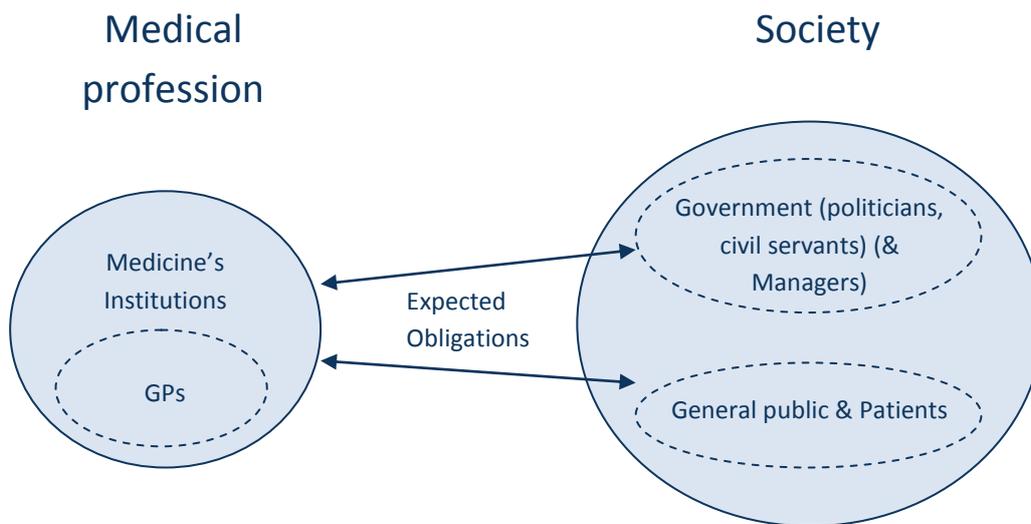


Figure 4.1 – The social contract between medicine and society (based on Cruess & Cruess 2008: 584)

In healthcare, 'the social contract (...) is a mixture of the implicit and the explicit, the unwritten and the written' (Cruess & Cruess, 2008: 583). Explicit are the laws that regulate the structure of the healthcare system, and thus among others the laws that have effectuated the system of managed competition. Furthermore, there are the ethic codes of conduct like the Hippocratic Oath or the physicians oaths of 1878 and 2003 (Dwarswaard, 2011: 3-5). However, implicit are the expectations we will turn to in the next paragraph.

#### 4.5 Expecting a professional identity

To conform yourself to the role of patient requires trust. Knowing that your physician has the knowledge and skills is insufficient. You also need to be convinced that the physician acts in your interest (Dwarswaard, 2011: 30). This automatically calls for safeguards against abuse of power like strong institutions (Anheier, 2005) and reliable self-regulation. Nevertheless, a social contract implies mutual expectations. In this thesis, I focus on the expectations both the medical profession and society have of GPs as medical professionals. In other words, it is about what GPs consider to be *their* role in relation to what societal parties consider to be the role of GPs. Naturally, these expectations are in line with each other, otherwise there would be no ground for a social contract. However, the social contract also works the other way around: GPs and society will have expectations about what the role is of society. This side of the 'social contract coin' is *not* the focus of this thesis. Nevertheless,

I cannot totally exclude it since a (social) contract has a reciprocal character. This means that whenever society changes its role, this can affect the role of GPs. This thesis tries to find out whether GPs have changed their expectation about their own role. In order to prevent a rough neglecting of the role of society, I will pay attention to it at the end of paragraph 4.5.2 by incorporating some elements as preconditions.

#### 4.5.1 Expectations

Earlier, professional identity has been defined ‘as the relatively stable and enduring constellation of attributes, beliefs, values, motives, and experiences in terms of which people define themselves in a professional role’ (Ibarra, 1999: 765; Schein, 1978). Having a functionalist perspective on the role medical professionals fulfil in our society due to the social contract implies there to be expectations about these attributes, beliefs, values, motives, and experiences that lead medical professionals – like GPs – to define themselves. In other words, they paint a picture of ‘the good GP’ and show what the professional identity GPs looks like. The expectations we can find in the literature of what among others GPs are expected to do and to be like, can be arranged along three lines: *excellence*, *ethics*, and *engagement*. First, I will go in to the expectations mentioned in the literature. Then I will order these expectations along the lines of the three dimensions.

Cruess and Cruess have formulated the expectations of medicine from society’s side both from the general public’s viewpoint and from government’s perspective (see table 4.1) (2008: 585-586).

Patients’/public’s expectations of medicine	Government’s expectations of medicine
To fulfil the role of healer	To assure the competence of physicians
To assure the competence of physicians	To show morality, integrity and honesty
To provide timely access to competent care	To comply with health care system (laws and regulations)
To have altruistic service	To be accountable (performance, productivity, and cost-effectiveness)
To show morality, integrity and honesty	To be transparent in decision-making and administration
To be trustworthy (codes of ethics)	To participate in team health care
To be accountable and transparent	To be a source of objective advice
To show respect for patient’s autonomy	To promote the public good
To be a source of objective advice	
To promote the public good	

Table 4.1 – The expectations the public and government have of medicine (Cruess & Cruess, 2008: 585-586)

More in general Cruess and Cruess emphasize the importance of *altruism*, in the sense that the interests of the patient should prevail over those of the physician, *commitment*, meaning that physicians are trusted to show empathy and dedication, and *independent professional judgement*, which is about the trust in technical competence (Cruess & Cruess, 2008: 583). Others have also formulated expectations. When we take a look at some of these, we see that they show great overlap. We already came across the description by Parsons that medical professionalism involves *specificity; expertness; affective neutrality; collectivity orientation; putting patient’s welfare above*

*one's personal interests* (1951 in Rynnänen, 2001: 33). Calnan and Rowe mention that trust in medicine (which underpins the social contract) occurs mainly due to expectations about the expertise of medical professionals and due to an influence of an 'affective component' (2008b: 61). The former is about trust in competence, and the latter is especially about trust in intention (Calnan & Rowe, 2008b: 62). Dwarswaard is inclined to emphasize the affective component by stressing the necessity that a patient must have the belief that a physician will always act in the patient's interest (2011: 30; see also Calnan & Rowe, 2008b: 61; Sullivan, 2000: 673). Van den Brink underlines that professionals in general have their work as main object of devotion, showing a great personal involvement (2012: 85-86). Almost all these expectations can be reduced to merely three core ones: GPs are expected to be excellent, ethical and engaged.

GPs are expected to fulfil the role of the healer who is an expert with specific knowledge (technical expertise) and high competence. Maintaining high standards of competency is expected to be guaranteed via professional self-regulation. All physicians must be transparent about their actions and decisions and they must be accountable for them. In other words, society and the medical professionals themselves want the jobs of GPs to be done technically *excellent*. This is the first line of expectations. The second is made up out of the expectations that concern the affective component. GPs are expected to deliver their services in a morally responsible, integer, and honest way and must be trustworthy. They must always act altruistically in the interest of their patients, providing them with objective advice and treating them in objective, scientifically justifiable ways. Moreover, they are expected to be transparent in their actions and accountable about them. In other words, society and medical professionals themselves want the jobs of GPs to be carried out in an *ethical way*. The third line of expectations also has an affective character. GPs are personally expected to have their work as main object of devotion. They should be very committed showing empathy for and dedication to their patients. They are expected to promote the public good. Moreover, they should have a strong sense of collegiality, implying a focus on the group dimension. In other words, society and medical professionals themselves expect GPs to be personally *engaged* with their profession and patients.

#### **4.5.2 Good Work & preconditions**

As discussed in the last paragraph, the literature of Cruess and Cruess offers important insights into the social contract between medicine and society and about the mutual expectations that come along with it. In order to prevent one-sidedness, I have paid concise attention to expectations formulated by other authors as well. As I have done in the last paragraph, it turns out that all expectations on medical professionals can be divided into three 'categories' that perfectly match the three considerations that together constitute Good Work. '1) It is technically Excellent; 2) it is personally meaningful or Engaging; 3) it is carried out in an Ethical way' (Barendsen, Csikszentmihalyi, Damon, Davis, Fischman, Gardner, James, Knoop, Nakamura & Verducci, 2011: 5; see also Gardner, Csikszentmihalyi & Damon, 2002). The specific answers to the questions evoked by the three elements of Good Work – What is technically excellent? When are you considered to be personally engaged? And when is the work carried out ethically? – together constitute a relatively stable image of what it takes and means to be a good GP. In the words of the definition of professional identity of Ibarra: they provide beliefs, values, motives and ways to cope with experiences for professionals in

order to be good GPs. One element of Ibarra’s definition remains uncovered: the attributes. She gives no clue about what she actually means by this. Is it about artefacts? Is it about features and characteristics? Or if I stretch it even further, is it about the essentials that are attributed to the profession? This last conception allows us to incorporate elements of the other side of the ‘social contract coin’ to which I shall now turn.

The focus of this thesis is on what GPs consider to be their professional identity and whether this has changed due to the modern economic environment. As already mentioned at the start of paragraph 4.5, these expectations of GPs about GPs are equal to the expectations society has of GPs. Otherwise, when expectations deviate there would be no such thing as a social contract. However, this is not the whole story. The ‘social contract coin’ also has another side: GPs and society will have expectations about what the role is of society itself. Again, these expectations are in line with each other. If these different perceptions of what good work is for GPs are not aligned, there would not only be no social contract and good work would not even be possible at all (Gardner, Csikszentmihalyi, Damon, 2010: 54 ff.). Based on figure 4.1 we can draw the callouts in figure 4.2 that visualize the above. The callouts represent the expectations the medicine and society have of themselves and of each other.

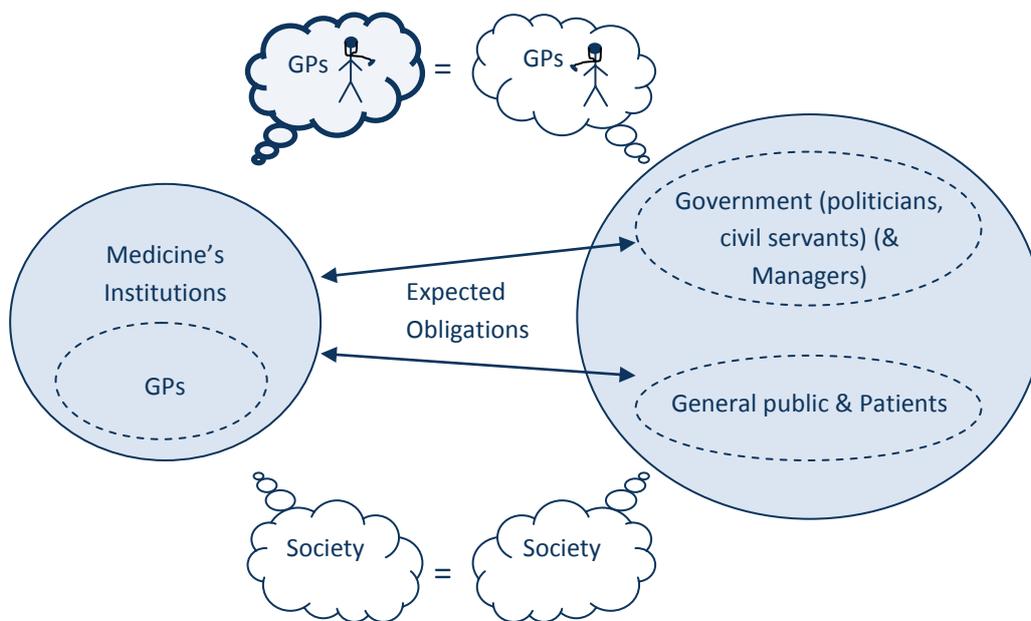


Figure 4.2 – The social contract between medicine and society: expecting a professional identity

The focus of this thesis is *not* on the callouts that visualize the expectations about society but on the left-upper callout that is about GPs in the eyes of the GPs themselves. However, I cannot exclude in advance that changes in the expectations about society’s role affect the expectations about the professional identity of GPs. For example, if a societal development like individualization (as discussed in paragraph 3.1.1) results in patients adopting a customer attitude, this could affect the status ascribed to the GP. As a result, the GP could reformulate his role as being more of a service provider than of an authority. Consequently, the expectations about society cannot simply be neglected. Instead, I will take them into consideration but since this research is not about the change of society’s role I will consider only several elements as preconditions for good work by GPs to occur.

With regard to the professional identity definition of Ibarra, I am talking about the essentials that are attributed to the GP profession.

Based on medicine's expectations of both patients/public and government formulated by Cruess and Cruess there are several factors that are relevant as preconditions (2008: 585-586). The first is autonomy. Society is expected to grant medical professionals like GPs the room to exercise judgement. Furthermore, there are the nonfinancial rewards respect and status which are intertwined. Respect is especially about the way in which the contact between patient and physician goes and status is about the ascribed position of the physician compared to that of the patient. In addition, there are the financial reward which is the money medical professionals earn: they expect to be granted a good living due to the investment they made for their long (expensive) training and the responsible work they do. Finally, they expect to play a role in the development of health policy. These preconditions are not only to be found with Cruess and Cruess. Together, good work and the preconditions form the conceptualization of professional identity (see figure 4.3).



Figure 4.3 – Conceptualizing Professional Identity: Good Work as the core

#### 4.6 Excellence, Ethics and Engagement of GPs

The preconditions are quite straightforward. The good work elements on the other hand could use further attention. When we speak of excellent work, we mean 'work that is high in quality and technically sound; it meets or exceeds standards by which other work is judged' (Fischman & Barendsen, 2010: 31). For this thesis, the content of the technical excellence of the work of GPs is assumed. Since I am not a medical professional myself, I cannot judge what is technically excellent and what is not. Consequently, I shall pay as little attention as possible to specific treatments and the like. However, a characteristic of professions is that the professionals and professional institutions

together determine the standards making it possible to focus on the interprofessional perception of technical excellence. Higher quality is one of the explicit aims of managed competition (Van de Ven et al., 2009: 26), that in this thesis is regarded as part of a wider trend of economization (see also WRR, 2012: 118). The expectation is that more competition among medical professionals, including GPs, will be an incentive for them to innovate, modernise and learn in order to stay competitive. Nevertheless, nowhere in the literature the technical excellence of Dutch GPs has been disputed in relation to an increase in economization and the introduction of managed competition. In other words, there are no clues that the 'know-how' of Dutch GPs has diminished or improved substantially. Therefore, the attention paid to 'excellence' during the research for this thesis will be modest compared to the attention paid to ethics and engagement.

Ethics is not about what *is* but what *ought to be* (Aultman, 2006: 130). With regard to medicine, it offers a 'coherent approach for guiding beliefs and actions and for resolving moral conflict' (Aultman, 2006: 132). This moral conflict can be understood in terms of experiencing friction between competing responsibilities (see also Fischman & Barendsen, 2010: 10). Consequently, ethics can be defined as 'social responsibility – being responsible for the impact that work, behaviour, decisions, and products can have on others' (Fischman & Barendsen, 2010: 67). Although it is up to individual physicians to apply the professional ethics in their daily activities, to a great extent all medical professionals share it because of the strong group dimension. Fischman and Barendsen distinguish between five major 'rings of responsibility'. Starting from the core, they are responsibility to the *self*, to *others*, to the *workplace*, to the *domain or profession* and to *society*. The 'others' include family, peers, and colleagues (Fischman & Barendsen, 2010: 10).

The 'rings of responsibility'-model is not perfectly apt for this thesis. The ring *others* that includes colleagues and peers strongly overlaps with the rings *workplace* and *domain*. For example, nowadays in the Netherlands GPs often work in group practices with other GPs. In this case, the three rings become almost the same. Moreover, in general the model regards *profession/domain* as the fourth ring. However, due to the strong group dimension of the professional identity of GPs the *profession/domain* is a ring of responsibility that should be closer to the *self*. Furthermore, the profession consists out of colleagues that can be regarded as *others*. So for this thesis I focus on the *self*, the *other* which is both the *patient* and the *colleague GP*, and *society*. Despite the *self* which is not included in the research of Dwarswaard, this is in accordance with her focus on three relations to which ethics in medicine relates. Namely, between physicians and patients, between physicians, and between physicians and society in general (2011: 7).

Engagement can be regarded as an important precondition for carrying out excellent and ethical work (Fischman & Barendsen, 2010: 107). It is about what people drives to care about their work. What makes them interested in and attracted to their work? This can be very personal and it can differ per individual.

Nevertheless, '[i]ndividuals need to care about the work they are doing and they need to find it personally meaningful to them in some way, in order to spend the time and energy it requires to produce work that is high quality and has a positive impact on others' (Fischman & Barendsen, 2010: 107).

As we have seen, professionals in general show great personal involvement with and devotion to their work (Van den Brink, 2012: 85-86). Fischman and Barendsen mention that once entering the 'actual working world' certain pressures often cause people to deviate from their early interests (2010: 107). Also during one's career pressures can cause a person's enjoyment of work to be tempered. In order to come to grips with engagement, this thesis aims to find out what GPs initially attracted to their vocation and whether this has changed over time due to economization.

## 4.7 Conclusion

In this chapter, I have conceptualized *professional identity* of GPs which is after *economization* the second central concept of this thesis. This forms the answer to the second sub question:

### 2) *How can we conceptualize the professional identity of GPs?*

As we have seen, professions and professionals can be regarded from multiple perspectives. In the literature and also in this thesis GPs are considered to be the gatekeepers of the Dutch healthcare system. Consequently, this thesis adopts a functionalist perspective whereas GPs are granted the position to play a key role in our healthcare system. The relation between GPs and society can be expressed in terms of a social contract. This social contract holds mutual expectations of both GPs and citizens. These expectations are mainly about the professional identity of GPs. Professional identity is 'the relatively stable and enduring constellation of attributes, beliefs, values, motives, and experiences in terms of which people define themselves in a professional role' (Ibarra, 1999: 765; Schein, 1978). Identity in general is simultaneously something individual and something collective. Within medicine, there is relatively little contestation among medical professionals like GPs about their professional identity implying a strong group dimension.

It is trust that underpins the social contract. GPs are trusted to meet expectations about the attributes, beliefs, values, motives, and experiences that lead medical professionals like GPs to define themselves. These expectations can be arranged along three lines: *excellence*, *ethics*, and *engagement*. GPs are expected to be highly competent. They are expected to deliver their services in a morally responsible way. In addition, they are expected to be very committed. It are exactly these three elements that constitute *good work* and due to the reciprocal nature of the social contract these expectations are shared both by GPs themselves and by society. By focussing on the expectations about good GP work, this thesis focuses on medicine's side of the social contract. It is beyond its scope to focus elaborately on society's side as well. However, it is only possible for GPs to realize the expectations about good GP work when society itself lives up to specific expectations as well. I cannot simply ignore these but instead I will consider several elements as preconditions for good work by GPs to occur. These preconditions are autonomy, respect and status, financial rewards, and the role GPs play in the development of health policy. Together, the three elements of good work (excellence, ethics & engagement and the preconditions form the conceptualization of professional identity.

# Chapter 5

## *Providing GP care in an economized world*

This chapter must be regarded as a short addition to the last two chapters. The main question of this study foremost focuses on the *effects of economization on the professional identity of GPs*. The second part of the question asks how we can *understand these possible effects*. For this second part, I want to add one important ‘dimension’ based on literature, which turned out to be useful during the analysis. As will be argued in chapter 6, this study has a qualitative approach. An important asset of such an approach is to stay as ‘open minded’ as possible. Nevertheless, as in the same chapter will be argued, this does not imply a complete exclusion of theory. Among others, literature can serve to enhance insight into the object under study during the data analysis (Tummers, & Karsten, 2012: 77). Consequently, in this chapter, I will bring together the two concepts discussed in the last two chapters – economization and professional identity of GPs – based on an insight from the literature gained during the data analysis.<sup>19</sup> In this chapter First, I will pay attention to the general debate on the tension between economic and professional values. Second, with an eye on scientific literature about identity and professionals, I will offer a rather unrefined schedule by distinguishing three possible reactions GPs can have to economization.

## 5.1 Profession & profit

The title of this paragraph is borrowed from Putters who wrote an elaborate study on necessity of support for the introduction of market incentives in the healthcare sector a few years before the system reform in 2006 (2002). The reason for him and many others to study the increase of an economic logic within healthcare has to do with expected conflicts between professional values and profit-driven service delivery (Putters, 2002: 27). Important professional values like ‘the expertise of doctors, the trust relation with patients and the professional autonomous position in the healthcare system’ can be at odds with economic values like ‘making profit, responsivity, demand-orientation, commercialism’ (Putters, 2002: 27). It is the debate between moral and market (see also WRR, 2012: 59). Or in the words of Dwarswaard et al., ‘[i]ntroducing consumerism or managerialism (or both) may threaten ‘the soul of professionalism’ (2011: 389; see also Freidson, 2001; Kuhlmann & Saks, 2008: 4-5). What exactly is this ‘threat’?

According to Hilhorst, two key values for the functioning of our healthcare system are put at stake by economization (2004: 11). The first is trust. As I have discussed in chapter 4, trust is the fundament of the relation between patient and care provider. The patient is in a vulnerable position. We can speak of an information-asymmetry since ‘GPs have more information about diseases, diagnostic possibilities and treatment effects than patients’ (Van Dijk, 2012: 17). Due to the important position of the GP in our Dutch healthcare system, patients depend highly upon the GP’s judgement for receiving care (Van Dijk, 2012: 173). The patient is the truster who has to believe that the GP as trustee will care for his interests (Hall et al., 2001: 615). GPs are in a powerful position. What will happen if money incentives lure the GP to abuse his power for his own good? This would imply a complete undermining of the trust relationship between GP and patient. The other value is ‘professional standard’, which more or less comes down to quality. Quality and costs are weighted

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<sup>19</sup> As I will argue in chapter 6, this thesis is a report of the entire study, not a complete chronologic overview of the research process.

against each other. It is feared that choosing one will go at expense of the other. Professional standards will show more variety (Hilhorst, 2004: 71).

In line with the debate mentioned above, this thesis assumes a tension between an economic logic and professional logic. What can we expect when it comes to the professional identity of GPs?

## 5.2 GPs' reactions

Thinking about how GPs might react to economization, there are two extremes possible: the professional identity of GPs does change or does not change. However, the discussion on ethics from the last chapter adds at least one important insight: ethics is not about what *is* but what *ought to be* (Aultman, 2006: 130). When I apply this on professional identity in general, there might be a distinction to be made between concrete actions of GPs (what *is*) and how GPs ideally should act (what *ought to be*). Again, there are two extremes. A GP's actions can follow the economization tendency within our society. In doing so, the economic values mentioned in the last paragraph – making profit, responsivity, demand-orientation, commercialism – gain importance. Or a GP's actions do not follow the economization tendency. Combining these two 'dimensions', we get a rough sketch that offers three categories. If a GP's actions are in line with economization, and his professional identity has changed, there is a certain *adaptation* to economization. If a GP's actions are in line with economization, but his professional identity is in line with a professional logic, there is a tension. In this sense, a GP's actions *alienate* from his identity. If a GP's actions are not in line with the economizing environment, and his professional identity is in line with a professional logic, there is a certain *resistance*.

Put more simply, the environment has become more 'A'. I speak of *adaptation* when a GP acts in accordance with 'A', and thinks in accordance with 'A'. I label it as *alienation* when a GP acts in accordance with 'A', but thinks in accordance with 'B'. Finally, if a GP acts in accordance with 'B' and thinks in accordance with 'B', I call it *resistance*. These categories are visualized in table 5.1.<sup>20</sup>

	Adaptation	Alienation	Resistance
<i>Acting in line with economization</i>	Yes	Yes	No
<i>Professional identity in line with professional logic</i>	Yes	No	No

Table 5.1 – Continuum of GPs possible reactions to economization in relation to their professional identity

This rough sketch of three 'ideal types' offers a hold to understand the possible effects of economization on the professional identity of GPs. Next, I will pay attention to the literature that underpins adaptation, alienation and resistance.

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<sup>20</sup> On purpose, I excluded the option of a changed professional identity and an unchanged way of acting. As follows from the literature on identity, identity and environment influence each other via actions (Ashfort et al., 2008). When environment and identity are aligned, there is no realistic reason to assume that a person would act consistently otherwise.

In chapter 4, I mentioned identity to be a process rather than a fixed fact. Identity in general, and thus professional identity as well, is an ongoing process influenced by situations and relations.<sup>21</sup> According to Adams et al., professional identity develops over time and is about constantly improving insight into professional practices (2006:56; Schein, 1978). Situation demands can lead persons to change aspects of one's professional identity markedly (Ibarra, 1999: 765). It is not a process in which the individual simply conforms himself to the new situation. Instead, it is a process of negotiated adaptation. Via this process, individuals 'strive to improve the fit between themselves and their work environment' (Ibarra, 1999: 765; see also Schein, 1978; Swann Jr. et al., 2009). Working in an economized environment (i.e. an environment that has a strong managerial and consumer logic) can lead a GP to adapt his professional identity to match this environment. According to Ashfort et al., this *adaptation* happens via actions: an individual starts to act in line with a certain identity and slowly the person's identity changes (2008: 340).

As discussed in chapter 4, professionals have a certain specialist knowledge and pursue a higher aim like health, justice, and intellectual development. Professionals identify strongly with their profession and they share certain occupational ethics. Sometimes professionals have to implement policy programs they have great difficulty to identify themselves with. Tummers writes '[r]esearch shows that public professionals are experiencing increasing pressure as they have to consider several output performance norms which often conflict with their own professional standards or with the demands of increasingly empowered clients' (2012: 65). In this case, professionals are trapped between what they actually would want to do and what they actually have to do. More general, policy alienation can be defined as 'a general cognitive state of psychological disconnection from the policy programme to be implemented, by a public professional who, on a regular basis, interacts directly with clients' (Tummers, 2012: 14). Policy alienation is local in the sense that it focuses on one particular policy. Furthermore, it is subjective since it is about the experiences of professionals themselves with the policy (Tummers, 2012: 120). This 'policy' can be defined as referring to 'the binding allocation of values, for society as a whole, in a situation of structural scarcity due, for example, to a lack of financial or natural resources' (Tummers, 2012: 67 based on Easton, 1965). *Alienation* has important negative consequences. It influences the effectiveness of policy programmes, just as the quality of the interaction between professionals and their clients/citizens. Eventually, this can have an impact on the output legitimacy of the government (Tummers, 2012: 65).<sup>22</sup>

Traditionally, Dutch GPs are self-employed. Even when they work in a group-practice, they rarely have an hierarchical superior. I have found no literature that explicitly describes resistance to change

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<sup>21</sup> When we refer to this process in the light of a broader collective, the scientific literature commonly uses the concept of organizational identification (or in negative terms identity disidentification) (e.g. Edwards, 2005).

<sup>22</sup> Subsequently, Tummers has developed a framework for the policy alienation concept by distinguishing between two dimensions: policy powerlessness and policy meaninglessness. The former refers to the perceived influence professionals have over the policy being implemented (Tummers, 2012: 120-122). It is beyond the scope of this thesis to pay close attention to the details of the policy alienation concept of Tummers. Here, the overarching idea is central: professionals experiencing a discrepancy between what they have to do and what they want to do as a professional.

by professionals that do not work in an organization with a distinct management. Nevertheless, within the context of medicine we do come across literature underlining the widespread notion that (medical) professionals are very reluctant when it comes to change (Noordegraaf, 2011a: 1350; see also Bloom, 1989). As Noordegraaf mentions, professionals are often said to resist control by managers who are 'are seen as the carriers of neo-liberal reform and organizational control' (2011a: 1350). In this thesis, *resistance* occurs when GPs refuse to act and think in line with the way in which their environment has changed, namely in line with managerialism and consumerism.

### 5.3 Conclusion

In this short chapter, I have brought together economization and professional identity of GPs. The main focus of this study is to find out whether and how the former has affected the latter. Basically, there are two options: GPs have adapted their professional identity, or they did not. However, reality is not always as it should be. Doing and thinking are two different dimensions that can differ. What if a GP has not changed his understanding of his professional identity but did change his actions? Together, these two dimensions provide an answer to the third subquestion:

3) *How can GPs theoretically react to economization?*

They create a small continuum with three possible stances that can help to interpret the results presented in chapter 7: adaptation, alienation and resistance.

# Chapter 6

## *Research design*

This study aims to find out whether and how economization has affected the professional identity of GPs. In this chapter, I will pay attention to the research strategy I have used to answer the questions above. Firstly, I will discuss the research perspective I adhere to in this study. This perspective 'guides' the choice for the subsequent research strategy. Secondly, I will pay attention to the data collection. This consists out of the respondent selection and the method that is applied: the semi-structured interview. Finally, I will focus on the data analysis.

## 6.1 Scientific perspective: an interpretative approach

The environment of GPs care is complex and dynamic: many organizations seem to play a role and over the past few decades, the healthcare system has been confronted with societal transformations and many policy changes. On top of that, there is a lot of diversity between GP practices. Some are solo-practices, others are health centres or group-practices. Some are located in a city, others in rural area. Some GP practices are very progressive, others are quite conservative. To this list, many other elements can be added. Due to these differences, it might very well be that GPs do not experience the effects of economization equally. Moreover, each of them can have his own reading of reality leading to differing perceptions. In chapter 4, I have argued that professional identity of GPs has a strong group dimension. Nevertheless, in the same chapter it is mentioned that identity is simultaneously also individual, which should not be neglected. Furthermore, identity is not something fixed but it can develop over time.

All these factors mentioned above – and without a doubt many more – contribute to a complex, dynamic and diverse reality. This study has an explorative nature since it wants to find out whether and how economization has affected the professional identity of GPs. Exploring a complex reality that can be perceived differently requires a research approach that is open to multiple perspectives. For this study, GPs' subjective perceptions of values and contexts are important. Consequently, this research belongs to the interpretative tradition (see Coghlan & Brannick, 2010: 41 ff.; Flyvbjerg, 2001: 42-43; Morgan & Smircich, 1980: 494 ff.; Van Thiel, 2007: 41 ff.). We cannot simply predict the reaction(s) of GPs to economization. If we want to understand whether, how and why GPs' professional identity is being affected by economization, we must look at their perceptions of their context and their more intrinsic and personal motives (cf. Van Peperstraten, 2007: 225). We will have to focus on how they experience economization and on the meaning they attach to it (Van Thiel, 2007: 41). In other words, we must look at their interpretations.

The assumptions presented above do not imply a total disconnection from already existing theory. In this study, I will use theory in a deductive way. '[A]n existing theory can form the guideline in a research; the researcher has a model of the examined situation and knows what variables, conditions and mechanisms he must look for' (Van Thiel, 2007: 41 [translated from Dutch]). I use the theoretical framework to study the responses of GPs' professional identity. The literature thus provides a 'skeleton framework' for the empirical part (Boeije, 2010: 23; see also Tummers & Karsten, 2012: 79).

A qualitative design matches this interpretative approach best. It offers room to enter the research field with an open mind to consider contextual factors and to pay attention to unforeseen circumstances and insights. Despite that some insights from the literature on case studies will be

used, the empirical part is not a case study (Yin, 2009; see also Seawright & Gerring, 2008; Stake, 1998). A case is a 'bounded system' (Smith, 1978 in Stake, 1998: 87). In this thesis, I will not just look at one or two GPs considering all possible relevant factors. Instead, I will focus on the *professional identity of GPs* in relation to *economization* by many more GPs. In other words, I do not study everything about some cases, but I study something (economization affecting professional identity) in many more cases. How many exactly depends upon when the point of *saturation* is reached. This means that data collection can stop as soon as newly selected cases do not provide new information (Boeije, 2005: 52). For this research, twenty-two GPs were needed to reach this point.

Despite many advantages, a qualitative study also has important weaknesses. It is good to be aware of these drawbacks. One of the most important ones is what Giddens calls 'double hermeneutic' (Flyvbjerg, 2001: 32-33): it brings along that the researcher will have to interpret the interpretation of the GPs. Moreover, the GPs who are object of study will also change due to their interpretations of their interaction with the researcher. Furthermore, reliability and validity are much less unambiguous compared to a quantitative approach. After all, to a great extent the analysis takes place in the mind of the researcher (Van Thiel, 2007: 165). As Van Thiel mentions, qualitative research often does not use the discourse of 'validity' and 'reliability'. Instead, researchers speak in terms of 'traceability of analysis' which is related to reliability, 'transmissibility' which is related to external validity, and 'plausibility of conclusions' which is related to internal validity (Van Thiel, 2007: 165; see also Yin, 2009: 40 ff.). From a quantitative perspective, qualitative research will always be crippled. Nevertheless, if we consider qualitative research on its own merits, there are definitely possibilities to improve the three elements mentioned above.

In order to improve the traceability of analysis, I will document the choices I have made and the considerations I had during this study in this chapter. This report in its entirety is not completely parallel to the chronological order of the research process. That is why in the next paragraphs attention will be paid to the sequential steps of data collection and analysis. As will be discussed over there as well, Van Thiel advises to use a computer programme to analyze the qualitative data (2007: 166). For this study, I have used the analysis programme NVivo (see also Bazeley, 2007). Transmissibility is the more appropriate term for what is known as generalization in quantitative research. For this thesis, twenty-two GPs were interviewed (and five experts). In total there are at least 9,891 active Dutch GPs. It is perfectly clear that whatever results this study shows, there is practically no statistical generalization. Instead, this study aims more at analytic generalization. In this sense, it strives for to find a particular set of general results that can contribute to broader theory (Yin, 2009: 43).<sup>23</sup> Consulting experts and using a member check can be very valuable for examining the plausibility of conclusions (Van Thiel, 2007: 165-167). For this study, I have consulted experts before *and* after the data collection (cf. De Graaf, 2007: 62). Moreover, during the last ten

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<sup>23</sup> 'Theory' from a more subjectivist stance does not imply laws as fixed regularities because that would require an exclusion of context. '[A] social science theory of the kind which imitates the natural sciences, that is, a theory which makes possible explanation and prediction, requires that the concrete context of everyday human activity be excluded, but this very exclusion of context makes explanation and prediction impossible' (Flyvbjerg, 2001: 39-40).

interviews I have shared my preliminary impressions, ideas (and codes) with the respondents after I had finished the topic list (see appendix II).

## 6.2 Data collection

Collecting the right data is of course a crucial precondition for reaching the aim of this study. Since the focus is on the professional identity experienced by GPs, it was most appropriate to interview GPs themselves in order to get to know their interpretations and contexts. Interviews are often used in qualitative studies (see Boeije, 2010; Van Thiel, 2007). In this paragraph, I will pay attention to the respondent selection and to the way in which the interviews were conducted.

### 6.2.1 Respondent selection

With 9,891 active GPs in the Netherlands, who should be interviewed? Two considerations played an important role in the respondent selection: a practical one and a theoretical one. The practical consideration was to find enough GPs to interview in the first place. It turned out that this was highly problematic. In the Netherlands, a system of *triage* is operational, which means that whenever you call or email a GP practice you will automatically be in contact with the assistant. Assistants usually are instructed to keep off everything that has nothing to do with patient care. Moreover, the national and regional departments of the professional association LHV, the scientific association NHG, and the after hours clinic in Tilburg were unwilling to bring me into contact with their members due to the overwhelming amount of requests from scholars. One of them did offer the opportunity to place a small recruitment text in their newsletter but there were no reactions.

Consequently, it seemed as if I completely depended upon the help of family, friends, colleagues and acquaintances. Eventually, I reached a breakthrough with the help of two organizations and several scholars of Tranzo, that allowed me to write to their GP network. The first organization was CAPHRI, School for Public Health and Primary Care which is part of Maastricht UMC+. The second was the Professional Pride Foundation. Moreover, via ‘snowball sampling’ I also found several respondents. Table 6.1 offers an overview of the number of respondents I have found via the different networks.

Network	Number of respondents (GPs)
CAPHRI	6
Professional Pride Foundation	4
Tranzo	4
Friends/family	4
‘Snowball sampling’	2
Others	2

Table 6.1 – The different networks and respondents

Eventually, I was in the luxurious position to be more critical to the selection of respondents based on more theoretical grounds. More or less in line with Dwarswaard, three characteristics seemed to be important: gender, age and kind of practice (2011: 50-52). Accordingly, I have tried to find a diverse group of GPs in order to make the exploration as broad as possible. Note well, as mentioned before, this does *not* imply that results of this study can be statistically generalized to the entire GP population. However, it does allow more perceptions to be incorporated in this qualitative study.

Table 6.2 offers an overview of the characteristics of the respondents. Since this thesis aims at finding out whether economization has affected the professional identity of GPs, a strong representation of GPs who might have experienced the increase in economic logic in environment is suited (cf. Dwarswaard, 2011: 50).

Characteristic	Number of respondents (GPs)
M: Male	13
F: Femele	9
Y: Aged between 25 and 40	6
M: Aged between 40 and 55	5
O: Aged 55 and older	11
S: Solo-practice	4
G: Group-practice	8
H: Health centre	7
W: Hires o.s. out as GP	2

Table 6.2 – Overview respondents (GPs) (n=22)

All the respondents received an email in which I introduced myself and explained the aim of this study. Moreover, I provided information on what the interview should be like. This letter can be found in the appendix (I). In case of no response, I send a reminder after exactly one week. In advance, it was unclear how many GPs had to be interviewed to reach the ‘point of saturation’. This point was reached after interviewing nineteen GPs.

The five respondents were contacted based on content considerations. Beforehand, I knew relatively little about GP care and the discussions the present-day discussions within the profession. For that purpose, I spoke to emeritus Prof. C. Spreeuwenberg (former GP and expert on integrated care for chronically ill) and Mr. J.E. de Wildt (director of the umbrella organization De ondernemende Huisarts). Moreover, I had relatively little knowledge on ethics. In order to find more starting points for literature on ethical dilemmas I spoke to Mr. F. Vosmans (scholar among others on medical ethics). During the research process, I also wanted to know more about ‘the other side of the story’, which is the side of a health insurer and a cooperation that has introduced a franchise concept into GP care. That is why I interviewed Mr. R. Jorna (former GP and medical advisor at health insurer Menzis on quality of primary care) and Mr. G.J. ter Braak (former GP and director of franchise health centres Zorgpunt). After the data collection and analysis, I had some minor questions on the remuneration system of GPs left, and I wanted to check the plausibility of my conclusions. For this purpose I consulted Prof. D. De Bakker (expert on the structure and organization of primary Healthcare). More information on the respondents can be found in the appendix (IV).

### 6.2.2 Interviews (& focus group)

The interviews I conducted for this study were all semi-structured. In such an interview, both the questions and the answers are not fixed from the outset. Other possibilities are closed interviews (both the questions and the possible answers are fixed, e.g. a survey) and open interviews (only the first question/topic is being formulated). The semi-structured interview technique forms an intermediate variant (Baarda, De Goede & Van der Meer-Middelburg, 2007). The questions/topics for

the interviews were derived from the theoretical framework and the expert interviews. A semi-structured interview offers the possibility to change the order of the topics if an interview gives rise to that (Baarda et al., 2007: 16). These kind of interviews also offers the possibility to deviate from the topic list in the sense that when during the conversation something interesting pops up new questions can be asked. It is not per se clear in advance in which order the topics will be discussed. However, it is obliged to pay attention to all the topics in order to have some consistency between the different interviews. The topic list I used to interview the GPs can be found in the appendix (II). Although I used the same topic list for the expert interviews, these conversations were more open.

Talking about quality of work, ethical behaviour and commitment is very personal. Social desirable answers formed a sincere threat that could undermine the legitimacy of this study. In order to offset this problem as much as possible, I used a technique from the Good Work project by consistently focussing on the 'abstract colleague' at first and then turning to the 'self' (Fischman & Barendsen, 2010: 13). Although it is impossible to check whether this technique has excluded social desirability, it was striking to notice that some respondents started the interview by saying they followed the rules. After talking about exceptional cases in which colleague GPs clearly did not, several respondents mentioned that they themselves were facing similar dilemmas and did not disadvantage themselves as well.<sup>24</sup>

Seventeen interviews were held face-to-face in order to have greater recognition of contextuality that is assigned a central role in this study. Two interviews were held telephonic. Three respondents were interviewed simultaneously as a small focus group. In a such a focus group, interaction between respondents is allowed. These three respondents were direct colleagues working in the same health centre. The total interview length of the interviews with the respondents is 24 hours and 51 minutes, which implies approximately 1 hour and 10 minutes per conversation (note well, the focus group with three respondents is counted as one conversation). Three expert interviews were also held face-to-face. The other respondents I interviewed by telephone. All interviews were recorded, and all respondents was guaranteed strict confidentiality and anonymity. In other words, the recorded interview and interview report will not be shared with others and will not be used for other purposes. Moreover, no answers/quotations can be traced back to a specific respondent. Finally, all respondents gave permission to add their name in the respondent list in the appendix (IV).

A limitation of interviews as a research method is the 'interview bias'. During the interviews, I asked for changes that happened in the past. The perception of the respondents may be coloured by personal and societal developments (see also Dwarswaard, 2011: 52). I tried to offset this limitation by interviewing a very diverse group of respondents: personal developments will differ per age category so I had to interview both older and younger GPs. Perceptions of societal developments may also differ per age category, but perhaps also per region. That is why I interviewed GPs across the country.

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<sup>24</sup> I want to emphasize that I do not insinuate these respondents are corrupt and their behaviour inappropriate.

### 6.3 Data analysis

In order to analyze the interviews, each interview was taped and afterwards an extensive report was written per interview. Unfortunately, they were *not* transcribed verbatim due to strict time limitations. Nevertheless, in order to do justice to the words of the respondents as much as possible, all reports were typed while listening to the recorded interviews. Subsequently, these reports were analyzed in line with the coding procedure as proposed by Boeije (2010). First, the extensive reports were divided into fragments. Each fragment was ascribed a certain code based on their essence/message by using the Nvivo 9 computer program (see also Bazeley, 2007). Van Thiel (2007: 166) also recommends using a computer programme to conduct a structured analysis of qualitative data. Nvivo 9 allows to retrieve relevant fragments that are attributed to a specific code during the analysis. This step is called 'open coding'. During this phase, no selection of codes or fragments was made in order to prevent bias as much as possible. Unfortunately, no 'inter-researcher traceability check' can be conducted for each interview due to the fact that a thesis trajectory is a rather solitary process. Nevertheless, as already discussed in the last paragraph, I tried to offset this problem as much as possible by discussing findings, impressions and codes with others (i.e. peer students, supervisors, external experts and respondents).

Next, no longer the fragments, but the codes became central. All codes were looked at again and they were compared in order to judge whether synonyms were used. The resulting codes were put onto a list, and by distinguishing between main and sub themes they were ordered into a 'code tree'. This categorizing will lead to the identification of the core concepts. This phase is called 'axial coding' (2010: 108 ff.). The final phase of the analysis is 'selective coding' (Boeije, 2005: 105). Associated fragments of the codes were related to each other to integrate the findings in order to make sense of 'what is going on'. This process formed the basis to discern the five 'tokens of economization' discussed in chapter 3.<sup>25</sup> The results presented in the next chapter contain individual quotations of the interviews to illustrate the findings. It is important to note that practically all these 'quotations' are not taken from the extensive reports. Instead, I have used the recordings to quote the respondents more accurate. Whereas all interviews were held in Dutch, I did translate all there 'quotations' for consistency and readability purposes.

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<sup>25</sup> As mentioned before, this thesis report is *not* entirely parallel to the chronology of the research process. Consequently, the 'tokens of economization' were identified based on the interviews and based on these the results are reported in the next chapter.

# Chapter 7

## *GPs 'in real'*

In this chapter I will discuss the results of the empirical research of this thesis. For this empirical part, twenty-two GPs and five experts were interviewed (of whom three had a background as GPs themselves). I will start by discussing some general notions I came across in the interviews. Subsequently, I will focus on the effects of economization on professional identity by discussing the three dimensions of good GP work and the preconditions (see chapter 4). For each of the three dimensions I will pay attention to the five tokens of economization (see chapter 3) and for each precondition I will describe how the GPs that I have interviewed experience possible changes. Nevertheless, beforehand I have two methodological notions. The first is that whenever I speak within this chapter of 'the GP', I refer to the GPs I have spoken with and not all Dutch GPs in general. After all, the results of this qualitative study are not necessarily generalizable to the entire GP population. The second notion is that despite all interviews were held in Dutch the quotations I use in this chapter to illustrate my interpretation of the results are translated to English for consistency and readability purposes.

## 7.1 GPs' story in the lime light

### 7.1.1 GP for a reason

For practically all respondents, becoming a GP was not something they dreamed of in particular as a child. For most of them, it all started with a fascination for human biology in secondary school which motivated them to study medicine. During their studies, most of them came to conclude that although illnesses and health complaints are interesting, they are not half as interesting without the combination with the person that has these illnesses and complaints.

'The sick person is more interesting than the sickness itself.'

'It is very holistic. It is family care. As a GP, you literally are close to peoples' homes. You are also very close to people themselves.'

One GP expressed it as follows: 'You are an associate in the life of your patients.'

The advantage of becoming a GP is the very emotional and intimate relation you can build up with your patients. Whenever a person visits his GP with a certain complaint, it is in advance unknown what the eventual diagnose will be: is it something somatic, something psychological, or is it perhaps just anxiety? For GPs it is an exciting puzzle to solve but the actual outcome of this process depends very much upon the context of the patient himself. As a GP, you get to know the context of your patients very thoroughly, not in the last place because of the close contact with family members of multiple generations allowing you to see possible interrelations.

'Sometimes we even have family members of four generations as patients. It is very important to know how people have learned things in order to understand why they come and visit your practice. For example how they have learned to deal with death.'

'Diseases are very unpredictable and they come irrespective of social status. (...) I know my patients through and through and that is an important added value. Simultaneously, it can also be a potential pitfall. The context in which people live their lives is very important. It is a patients' background that determines peoples' behaviour and how they deal with disease.'

This also catches a great part of the core of the commonly shared aversion for working in a hospital. Most of the respondents decided to become a GP after having experienced what it is like to work in a hospital during their studies. They experienced the work of a physician working in a hospital as very superficial and impersonal when it comes to patient contact. In hospitals, patients are ‘ailments with people around it’ whereas the illness is central and not the person behind it. Moreover, many respondents emphasized that an important element of GP work is the breadth of the profession and the variety they come across during their consultations. Even the internist is more of a specialist than a generalist compared to GPs.

‘It is a very broad profession. There is no boundary to it. You cannot say in advance to your patients : go and see someone else. The medical aspect can be a next stage of an unresolved social of psychic conflict. Everything that is not being resolved will eventually become a medical problem. (...) It is fun to frame and puzzle as fast as possible in order to find an appropriate solution.’

Finally, an important element the great majority of GPs mention is the leeway they have within their profession. Especially compared to hospitals, GPs have a substantial freedom of choice.

‘As a GP, you can be a doctor in your own way. In the hospital, it is more about excelling and there is much hierarchy. (...) Moreover, over there you have more colleagues and deviating behaviour is more difficult.’

‘I do feel myself to be a free professional (...). My daily schedule and professional practice is limited to a certain extent, but since you are a kind of self-employed entrepreneur you have relatively much freedom.’

For at least nineteen of the twenty-two GPs interviewed their initial expectations were realized. However, some of the GPs emphasized that sometimes compromising factors have negatively influenced their initial enthusiasm to become a GP. Most of the GPs mention bureaucracy as such a compromising factor. One GP mentions that also the big number of people that only think they are ill without actually being it is annoying. This is something mentioned by many GPs: around 80 percent of all patients that come to visit their GP only suffer from anxiety about their health.

### **7.1.2 GP care in transition**

In chapter 2, I have presented some facts and figures about GP care in the Netherlands. The trends observed there are also to be found among the GPs I have spoken to. The feminization of the GP profession is one of them. The characteristics of the group of respondents interviewed for this thesis show clear signs of feminization. Out of the eleven GPs that belong in the oldest age category spoken to, eight were male. Of the middle age category, only one out of five GPs was female. However, in the youngest age category it was the other way around: just one out of six GPs was male. Nevertheless, only three GPs mentioned feminization as an influential development, noticeably enough practically all GPs that bring up feminization were males themselves.

‘We must open our eyes and see that the profession is changing. Feminization. Women are different than men, they are less business-oriented. In places where decisions are being

taken are nowadays still more men than women. However in ten years there will only be women.'

'Ten or twenty years ago, there were many male GPs that simply worked constantly. Nowadays, there are many women who work three or four days a week and who prefer to be on a payroll instead of being self-employed. They want to work less shifts and to have more freedom of choice. Thus less obligations.'

A more prominent development is that of changing work preferences and increased collaboration in particular. In line with the general trend discussed in chapter 2, most of the respondents nowadays no longer work in a solo-practice. Instead, the majority of them work in a group (e.g. a group practice or a health centre). Even most of the GPs that belong to the oldest age category work in a group practice. At least two of them started to work in such a practice very shortly before their retirement. After all, practically no young GP wants to take over a solo-practice nowadays. For practically all other GPs, the reason to choose for a group-practice is that a group can fulfil a buffer function. Whenever an assistant is ill, or the GP him-/herself, the workload can be divided among the remaining colleagues. Furthermore, many GPs prefer to work part-time, which is practically impossible in a solo-practice. Moreover, most GPs working in some sort of a group relation mention that being able to collaborate with colleagues is very important to them.

'I wanted to share the risks. As a GP having a solo-practice you are crippled as soon as your assistant gets ill. With more GPs you can offset possible risks more easily.'

Besides, 'you can explain things to each other, you are more consciously engaged in your profession and you can easily make work arrangements.'

This process of collaboration is not always easy. GPs are very individualistic professionals that like to determine their own course.

'Collaborating is difficult for GPs because we are loners. People that have their own way of working. Nowadays, we are forced to collaborate, which is a good thing.'

Another GP refers to the transition from solo to group-practice: 'the collaboration process was difficult. We had a different focus on the horizon. We needed to cooperate legally, financially, architecturally and agogically. These four kinds of cooperation needed to be aligned. (...) We needed an external process manager for that.'

### ***7.1.3 Economization in GP care***

The group of respondents interviewed reflect the two tendencies (i.e. feminization and changing work-preferences) discussed in paragraph 2.2.2. However, these are not the only developments that have influenced the work of GPs. This thesis aims to find out whether economization has changed the professional identity of GPs. Many GPs have mentioned developments that according to them show clear signs of economization. In this paragraph, I will pay attention to the empirical ground to label five of these developments in this thesis as tokens of economization (see chapter 3). One of the most prominent developments the respondents have mentioned is the revision of the healthcare system with the remuneration change in particular. Most GPs argue that the combination of

capitation fee and fee-for-service has changed the administrative tasks they need to carry out, especially with regard to the reimbursement of costs by the health insurer.

‘The most radical change has been the change of a mixed insurance system to a uniform system.’

One GP mentions that this uniformity of insurance has led to a decrease in administrative burden. However, all other GPs emphasize the opposite. Or as one of them expresses:

‘It is an increase in administrative burden of all kinds of nonsensical things.’

A second important development is standardization and performance measurement. All GPs mention that guidelines, codes and performance indicators have come to play a very influential role in their daily practice. These guidelines and indicators serve to increase quality, uniformity and transparency of GP work, and to make it more evidence based.

‘The most important change is the increase in bureaucracy, protocols and regulatory pressure. In the core, this is a good thing because society has the right to know. The consumer may expect verifiability.’

A third development is the internal organization of the GP practice. A majority of the respondents state that they have come to provide more care, which increases their workload drastically. This increase in care provision is for the most part voluntarily. However, many GPs experience it to be undeniably dictated by the spirit of the age. Patients, colleagues and government seem to expect it.

‘We have always provided basic care, but we have started to do more. We took over tasks from hospitals. (...) You have three kinds of care. First, you have basic care. Second, you have additional care which is the care taken over from hospitals and diagnostics. Third, you have multidisciplinary care, which are the care programs for chronically ill. The basic care has increased and the other two were added. At least, we always have done some of it, but that was very small in volume. (...) Additional care and multidisciplinary care are not imposed. That is voluntarily. Additional care is often diagnostics with a technical character. (...) From two sides the need for additional care has increased: the doctor itself thinks ‘is this really true?’ and the patient that says ‘yeah sure, but...’.’

In order to offset the increased workload eighteen of the twenty-two respondents have (had) employed a ‘practice seconder’ (POH). Most of these were on diabetes treatment, but several practices also had a POH for long disease, elderly care and mental healthcare.

‘The workload has increased from three sides, so there has to be a part you must outsource to POHs.’

A fourth development is the increase in collaboration between GPs on urban/regional level. As we have seen in paragraph 7.1.2, many GPs – some of the respondents as well – that used to be soloistic have started to work in a group practice. In this way, tasks can be divided and risks shared. Another very important development has caused collaboration on urban/regional level to increase: GPs have joined forces via the after hours clinic. These clinics were founded to unburden GPs during the

evening, nights and in the weekends, which is in itself not an economic consideration per se. However, they have professionalized to a great extent and the majority of GPs argue that nowadays they have encouraged patients to become more like customers by strengthening the 24/7 mentality.

‘The after hours clinic. At first, this was very pleasant for the GP himself. Now you had less shifts. However, nowadays it has changed into a pleasant effect for the patients: they know the clinic is there and the demand for care has risen drastically. People have a 24/7 mentality. It is no longer an emergency clinic.’

A fifth development is the founding of healthcare groups and multi-disciplinary care. GPs nowadays are organized in healthcare groups, which are regionally bound groups of primary care providers (especially GPs) that form the negotiating party for health insurers. Multi-disciplinary care is care organized as modules by and within these groups.

‘The government wants us to provide chronic care as modules. Diabetes, long disease, elderly care. In the past, you received a capitation fee, but now they want to purchase this kind of care and negotiate about the price. As an individual GP you are not a market party. So we are forced to clump together in new organizations and we are forced to found these new organizations.’

## 7.2 Excellence

In chapter 4, excellent work has been defined as ‘work that is high in quality and technically sound; it meets or exceeds standards by which other work is judged’ (Fischman & Barendsen, 2010: 31). As argued in the same paragraph (4.6), I will pay as little attention as possible to the content of excellent GP work since I am not a professional myself. The question that is central in this paragraph is whether GPs have come to a different understanding of what excellent GP work is.

### 7.2.1 Remuneration system

Nowadays, GP receive a combination of a capitation fee for every patient they have listed, and a fee for every operation/service. This former aims to support a strong relationship between patients and GPs and simultaneously the latter aims to reimburse extra work and to encourage a more commercial attitude. All respondents state that a good and strong relation between a GP and his patient is essential for the quality of GP work. Namely, the medical-technical aspect is only half of GP excellence. The other half is the subjective experience of patients themselves about the GP care they receive. For both aspects good medical knowledge, and good communication and trust are important. According to all GPs, the new remuneration system has not led to a radically different understanding of what excellent GP work actually is. Excellent work is still a combination of good somatic know-how and the subjective experience of the provided care by the patient itself (see next paragraph). Especially because of this last element, many GPs attach great value to the capitation fee.

‘Now you have the capitation fee and the fees-for-services. It is a good thing that the capitation fee exists, because in that way you do not have to get everything out of

reimbursements. There are plenty of GPs that cannot handle pressure and start to reimburse all kinds of costs.'

Nevertheless, it has undoubtedly changed the care provision of GPs. The government and insurers have encouraged GPs to take over secondary healthcare from medical specialists/hospitals, in order to provide it in the less expensive primary care echelon. This has led to task rearrangement and multi-disciplinary care (see paragraphs 7.2.3 and 7.2.5). So in essence, the qualification of *excellence* has not changed, however GP work itself has become more comprehensive. Besides basic care, GPs have started to provide additional care and multi-disciplinary care which is all a(n) (in)direct consequence of the change in remuneration system.

'If we all agree that small surgical operations need to be carried out within the primary instead of the secondary care echelon, you should not work with a capitation fee. A volume incentive works better. The volume incentive serves to transfer work.'

Often encouraged by the new remuneration system, many GPs try to do as much as they can themselves and have actively tried to improve the medical-technical quality of the care they provide. They have invested in the internal, horizontal and vertical organization (see paragraphs 7.2.3, 7.2.4 and 7.2.5). They have done so via extra education that allows them to provide additional and multi-disciplinary care, they have hired extra staff (e.g. extra assistants and POHs) and they have invested in new equipment and in the housing of their practices. All these activities are said to be voluntarily. However, according to the respondents reality teaches that as an individual GP you simply have to move along with the developments. Some GPs try to refuse to do so and consider these changes not as quality improvement.

'Again and again you have to do these projects under the name of quality improvement. You have to free up time for that.'

However, this stance is exceptional. The majority of GPs do find these developments important for the quality of GP work and have put a lot of effort in them. Most of them consider it to be justified that those who invest in equipment and education receive good fees for the extra services they deliver.

'With the new Health Insurance Act indeed something has changed. In the past, there were colleagues that received no patients after one o'clock and they earned the same as someone who worked himself to death with all sorts of surgical operations and the like. So I think it is a good thing that these extra operations are being rewarded.'

However, in reality practically all GPs emphasize that the system nowadays is crippled and this touches upon a deep frustration among GPs. Although I will pay more attention to this in paragraph 7.5, it is about the following. Many GPs have invested with the presumption that the remuneration system allows for the reimbursement of the extra care they nowadays provide. Some respondents argue that the higher income generated by these additional activities is not proportional to the extra work they do, but in general, even those GPs are satisfied with their income. Nevertheless, taking on more tasks in order to improve their care quality has caused GPs to increase their sales volume substantially. Consequently, in the fall of 2011 the government decided to reclaim millions of Euros

from all Dutch GPs because they had exceeded the macro-budget over 2009 and 2010. Except for one, all respondents consider this to be very unjust. Some even see it as the deathblow for further investments in quality improvement.

Another frustration among many respondents is about the position of the health insurer. In the new healthcare system with its different way of remuneration the health insurer has come to play a more prominent role. A few of the GPs I have interviewed are satisfied with the insurers they encounter. However, the majority of the respondents emphasize that health insurers have started to interfere with the medical-technical content of GP work. The most prominent example is the preference policy of health insurers that pressures GPs to prescribe only generic medication instead medicines of a specific brand. In itself, most GPs do not consider this to be problematic, but the implementation often evoke aversion.

‘The power of the health insurer increases. They set requirements for the healthcare they purchase. They want to see what it is exactly you are doing, but it is the individual GP against the big organization.’

‘The insurer determines that we have to prescribe generic. We already did that, but the insurer decided that they prescribe generic in a good way and I do not. Nobody can see on the prescription who has prescribed it. We already did it as cheap as possible! They have some sort of a computer programme and unilaterally determine that they do it correct and I do not.’

In general, many respondents experience the health insurer as an interfering force that interferes with their professional judgement and in that sense impedes excellence.

‘Negotiating with the health insurer goes way too far. It is demotivating. It does not improve quality. For example, an accreditation trajectory you have to go through. It takes so much time. It does not result in profit for the patient.’

‘Now the health insurer determines a lot of things. Now you have to ask your patients, do you want an eyelid correction? Go and ask your health insurer. We have been completely tamed.’

Finally, I want to mention the fee-for-service element in the remuneration system that aim to encourage more competition among GPs and between GPs and other care providers. Two respondents state that in a sense they also try to differentiate themselves from their colleague GPs but even those mention that it is not really in a GP’s nature to compete with other GPs. Most respondents hardly notice any competition in their direct region. For practically all of them, the striving towards more competition is a thorn in the side that undermines the excellence of GP work. Most GPs indicate clearly that competition is not the way they want to work. Whenever they do discern any competition, for example from other GPs, most of the respondents only feel annoyed but do not really notice any difference in their relation to their own patients.

‘[I do not notice a lot of competition.] (...) A number of colleagues in our region have promoted that they will do an elderly examination (hearing test, tension measurement) for

all people aged 60 years and older. More profiling. We more or less also do that, to show that you do certain things more or better than your colleagues. But if that really takes away patients from others, or result in patients that 'shop around', I do not really notice that. Patients are very loyal.'

'No! Real competition prevent modernization and innovation! It decreases quality, I am convinced of that. What we try to do as academics is to collaborate as much as possible. In the health centre, we start to collaborate with secondary care providers. We are going to start up all sorts of projects to provide better care. If there would be competition (...) you should not do that.'

Instead, all GPs interviewed mention that the only way for GPs to improve the quality and excellence of Dutch GPs – which they commonly regard as already very high – is collaboration instead of competition.

### ***7.2.2 Standardization & performance measurement via guidelines & indicators***

Standardization and performance measurement serve to come to grips with the excellence of GP work by increasing quality, uniformity and transparency. As briefly mentioned in the last paragraph, according to the respondents GP excellence has two sides. The first is the objective side of GP professional work. It is mainly about the medical-technical side that is about the quality of GP work from a somatic perspective. However, to be able to provide care that is medical-technically excellent good social skills are imperative because good GP work depends greatly upon good communication and trust.

'The right intervention for the right problem at the right moment. To do not too much and not too little. And sometimes do nothing. You should not over-medicalize. You should listen very good, but you should not make people more sick than they are. You have to estimate the strength of a patient very well in order to maximize the use of their self-supporting power. However, that is just one piece of course.'

'Somatically seen you need to be very well-informed. You need a good gut feeling and a lot of knowledge. You also have to be able to communicate very well.'

The second side of GP excellence is the subjective experience of patients about the quality of GP work. For this side, providing care that is medical-technically very good is important. Or as one respondent puts it 'you must make people really healthier.' However, the social aspect of good communication and trust is even more important for this side of GP excellence.

'GP excellence has two sides. Patient satisfaction is very important because you cannot measure everything. If in general your patients are very content about your work (both medically as well as communicatively and trust worthy), then I believe you are doing a good job as a GP.'

One respondent summarizes it very straightforward by stating that as a GP you must be 'capable and kind'. Half of the respondents also add other things to GP excellence like reflexivity and societal responsibility but there is no clear consensus about these.

In order to end the huge diversity in ways of acting by GPs and to improve quality, the NHG has formulated guidelines. When the respondents speak of medical-technical excellence, most of them automatically refer to these NHG-guidelines. From the interviews it follows that they have become very influential whereas many GPs use them on a daily basis. In fact, it turns out that the guidelines have become the norm. It seems that this is prompted by two reasons. On the one hand, the respondents are convinced that the guidelines can improve GPs' medical-technical excellence, because they are evidence based and provide GPs with a professional best practice.

'When talking about excellence, then it is important to read the literature. You must embrace and respect the scientific grounds and need to act accordingly. Otherwise, you are the level of a quack who thinks to know what is best for a patient. You must keep connecting yourself to our scientific guidelines in general and you simply must keep up with your literature. (...) Evidence based medicine. That is more than merely enumerating medical literature, it is also bringing into practice the best medicine has to offer a certain patient.'

On the other hand, the NHG-guidelines turn out to be very important for accountability purposes. The guidelines form an important hold for GPs to be sure that they are not to blame whenever anything goes wrong. Everybody makes mistakes, but within the healthcare sector this is very delicate. Also for GPs making mistakes becomes even more and more out of the question.

'Everybody makes the same mistakes and has the same difficulties. The drawback is that you have the idea that you are not allowed to make any mistakes anymore.'

That the guidelines have become the norm is not only the case for external but also for internal accountability. In response to a question about bad work done by colleagues, a great many of the respondents mention that whenever they came across such work it was bad because it was not in line with the NHG-guidelines. It needs to be added that except for one or two GPs most respondents emphasize that real bad work is exceptional.

'Sometimes you come across things I would do differently. That also should have been done differently according to the guidelines.'

The NHG-guidelines can help GPs to make their work more transparent and to improve quality. The respondents generally regard this to be a good thing. After all, society has the right to know what is going on within GP practices and GPs must do their best to improve their care constantly. However, the striving for more transparency of GP work has gone much further than simply encouraging GPs to follow guidelines that are formulated by their own profession. Practically all respondents emphasize that they experience the way in which they have to live up to the demands of transparency and quality measurement as dreadful and totally inadequate. The quality of GP care is being monitored via a system of performance indicators (see Van Doorn et al., 2009). An important facet is the coding system GPs have to use to get all their actions documented and their operations reimbursed. One of the respondents explains this system.

'Whenever you have had a consultation, you must add a specific code to it. For example in the case of knee complaints, you must look at musculoskeletal, knee, meniscus et cetera. With these codes there comes along an entire formulary: whenever you use the code bladder

infection, the formulary indicates what to prescribe. (...) If everyone follows this system, then you can easily filter out all GP systems the code of bladder infection in order to study how they were treated, how often patients received treatment, whether a sample was researched et cetera. That is coding.<sup>26</sup>

All GPs consider the amount of data they have to provide to health insurers completely overdone. Some emphasize that the bureaucratic burden that comes along is very troublesome. Even more importantly, according to a great majority of the respondents the data they must provide does not even come close to capturing the core of GP excellence. Every single possible operation performed by a GP is delineated and should be classified via the coding system. Together with other information about individual patients (e.g. certain blood values) the coded information about GPs' actions feed into the indicators that measure GP performance. Since it means a great deal to all respondents, I will mention several quotations that illustrate this important point.

'Everything we do is being put under a magnifying glass. The performance indicators form an overdone way to gather all kinds of incomparable numbers that say nada about quality.'

'Everything is being expressed as little blocks and there is active steering based upon these little blocks.'

'The proof you have to provide to the health insurer goes too far. There is no attention for whether a person is 19 or 89 but in the lab for example you need to have a certain value below 2.5. What are we doing?! Do we have to fill them up with pills because otherwise we cannot prove that a patient is below 2.5 because otherwise we will receive no or less money. You do not look at the patient. Does he/she even want to? Et cetera. You should not look at how many pills I must put into a person to achieve a certain value.'

'Everything has become cost-steered. But what if a patient only comes to cry a little. Yeah I do not have a code for that! There is no defined picture for that. What code should I give?! What should I tell the health insurer? Everything is being delineated and that is not possible in our profession. (...) Making things measurable is good but not everything is measurable. For example diabetes. The health insurers and the NHG have formulated indicators that they believe are factors they want to measure. If the HBH1C has a certain value, then you are doing a good job. That is really short-sighted! You have a lot of people you provide with excellent care, you guide them, prescribe medication, control it, the patient is being seen by nurses, and still they have a very high HBH1C! Sometimes patients have a very bad personal responsibility for their disease. Then I am being judged for a bad score of a specific lab value while I am convinced that we put a lot of effort in a patient and guide that person very well. (...) I have done the best I can and subsequently I am being judged on a low number!'

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<sup>26</sup> These codes are the ICPC codes. It is the International Classification of Primary Care (ICPC). This classification system 'is in the Netherlands accepted as the standard for coding and classifying complaints, symptoms and disorders in the GP practice' (NHG, 2012b).

‘To measure is to know, but to know is not to measure! If you want to know whether a GP does a good job, you cannot only look at the medical-technical side. There are so many factors in the work of a GP that are very valuable and cannot be measured. Personal engagement, how you approach your patients, your prior knowledge of people, taking initiative, curiosity, the time you want to spend on people. It is actually not measurable. The other party feels peevisish by that. They do not say ‘it is not measurable’, no they say ‘we are going to measure it and we are going to make booklets. We make it measurable.’ These are those dumb lists.’

All these quotations show a great aversion for the way in which GP excellence is being made ‘transparent’. According to the respondents, only half of the work a GP does, can be expressed via a code. In that sense the coding system falls short just as the performance measurement system. The performance indicators focus on things like number of consultations, blood values, percentages of patients that for example smoke. The GPs interviewed unanimously state that this is not just, because it overshoots the fact that there is an entire process attached to the provision of GP care. According to some, there is nothing wrong with approximately 80 percent of the patients that come to visit them. They only need to be reassured, but there is no ‘target’ for that. Moreover, four GPs mention that there is also another aspect: GPs are not the only ones that are allowed to prescribe medication. Specialists may do so as well. Some specialists do not prescribe generic medication, but ultimately it is the GP that is being held responsible for that by the health insurer.

‘Specialists prescribe medication not in accordance with the guidelines (they do not have the same guidelines). But it is strange that I am being cut down on medicines that are prescribed by a specialist! That I am being judged based on that. (...) I want to meet the norm, I know I do meet it, but then I need to debate with my patients about medication prescribed by specialists!’

### **7.2.3 Internal organization: task rearrangement**

For many GPs who belong to the middle and oldest age category, their practices have changed considerably over the past decade. One of the developments is that they have come to provide more (and different) care leading to task rearrangement. Eighteen respondents have (had) employed a ‘practice seconder’ (POH). Moreover, at least nine of the GPs have received extra education in order to be able to provide additional care and/or they have specialized in some way to provide extra care. Some of them specialized already many years ago and most respondents mention that there are two arguments for GPs to specialize: some simply want to know more about a certain aspect they find interesting. Others are triggered by economization arguments (e.g. being more customer-focussed, increasing one’s income, improve efficiency) and this last group is nowadays more prominent.

‘Some colleagues have a speciality in ultrasound diagnostics, another colleague has a specialisation in sports. Nowadays, you see many expert GPs who show they have a little more knowledge than their colleagues.’

With regard to excellence, the respondents show a diverse picture when it comes to task rearrangement. Nineteen respondents are not negative about specialization by GPs. Most of them

consider it to be a slight increase of medical-technical capabilities within GP care and thus as an improvement of excellence.

'You start to focus on specific tasks within a group practice. I think this is satisfying both for the GP and the patient. So it is quite positive.'

'Collaboration causes more differentiation. It is task division. I do [specific kind of care]. Then you can mutually advise each other. Assistants have that as well. They also have a core task and something specific like taping or spirometry.'

'It has only good sides! After all, you cannot know everything yourself.'

Two GPs strongly oppose specialization by GPs and one has his doubts. They consider it to be the demise of the general character of the Dutch GP.

'We are generalists. We are diagnosticians because we know a thing or two about what can be wrong with people and about which disease matches what pattern of complaints. That is our specialty!'

Although the majority of the respondents have (had) employed a POH, they do not necessarily delegate all 'simple' and 'routine' tasks to assistants and POHs. After all, whenever a person appears to have multiple complaints, he or she still needs to visit the GP.

'Tasks can be delegated, but if a patient says 'when I fell, I also had a pain in my elbow', such a person still needs to be referred to us.'

Moreover, simple tasks provide GPs with the opportunity to strengthen their relation with their patients and thus improve their 'excellence'.

'The tendency is to hire assistants that can carry out protocols. However, the essence is that when a mother visits us with her child having little bumps, you can ask simultaneously 'how is your husband doing?' (...) I need this to provide family healthcare.'

#### ***7.2.4 Horizontal organization: more cooperation & after hours clinics***

Modern GPs are no longer loners. Instead, they have joined hands for mutual benefit and increased efficiency. Twenty respondents emphasize that collaboration between GPs who have their practice in the same region has all sorts of advantages. For example working in a group practice can have preconditional advantages like cost-shared and economies of scale. However, more importantly collaboration is said to have advantages for the quality of GP care. The most important of these is the buffer function a group has. As soon as one GP or one of the staff temporarily is absent, his or her colleagues can take over one's patients.

'I wanted to spread the risks better. When one of your assistants gets ill, you are crippled as a loner. Together you can offset such things and you decrease acute risks.'

Collaboration also has medical-technical advantages. Especially within group-practices, collaboration encourages task division. This strengthens the tendency of specialization discussed in the last

paragraph. In that paragraph, I mentioned that most respondents regard specialization as a good thing. After all, it improves the care a GP can provide. However, one might expect that specialization also leads to an increase in knowledge transfer among GPs themselves. This turns out to be very limited.

‘GPs do not enter into deliberation together. If you want to consult someone, you call the specialist.’

Nevertheless, all GPs mention that collaboration – and definitely not competition – ultimately improves the quality of GP care. The most important form of collaboration between GPs can be found in the concept of the after hours clinic. Although this clinic is not founded based on obvious economization motives, it has strengthened consumer logic within GP care drastically. Although all GPs regard the after hours clinic as convenient in the sense that they themselves do not have to provide care during the evenings, nights and weekends, the respondents share the conviction that they have negatively affected GP excellence. The after hours clinic started as an emergency clinic, but the only ones that regard them as emergency services nowadays are the GPs. Patients see them as convenient places to ‘consume’ care. The after hours clinic has several important drawbacks.

‘They had a 70 percent increase in volume. This is due to the consumerism! The 24-hours a day economy. (...) The after hours clinic has several disadvantages. First, they are nine times as expensive as in the daytime which is a cost problem. Second, the care is not provided by your own GP which cuts out the added value of the GP. Third, care is being delivered on an unsuitable time. After all, the GPs working there have also worked during the daytime, so from a safety perspective it is undesirable.’

Most GPs emphasize that especially the second element of the quotation above is dreadful: the impersonal character of the after hours clinics. Patients come over with all sorts of problems that are not necessarily emergency cases. As a GP you rarely know these patients so you do not have any background knowledge of the person in front of you. This makes it a lot harder to make a reasonable estimation of the situation.

‘Customer behaviour is especially visible in the after hours clinics. You come across people that say ‘I was in the neighbourhood’ or ‘I was not able to come earlier’. They see it as something they have a right to. They surpass the fact that it is an emergency clinic. (...) Especially the after hours clinic is more anonymous so that is why they grow substantially. In your own practice you know the patients personal and you come across that kind of behaviour less often. (...) When the personal relation disappears, the customer-behaviour increases.’

The next quotation is an example of how after hours clinics can reduce GP excellence also from a medical-technical point of view.

‘A simple example. A patients visits me with a throat ache. I take a look at the patient and ask some questions. I believe it to be a simple infection, take your some time (a day or three or four)and then it will be gone. Some cold beverages, done. The next day the patient visits the after hours clinic. His throat still hurts and I did not give him what he wanted. My colleague

prescribes antibiotics which is unnecessary. The patient did not ask me what he actually wanted, and the next day he thinks: 'wait a minute, I will get it my way!' The colleague has no other choice unless he is really courageous and says: 'you came here, but yesterday your GP has made an excellent choice.'

So whereas collaboration in itself is said to lead to an improvement of GP excellence, the prime example of collaboration between GPs – the after hours clinic – clearly does not.

### ***7.2.5 Vertical organization: healthcare groups & multi-disciplinary care***

Individual GPs do not negotiate with health insurers. Instead, they have formed healthcare groups. The respondents often mention the healthcare groups they are part of, which is a clear indication that these groups have become very influential. Health insurers encourage care providers to develop new multi-disciplinary projects that serve to improve care and to substitute secondary care. For these projects there is a budget available and whenever the projects meet strict demands GPs can get their activities reimbursed. These projects fall in the 'modernization and innovation' category that has free negotiable tariffs. In general, but also among the respondents' practices, diabetes care is the most advanced, followed by lung disease, cardiovascular risk management, elderly care and mental healthcare. M&I activities usually result in task rearrangement and they require much collaboration. In this sense, I already discussed them in the last two paragraphs. In general, most respondents regard M&I activities as an improvement of care and are triggered by the extra budget health insurers have available for these activities.

'Health insurers come up with things like elderly care, mental healthcare et cetera as modernization and innovation activities. This makes you think about it.'

In case of multi-disciplinary care, healthcare groups need to develop protocols and programmes that are in accordance with the health insurer. At least two of the respondents have even worked for their healthcare group by making protocols and programmes. However, many respondents argue that the development of M&I care has brought along a lot of administrative burden.

'At first, I was really enthusiastic about the fact that you can start up projects because there is budget for that. But in reality that is very difficult and it is disappointing.'

'Anyway, we are obliged to found all sorts of new organizations and that brings along a lot of meetings and overhead. For that we need all sorts of new forms and we need to register patients and we need new protocols that subsequently nobody looks into. We do use those protocols, but the physical things of course you do not use. These are neatly in a folder for when someone comes in to check it of course.'

Nevertheless, except for two of the respondents who fairly oppose the idea that M&I services improve GP excellence, most respondents are actively involved in M&I projects that aim at improving and expanding the care they provide.

### **7.2.6 To conclude**

The understanding of GP excellence has not really changed. GP excellence has an objective and a subjective component. The objective element is the part that is about really improving peoples' health and the subjective part is about peoples' experience of the quality of a GP. For both components, a GP needs to be capable both medical-technically and socially. For objective excellence, the focus is on the medical-technical capabilities of a GP, while for subjective excellence the focus is more on a GP's social skills. Developments that strengthen an economization tendency seem to focus unilaterally on the objective side of GP work. In that sense, they sometimes are at odds with GP excellence.

The new remuneration system has encouraged many respondents to expand their care services. Most respondents think the system with its mixture between capitation fee and fees-for services is honest. After all, those GPs that do more will earn more money. However, practically all respondents feel scammed by the Dutch government that wants to reclaim millions of Euros from all Dutch GPs. Moreover, many fear that the influential role of the health insurers is threatening their professional judgement. Especially since both government and health insurers want GPs to compete with one another, many GPs are worried that this will affect the medical-technical quality of their care (e.g. because they will save on further investments).

Standardization and performance measurement leave no room for those things that cannot be measured, which is half of GPs' work: the social relation with their patients. The NHG-guidelines are generally seen as an improvement by strengthening the medical-technical GP excellence. The codes GPs have to use and the performance indicators they have to meet however are often experienced as totally inadequate. It brings along bureaucratic hassle and is highly experienced as a system that totally overshoots its purpose of quality improvement.

Under the direct influence of new managed competition healthcare system, GP practices in the Netherlands have reorganized internally, horizontally and vertically. Internal reorganization has mainly happened for efficiency purposes. GPs have started to rearrange and delegate certain tasks, especially to POHs. Moreover, many GPs themselves have started to specialize. Most GPs consider this to be a quality improvement but some have their doubts because this internal development can weaken the strong relation between GP and patient that is pivotal for GP excellence. Horizontal reorganization refers to the increased collaboration between GPs in specific regions. Collaboration is generally experienced as the best means to improve the quality of GP care. Especially the after hours clinic is a very important expression of GP collaboration. However, practically all GPs emphasize that these clinics have had a perverse effect: they have strengthened consumer behaviour by patients drastically and in that sense they form a threat for GP excellence. Vertical reorganization refers to the formation of healthcare groups and the development of multidisciplinary care. Despite the extra bureaucracy that comes along, many GPs regard this as a quality improvement. Consequently, most GPs participate in M&I programmes protocolized by their healthcare groups and the health insurers.

## **7.3 Ethics**

In chapter 4, ethical work has been defined as work with high 'social responsibility – being responsible for the impact that work, behaviour, decisions, and products can have on others'

(Fischman & Barendsen, 2010: 67). In this paragraph, the question is central whether GPs have come to a different understanding of what ethical GP work is.

Before turning to the five tokens of economization, first some words on the sense of responsibility of GPs. In chapter 4, I spoke about possible 'rings of responsibility'. To whom you feel first responsible to, is influential for the choices you make. This also counts for GPs and will prove of importance in this chapter. Eighteen GPs mention that they foremost feel responsible for the patient and their patients' health. With a modest distance, this is followed by the GP him- or herself. Many GPs refer to their own conscience, because after all 'you have to be able to go to sleep' as one GP expresses it. A feeling of responsibility towards the macro-costs follows these two rings of responsibility. After all, GPs consider themselves as gatekeepers. This is followed by a diverse set of others. Some GPs mention society in general, others mention their (direct) colleagues and again others mention the government. One or two mention the health insurer as well, but simultaneously one or two others explicitly exclude the health insurer from their responsibility scope.

### **7.3.1 Remuneration system**

Whereas the remuneration system works with both a capitation fee and a fee-for-service, GPs are encouraged to improve their care and to provide as many services as they can themselves instead of referring patients to secondary care. All GP services are predefined and are set to a certain tariff. Most GPs regard this as an honest payment system because if you decide to increase your workload, you will also increase your salary. Nevertheless, the crucial question that comes along with the fee-for-service payment is whether this has stimulated improper – or even fraudulent – behaviour. The answer to this question has two foci. On the one hand, it is about whether GPs have come to provide care that is doubtful from a medical-technical point of view. On the other hand, it is about 'the grey area' that comes along with the reimbursement of services.

With regard to the first focus, the respondents paint a diverse picture. Most of them emphasize that GPs provide care in the relationship between themselves and their patients. Consequently, GPs do not come across each other's work that often, making it hard to estimate whether their colleagues always act in a socially responsible way. Only in the after hours clinic a GP is directly confronted with work done by colleagues. Nevertheless, the levels of trust among GPs seem very high. The majority of the respondents is confident that most of their colleagues also strive to provide the best care possible.

'I think I have very good colleagues. I really trust them: I would send my kids to any of the GPs. Medical-technically without any doubt. Why? We all really believe that our job is a lot of fun and are open to criticism and learning and helping each other. So that atmosphere results in high levels of trust.'

Nevertheless, all respondents acknowledge there are irregularities within GP care. They most commonly mention a difference in interpretation. Most GPs will always act in what they perceive to be the patient's interest. However, there is some diversity among GPs when it comes to this perception. From the interviews it follows that many GPs hesitate to label controversial work done by colleagues as 'wrong'. Instead, they often phrase it like 'I would have done that differently'.

'It is too rough to speak of right and wrong, but I do come across things I disapprove. When certain care is lacking. Sometimes certain medicines are prescribed or not. Or for example when someone is dying and you still have to make clear [to the person and his/her family] that someone is really going to die. I believe that to be bad care.'

In the quotation above, there are no clear economic considerations. When talking about ethics, examples like these are most commonly heard because they affect the patient most directly. When asked explicitly, all GPs acknowledge that there are also examples to be found that do show a clear economic motive. However, the great majority of them (i.e. nineteen respondents) state that these examples are very rare. Three respondents argue that care provided on economic grounds is not exceptional but in fact happens regularly. Nine respondents have come across examples themselves. Although the majority of the Dutch GPs acts in the best interest of their patients, these nine respondents state that some GPs are too economically driven. The most important example of this is when GPs offer all their patients that belong to a certain 'risk group' the opportunity to take a certain test. In these cases, there is no real medical-technical necessity. Sometimes even the added value of the results of a certain test is debateable. At the same time, most GPs believe it to be really hard to confront these colleagues with their behaviour. After all, it all happens within the relation between the GP and his patient and it is none of their business to interfere in these practices.

'The commercialization goes very far. There are excesses. For example in the M&I category you can let everyone take a memory test. That will give you only a broad estimation. You should only offer the test to people who have memory problems and that want to have a closer look at it. There are GPs that have summoned all their patients above a certain age to take the test. Ethically seen that is despicable. It is just because of the M&I module. You simply invite entire groups. It happens. It bothers me but simultaneously it is everyone's own responsibility. I will say I think or two about it if I know the colleague a little better. I will mention that there is no added value for someone's health.'

Especially the Electrocardiography (ECG) turns out to be very controversial, though it is a very popular test to perform for some GPs.

'An ECG for every diabetic. Is it useful? No! It just brings in money! Removing spots is also one of these things. The commercialization sneaks in.'

Let me emphasize it again that according to nineteen respondents, these large scale controversies are very uncommon. Nonetheless, all GPs acknowledge that small scale controversies unavoidably happen more frequently. For example, GPs that have ECG equipment and are certified to use it automatically will make more ECGs. The financial incentive simply lowers the threshold to make use of certain tests.

'It is not that extreme. Sometimes there is more creativity. For example the ECG. If you have it, you will use it more. Some colleagues are a little creative. Sometimes the threshold is being lowered too much.'

'We have ECG-equipment, lung function, we also have minor surgery. That is the reverse that I cannot deny: eventually, you do things more easily. (...) The big question is of course

whether there is any surplus value for the patient. If you can get it reimbursed, there is a perverse incentive that you just do it. It is a very difficult choice!’

Once or twice, a respondent has mentioned that every now and then economic motives pop up when it comes to the care which is being provided in the GP practice.

‘For example small surgery. In the past, I offered my patients the choice: go the hospital or let me do it. Now I think, let me do it myself. It brings in money and it is fun to do. I do grant myself a piece of the pie as well.’

In many cases, it is not just the GP that palms care off to his patients. On the contrary, it often goes hand in hand with consumer behaviour by patients. Nowadays, patients have become more demanding when it comes to GP care. The most mentioned example is that of removing spots and little pimples. In most cases, there is no real medical necessity to remove these kinds of skin imperfections. Instead, there is a cosmetic ideal behind it. Together with the financial incentive, GPs have become less hesitant in following the preferences of their patients.

‘Many operations are not really necessary. For example ‘tele-dermatology’. A picture is via email send to a dermatologist. In itself, this saves money. However, the GP receives a fee. A normal referral does not result in a fee for the GP. Consequently, more is being send to the dermatologist. Skin spots that are not harmful are being cut away which is a small surgical operation. The patient is happy with it, the GP is happy with it, but it does cost money. It annoys me because you go along in this madness.’

The second focus of the answer to the question whether GPs have become more sensitive for financial incentives is on ‘the grey area’ of reimbursement. Approximately one third of the respondents mention that they sometimes are a bit ‘creative’. There are three reasons the respondents in total have mentioned: confusion, a sense of justice and protest. Confusion has to do with the codes GPs have to use. Since their entire consultation has been cut into pieces, some GPs often find it difficult to attach the proper codes to their diagnosis and treatment that serve to get their services reimbursed.

‘Sometimes it makes you wonder: what exactly have I done for a patient and what should I put on the invoice? Is it a regular consultation? Is it a certain operation? Is it an operation that replaces specialist care which is also a code? Whenever you have given a certain injection or performed a certain operation, you sometimes think: ‘I just do not know at the moment because not everything is very well defined. I will just choose one.’ Of course, this is almost always in your own advantage.’

Some GPs every now and then suit the rules to themselves in line with their sense of justice. The length of the consultation was mentioned a couple of times during the interviews. The length of one consultation is set to ten minutes. A GP can issue an invoice for two consultations to the health insurer whenever it takes longer than twenty minutes. This seems clear but in reality this is not always obvious. What if a consultation takes fifteen minutes but a GP has managed to pay attention to several different complaints a patient has?

'Every time you access a patient's file you have to leave it via the checkout. You must choose what kind of consultation you want to be reimbursed or you choose not to charge anything. All little decision moments. I sometimes press the button for a double consultation when someone has been here for eighteen minutes. Or whenever I treated three complaints in fifteen minutes.'

Thirdly, there is the protest category. Several respondents sometimes disagree with the system, for example when it comes to the telephonic consultation. This will only be reimbursed when the patient calls to the GP, so a GP will not receive a fee for calling to patient him- or herself. However, all GPs consider the personal relation between a patient and his GP to be an essential asset of our Dutch GP system. Some respondents regard it as unethical if you do not invest in this crucial relationship by actively informing about a patient's health. For example, whenever a patient has been to the hospital for something very serious, several GPs do call to ask how a person is doing. The remuneration system does not offer any room for this, leading some respondents to charge a telephonic consultation as if the patient had called him/her instead of the other way around.

'The telephone call is purely because I want to know how a patient is doing. Not because I want to make 4.50 Euro. That does not say that I do not charge the call. It is part of the care I provide! (...) It is part of your task as a GP so that allows you to get that reimbursed as well. Or you should think: 'I will not charge this one'. It really depends on the case itself of course.'

Every now and then several respondent have mentioned that the entire system of managed competition together with the government reclaiming millions of Euros from GPs encourages mischief.

'You get the feeling: 'Just get lost! They want to fine me?! I will get back to them!'

All in all, the answer to the question whether the remuneration system has had an effect on GP ethics is 'yes, but only slightly'. In this paragraph, I have focussed on the exceptions mentioned by the respondents in order to paint a detailed picture of what improper behaviour in GP care looks like. Nevertheless, it is good to emphasize that this is exactly what they are: exceptions. The majority of the respondents state that obvious controversial behaviour does not happen that often. Most of them disgust large scale care delivery that is questionable from a medical-technical point of view. Approximately eighteen respondents regard money as a 'necessary evil' within GP care and almost all respondents really hate the hassle that comes along with getting their services reimbursed by the health insurer. Some consider it a big loss for GP care that economic considerations have forced their way into the consulting-room. Even more strongly, many respondents feel aggrieved by the constant portraying of GPs as money-grubbers.

'You get the feeling that you are a crook! As if the GP does whatever he pleases!'

'I do not do more small surgical operations because they bring in more money. It is annoying that the suggestion is often evoked! As if you do things solely because you get paid for it. (...) I do not do more euthanasia's because I get a compensation for it!'

When focusing on ‘the grey area’ of the remuneration system, it stands out that most of the actions discussed above are centred around the patient’s interests and that of GP. This is completely in line with the two most important rings of responsibility in the last paragraph: GPs provide the care they consider to be important for their patients and if possible they will not do themselves short in the meanwhile. Fuelled by feeling disadvantaged and distrusted by the health insurer and the government, approximately half of the respondents have become less reserved in showing some creativity at the expense of the health insurer over the past couple of years. Nevertheless, this is not something that happens on a daily basis. After all, in the end this would be conflicting with the third ring of responsibility, the macro-costs.

### ***7.3.2 Standardization & performance measurement via guidelines & indicators***

In the past, the difference between right and wrong was for a very important part something determined by each individual GP. This has changed. As mentioned in the paragraph on excellence, guidelines that serve as a hold for GPs have become the norm. ‘Right’ nowadays is acting in accordance with the guidelines. ‘Wrong’ is deviating from them without having a very convincing reason to do so. None of the respondents regards the guidelines as annoying. After all, they are formulated by the profession itself and serve to help GPs. Especially the young generation tends to make use of these guidelines in order to level the lack of experience compared to older colleagues.

‘About the content of the profession you can look at whether you do a good job medical-technically seen. You could say, in order to achieve that a GP acts in accordance with a certain guideline. To me, this does not always imply that you do a better job than by following your own guidelines. There are many GPs with thirty years of experience that do things very differently and that works out as well. I do follow guidelines because I do not have the experience.’

The guidelines focus on the medical-technical side of the GP profession. They have not influenced the social side. In other words, how to deal with patients is still up to the individual GP. This is the ‘craft of consulting’. The guidelines allow for deviation from the medical-technical best practice they prescribe whenever a GP really believe that to be necessary. Sometimes the social side of their professional practice urges to do so.

‘It is all about differences in nuance. An X-ray photograph of someone’s back for example. If someone really wants it and I think it is unnecessary (of course I do not know it for sure as well!) I will say so but I do allow the patient to have the photo taken.’

The GP quoted above mentioned that this decision was ethical because it was in the interest of the patient. Medical-technically seen it was perhaps unnecessary to write a referral for having the X-ray photograph taken. The NHG-guidelines allow for such deviation. The codes and indicators used by the health insurer are more strict. As mentioned in paragraph 7.2.2, they focus strongly on the medical-technical side of the GP profession. Many GPs struggle to fit their professional ethics within this system. One respondent mentions that sometimes the system falls short in estimating the personal situation of a patient. In some cases, the health insurer does not cover certain medication when there is no ‘medical necessity’. This implies that a patient itself must pay for the medicines, but

some patients simply cannot afford them. This GP lends a hand by being a bit less reluctant in calling the case a 'medical necessity'.

'Every now and then I do not really mind to call something a 'medical necessity' while the criteria do not really define it as such. I choose for the patient and not for the health insurer.'

One respondent clearly expresses what many other GPs describe: it is the core of a GP's professional ethics to help the patient in shared responsibility.

'[The core of my professional ethics is] whenever I have the idea that I have helped my patients to get one step further ahead. To cure someone is nice, but ultimately that is not what it is all about. You have to help people to get ahead and it is even more rewarding if you hear it afterwards. Sometimes things do not work out. Nonetheless, you simply have to come up with a plan together with the patient. The patient also has a shared responsibility. (...) It is a shared decision model.'

The system of codes and indicators that aims at making the performance of GPs transparent seems to focus solely on the curing of patients. In this sense, it hinders GPs to act in accordance with their professional ethics that goes further than this. Overall, only standardization via NHG-guidelines has affected the professional ethics of GPs. They have become rules of conduct for the medical-technical side of GP care. GPs have not adapted their professional ethics to match the system of performance measurement. The patient's welfare is still regarded as the leading principle, even whenever this implies that a GP will not meet certain indicators like for example specific blood values.

Nevertheless, although there is no real effect on the professional ethics, there is one important drawback to the striving for more transparency. None of the respondents objected to the idea that GPs must be open about their work. However, the use of regulations and all sorts of indicators that only focus on one half of the GP profession is widely experienced as a huge sign of distrust. In the last paragraph, I mentioned that their portraying as money-grubbers aggrieves GPs but it goes further than that. GPs not just feel distrusted when it comes to money, they also feel distrusted when it comes to their good intentions and capabilities. Many respondents express their disappointment that sometimes even shows clear traits of resentment.

'There is a lack of appreciation and trust. We are being distrusted!'

'For example at the after hours clinic. For every child younger than eighteen you need to press some buttons about whether there has been child abuse. In that way, you are said to pay attention to child abuse every time in case of a bruise or a broken bone. No way that I can say go to Pauw & Witteman and say that this is a wrong thing to do. Everybody will say: we are talking about child abuse and you should be alert to that! In the everyday practice, it implies that for the next three, four or five years I have to press the buttons so many times that I will not even read them anymore. Until a child comes in by whom I would have seen it anyways! It is very frustrating! I experience it as a lack of confidence in my capabilities!'

The respondents mention that this feeling of being distrusted is evoked by the government, the health insurer and by the general public (i.e. media, public opinion). In the individual contact with

their patients, practically all respondents experience substantial levels of trust. This is regarded as a good thing because trust is seen as the fundament of the strong relation between the GP and the patient that is crucial for proper GP care.

### ***7.3.3 Internal organization: task rearrangement***

Nowadays, many GPs have employed several staff members ranging from assistants to POHs and other GPs. This also counts the respondents I have interviewed. All of them work with assistants and many of those have been delegated small tasks. As we have discussed earlier, eighteen GPs have (had) employed a POH. Moreover, many respondents have invested in extra education and equipment in order to be able to provide extra care. Has this task rearrangement affected the professional ethics of GPs? In essence, it has not implied a complete reconfiguration. GPs still feel responsible for their patients, themselves and for the 'broader whole' like macro costs or society. However, there is one very important development. Besides being a professional, most GPs have also become entrepreneurs with all the associated responsibilities as consequence. For some GPs, this sometimes leads to tensions between a professional and an economic logic.

'[Besides patient and professional orientation] it has become more profit oriented. Our building has cost a lot of money. It is an organization with profit. We need to recoup [our investments]. However, we do not have the possibility to cover the entrepreneurial risk by refusing patients!'

Being more entrepreneurial brings in extra responsibilities. Especially with regard to the staff that works in a modern practice. Responsibility towards personnel has become an extra 'ring of responsibility'.

'Now you have to lead an organization. You are responsible for your staff. You need to pay for them and they have all sorts of problems. (...) We are now with [number] people. There are all sorts of regulations that come along. They need to have job evaluations conversations as well. You must manage et cetera. (...) In the past, you worked with your assistant. Often husband and wife. Now everything must be arranged: safety and health, collective agreement et cetera. You need an entrepreneurial approach.'

This does not mean that GPs are good at it. On the contrary, three respondents state that most of their colleagues have practically no idea what they are doing when it comes to entrepreneurship. Several GPs acknowledge this by emphasizing that they have not become GPs for the entrepreneurial side of the profession.

'It was not included in our education. I never heard of bookkeeping. I knew nothing! Nevertheless, you have to do it!'

'All of a sudden we need to talk about an Employees Council. What should you think about that as a GP?!'

Overall, the change in the internal organization of most practices has not really led to a change in the professional ethics of GPs. Nevertheless, it has resulted in an extra ring of entrepreneurial responsibilities that sometimes can be at odds with the professional responsibilities of a GP. Most

GPs are not very talented entrepreneurs and let their professional responsibilities prevail completely. One GP exemplifies this very strikingly in answer to a question about the possible change of income.

‘I am not sure. I do not really think about that. That is actually quite bad. [For example the question] ‘does the POH bring in money?’ I have no idea. Everybody should enjoy the work they do! That is much more important than making money.’

#### ***7.3.4 Horizontal organization: more cooperation & after hours clinics***

The increase in collaboration between GPs to improve efficiency has not really affected their professional ethics. To practically all respondents, the core of their professional ethics has everything to do with the mutual character of the relationship between themselves and their individual patients. Earlier, I gave the example of a respondent arguing that providing GP care is not just about curing people. Instead, it is about helping people to get ahead. Each decision a GP takes is in shared responsibility with the patient and is tailor made. Basically, this implies that in case A a person’s medical condition can lead to a treatment, while in case B the same medical condition is not being treated at all. It is not just about the objective condition, there is a subjective experience of that condition attached to it. The professional ethics of GPs is all about finding the right balance in the relationship with their patients. Collaboration between GPs has not changed this experience of what GP ethics looks like. It has only made it a little less lonely for the GP. After all, now there is the possibility to share doubts and to deliberate with colleagues about difficult patients.

The after hours clinic has brought a different dynamic. As already discussed, practically all respondents emphasize that it has stimulated consumer behaviour of patients to a great extent. Although this kind of behaviour also occurs in the normal practice, the respondents most strongly experience it in the after hours clinic.

‘People expect more. They have to work until five o’clock and afterwards they want to stop by. The after hours clinic stimulates that. ‘I will not come during the day, but I will go tonight.’ The after hours clinic is for emergencies! But people think they should be able to go anyways. (...) Emergencies are defined as what people believe to be an emergency.’

A GP has no relationship with the patients that enter the after hours clinic. Since GPs do not know the context of these patients, it is extra difficult to estimate the situation properly. Especially when people come in to demand a certain kind of medication or a certain kind of test to be taken, many respondents admit that they give in more easily than they actually should.

‘I do like the work. There are many aspects that are very nice. Nevertheless, there is this hassle of ‘you name it, we have got it’. Besides, you do not know the people so you cannot fight the decision. All you will get is conflict. Then you have a headache and you still need to work for six hours. The way people treat me in the after hours clinic is very different from the way people treat me here. (...) Definitely. That is sometimes difficult. (...) This week a woman who had a headache for five weeks called. I asked her: ‘what do you expect us to do? I think it is unnecessary to come over.’ Well, then you end up having a huge quarrel via the telephone. I think that is madness! I am being yelled at that I am unprofessional. I believe it to be very professional what I was doing!’

The respondent in the quotation above was critical towards the demand of the person calling to the after hours clinic. However, many others state that most of the times they simply want to avoid conflict.

'You do become more indulgent. You enter into conflict with the patient less easily. Otherwise, if you do that, you have conflicts every day. You know your own patients, so you know with whom you should not engage in debate. You have so many other things to do! You can quarrel with the patient for ten minutes, but you can also say: just go to the pharmacist. Sometimes you feel like discussing, and sometimes you do not. You do change your ethics.'

### ***7.3.5 Vertical organization: healthcare groups & multi-disciplinary care***

The interviews give no indication that the formation of healthcare groups and the development of multi-disciplinary care have affected GPs' professional ethics. There is just one to be mentioned and that is on the voluntary nature of these developments. In essence, GPs can individually decide whether they join in multi-disciplinary projects. However, many respondents experience this not as voluntarily as it is said to be. In this sense, the decision of what counts as good care and good care provision sometimes feels dictated.

'You have to get along with these developments that in itself improve quality like healthcare group protocols but also result in a lot of 'overhead'. Many extra administrative tasks.'

'Everything happens with budgets. Eventually, you do things because otherwise you will miss out on income. You are being blackmailed by it: if you do not join a multi-disciplinary care organization you will not get paid anymore for your diabetes patients. You just have to do it and then you are in a certain organizational structure that is being monitored. You are being paid for it, so you have to do it, otherwise you will not get your money. (...) You are being directed via money.'

Two respondents are especially fierce about this development and one of them even calls the health insurer an indemnity insurer.

'Of the healthcare system I notice an increase in control by the health insurer that, negatively formulated, with financial motives tries to take over control. We sometimes call them indemnity insurers. Often they rely on improper motives. (...) My care provision sometimes feels quite compulsory when it turns out that I have signed a contract with the health insurer that for example frames my service hours and service delivery outside office hours.'

Nevertheless, this is only a minor point of attention and in general developments within the vertical organization have not affected the professional ethics of GPs.

### ***7.3.6 To conclude***

The understanding of GP ethics has not undergone a tremendous change under the influence of economization pressures but it does show a slight change. Ethics can be explained as a model with separate rings of responsibility. The respondents have always felt most responsible towards their patient. Consequently, the choices they make will not harm the interests of their patients. 'The self'

is for practically all respondents the second ring of responsibility. GPs want to be able to go to sleep without a feeling of remorse about whether or not they have provided their patients with excellent GP care. However, they will not do themselves shot along the way. Encouraged by the remuneration system, GPs take a critical look at their care provision. But has it encouraged improper behaviour? Large scale unethical behaviour to increase one's income is exceptional but it does happen. More frequently, GPs grant themselves a piece of the pie when it comes to 'the grey area' of reimbursement. This happens due to confusion, a sense of justice and as a form of protest. Nevertheless, this is not completely exorbitant because that would lead to a conflict with the third ring of responsibility, that of the macro-costs. The respondents really feel aggrieved by the suggestion often evoked by the government and the media that they are money-grubbers.

Standardization by the NHG-guidelines has had an impact on GP ethics in the sense that it provides GPs with a hold to fill in their responsibilities towards their patients when it comes to the medical-technical side of their care provision. The guidelines have become the norm but deviating from them, for example because the social side of the GP profession requires to do so, is not prohibited. The system of codes and indicators used by the health insurer (and healthcare group) also focuses on the medical-technical side of the GP profession and thus on 'curing'. However, this system leaves little room for the social side of GP care. Many respondents struggle to fit their professional ethics within this system. According to them, their responsibilities as GPs go beyond 'curing'. They are about helping patients in shared responsibility to get ahead. Mere medical-technical 'curing' does not necessarily coincide with the patient's interests and the majority of the respondents feels hindered by the system that leaves little room for this social side of the GP profession. I have found no indications for a shift in practice: the respondents rather enter into conflict with the system than change the way they feel they need to act. In other words, emphasis on medical-technical matters has not changed their professional ethics. However, the system is experienced as a huge vote of no-confidence. GPs feel distrusted especially by the government and the health insurer when it comes to their good intentions and capabilities. According to most respondents, fortunately the trust within the individual relation between the GP and the patient is still high.

Changes in the internal organization has left most of GP ethics intact, however an extra ring of entrepreneurial responsibilities is added. After all, GPs have become managers having a business and employing personnel. Most GPs turn out to be not very talented entrepreneurs and simply dislike the responsibilities that come along. Developments within the horizontal organization of GP care have affected the professional ethics of GPs. The increase in collaboration in itself has not had an effect, however the after hours clinic has. Since the social relation between the GP and the patient is lacking making it a lot harder to make an adequate diagnose, especially when patients turn out to be very demanding. GPs have become more indulgent and in that sense have changed their professional ethics. The change in the vertical organization by the development of healthcare groups and multi-disciplinary care has not affected GP ethics. There is one element to be mentioned which is the involuntary nature of these developments: what counts as good care and care provision sometimes feels dictated by the health insurer.

## 7.4 Engagement

In chapter 4, it was argued that engagement can be regarded as an important precondition for carrying out work that is excellent and ethical. It is about what people drives to care about their work. When people do not consider their work personally meaningful, this will have consequences for the time and energy they will put into it. Already in paragraph 7.1.1, we have seen that practically all respondents have become a GP because of an interest that went beyond the scope of a mere interest in the biology of the human body. Instead, most respondents consider the person behind the complaint with whom they can build a very strong relationship as even more interesting. Engagement more or less *is* the social side of GP care as discussed in paragraph 7.2 and 7.3. It may not come as a surprise that all respondents consider Dutch GPs as very engaged persons when it comes to the GP-patient relation.

‘Engagement is that you follow what happens with a patient. That you are in control. Nowadays they call it case management, that you are the central contact for a patient for all his problems. You are the spider in the web where all data comes together. Engagement means that you know about the ins and outs of person and that you can advise a person well.’

Engagement does not limit itself to the relationship between GPs and their patients. There is also the engagement with the profession itself. This is about the relationship among GPs and between GPs and external parties like the government. Most GPs consider their colleagues as very engaged with their profession. Notably, many do not consider themselves very engaged. However, when asked, many of them turn out to be active in all sorts of commissions ranging from NHG-commissions to advisory commissions for hospitals. Apparently, engagement with your profession to many respondents means at first sight that you should fulfil some sort of an advocacy role.

‘The world outside must know that we are very important. We have a lot of partners in the healthcare sector that we have to deal with. So you must show that you are there! We are the spindly in the healthcare system and as a profession we must show that we can be involved with all those people.’

The question that is central in this paragraph is whether GPs have come to a different understanding of what engagement is.

### 7.4.1 Remuneration system

The interviews give no indication that the engagement of GPs with their patients has changed due to the developments in the remuneration system. Only in one interview there is something mentioned which is relevant in this context. From that interview, it follows that patients are not informed about the reimbursement to the GP by the health insurer. More openness about this reimbursement could have a severe impact on engagement. In the last paragraph on ethics, I already mentioned that several GPs consider it essential for their care provision to take the initiative to keep in touch with severely ill patients. Consequently, they judge it as honest to get these services sometimes reimbursed as normal consultations. From the specific interview, it follows that more openness

would place all GP actions under extra scrutiny, cutting out the discretionary space to manoeuvre. It would bring a new dynamic to the accountability relationship GPs have with their patients.

‘You would hear it from your patients: ‘that GP came by to visit me which is very kind. However, afterwards I received a bill for a consultation!’ Those people are furious! It does make a difference that the patient has no insight in the reimbursement to GPs.’

It goes too far to conclude that this would count for all respondents, but it might very well be that more openness on the reimbursement to the GP by the health insurer would negatively influence the trust relationship between patients and their GPs. After all, the care they receive would suddenly have a clearly visible price tag attached.

According to all respondents except for one, the combination of capitation fee and fee-for-service has also had no impact on the engagement of GPs with the profession itself. Only one GP mentions that engagement has become less obvious. Especially the organizing of collective activities used to be something GPs just did in their spare time. Nowadays, GPs are very busy people of whom many work part-time. According to the respondent, everything engagement within the profession has become more business-like. For example, the commissions that have a reimbursement, like the council of the after hours clinic, are clearly more popular.

#### ***7.4.2 Standardization & performance measurement via guidelines & indicators***

Comparably to the remuneration system, the guidelines have not affected the engagement of GPs either. Many respondents attach great value to the guidelines as evidence-based best practices that can improve the quality of GP care. Nevertheless, deviation from the guidelines is possible, allowing GPs to provide tailor made services to their patients. The interviews provide no indications that the guidelines have had an impact on the personal involvement of GPs with their patients. The interviews do evoke the impression that the guidelines have slightly increased the engagement of GPs with their profession. Several respondents have been part of commissions that have been involved in formulating these guidelines. Moreover, as mentioned in paragraph 7.3.2, the NHG-guidelines have become the norm and in that sense, they have increased the uniformity of GP care. After all, they provide a certain measuring-staff to compare their own actions and those of their colleagues with.

According to twenty-one respondents, the system of codes and indicators on the other hand does have an effect on GP engagement. There are no indications that the engagement itself has changed, but it seems as if the preconditions for engagement have been altered. The respondents emphasize that it takes more effort and creativity to be as engaged with their patients, as they believe GPs should be. The most prominent is the delineation of the time a consultation takes. One consultation is set to ten minutes. Except for one, all GPs experience this as a huge time pressure that hinders them in carrying out their tasks as a GP. After all, the codes and indicators seem to miss out on the fact that half of a GP’s care provision consists out of a social side (see among others paragraph 7.2.2).

‘Relational quality is the first thing that is being cut out. Somehow, the pressure on the practice only increases. People have more questions. Time is pressured constantly. We are too much in a hastiness mode.’

Most GPs emphasize that time as a factor is very important for GP care and should not be underestimated. Especially during the consultation, time is essential to find out what the complaint of a patient really is. After all, sometimes a patient comes in with a certain somatic problem that actually has a psychological origin. Formulating a proper diagnose takes time. Consequently, many GPs emphasize that you cannot always be very engaged and deliver excellent GP care, because you do not have the time to do so.

'If you want to score an eight or a nine during every consultation, you will not hang on. Sometimes you score sixes. You only have little time, you cannot let very patient finish their story and you must act fast. It is wry if you make mistakes. Medical mistakes remain most of the time unnoticed or you can correct them. After all, we highly depend upon our senses. People come in with all kinds of vague complaints and we must work with a probability diagnose. It makes us vulnerable.'

The entire GP care system with its codes and indicators seems to be aimed at production. Patience has become more rare within GP practices. However, since most of the patients that come to consult their GP are merely worried and have no severe health risk, the diagnose 'just give it some time and if the complaint remains for an x number of days, come to visit me again' is very legitimate. Some GPs mention that it is of course possible to plan a double consultation or to ask a patient to have a second consultation shortly after the first. However, in reality this is more difficult than it seems because GPs do experience a severe time pressure.

'It is all very hectic: it goes on and on. The time pressure is immense. This is caused by multiple factors. I would really like it if I did not have to rush along constantly. Sometimes I simply take time for my patients causing a consultation to exceed its time.'

One respondent clearly expresses that the time pressure really is troublesome for the GP profession resulting in a clear decrease in service motivation.

'The pressure has increased. I have almost no time to take a moment's rest in order to consider other options. The story behind a complaint is very important. Now there is an overdone striving for efficiency. The norm practice has 2,350 patients. It is impossible to provide care the way I want it! You are confronted with your own frustration! If this continues, I will decide to have less patients, or I will quit my job.'

That the modern practice sometimes is too busy is illustrated by one respondent who mentions that together with several colleagues they temporarily hired a GP in order to be able to meet the demand for care. There is only one respondent who strongly disagrees with this commonly heard complaint that the time pressure is excessively high. This respondent argues that whether you have enough time for your patients or not solely depends upon how you organize your practice. According to this GP, most colleagues simply do not know how to be entrepreneurial. However, this stance appears to be very exceptional.

When it comes to engagement with the profession, none of the GPs mentions that the system of codes and performance measurement has had a direct influence. Practically all respondents argue that the involvement with the profession is still very high among GPs in general. However, some of

them do mention that the chronic lack of time in the GP profession also causes involvement to become more difficult. To take on all sorts of extra tasks requires an investment of time and effort. Several GPs mention that they already work a lot outside office hours, for example in the after hours clinic or because a severely ill and dying patient requires extra care.

#### ***7.4.3 Internal organization: task rearrangement***

Did task rearrangement affect the understanding of GP engagement? According to practically all respondents, this is not the case. However, several respondents mention this is due to their own effort not to let this happen. As already discussed in paragraph 7.2.3, some GPs explained in the interviews that although they have (had) employed POHs and assistants they do not always delegate the simple/routine tasks. These tasks sometimes provide an excellent opportunity to strengthen the social relationship between GPs and their patients but of course, due to the time pressure discussed in the last paragraph, it is not always possible for GPs to carry out these tasks themselves. Therefore, although it has not really affected the understanding of GP engagement itself, reality teaches that task rearrangement sometimes is experienced as a factor that hinders true GP engagement.

‘Recently, you see much task delegation. I believe that the GP practice should actually be smaller because of the relationship with the people. That has all changed and that is a pity.’

Nevertheless, that is only a relatively minor point whereas practically all respondents answer with a firm ‘no’ to the question whether economization has had any influence on the engagement GPs have both with their patients and with the profession.

#### ***7.4.4 Horizontal organization: more cooperation & after hours clinics***

The interviews show a more diverse picture when it comes to the effect of collaboration between GPs on engagement. Some of this diversity can be explained by a difference in the understanding of the concept of ‘continuity’. Traditionally, the GP as a family doctor was available twenty-four hours a day, seven days a week. Continuity in the sense of constant availability was a high value within the profession. Nowadays, the definition of continuity within GP care has changed. This also counts for at least nineteen respondents. Continuity is no longer defined as constant availability by the specific GP him-/herself. Instead, it is about organizing your care as a GP in such an efficient way that a colleague can help your patients if necessary (see also Dwarswaard, 2011). For example, this happens a lot when GPs work part-time. Continuity has become continuity in care and less in care by a specific GP. The few respondents that adhere to a more traditional stance on continuity seem to consider this as a huge deterioration of GP engagement. One of them illustrates this by providing a thought experiment.

‘You feel a marble in your neck that was not there before and that is growing. Then there is only one thing you can think of from that moment on: ‘as long as it is not a cancer!’ (...) As soon as you start calling, what do you want to happen? Then you do not want to hear: ‘you have reached GP practice x, press one for emergency, press two for the prescription line...’ You do not want that! You want to hear: ‘with [name]’ ‘Hi [name], I am the neighbour, I know it is four o’clock, but I am really worried.’ ‘You should have called earlier, but since it is you I will ask the GP whether he will take a look.’ Then you also do not want it to be a young

person who thinks: 'I have to pick up my kids in ten minutes'. You want an old, grey, slightly rough man, actually exactly that which is hated these days (...). You want to have him because he makes time for you, he knows you, and he has seen it many times before and realizes how worried you are. And he knows the internist you have to visit and he will say: 'I will call for the ultrasound image and make sure you can go there tomorrow.' And when you have had the research (...) you want to go back to the same GP afterwards. You do not want to be helped the same day if it is by a different GP. You want to see the same person! When you get ill, you do not want anything to do with a cumbersome organization. You want a real GP!

The respondent quoted above clearly considers GP care not as something that can be organized as delineated services, which are provided within office hours by a GP *or* by his colleague. It is all about the personal relation between a specific GP and the patient. From this perspective, collaboration aimed at making an efficient time distribution possible is regarded as an impoverishment of GP engagement.

Nevertheless, the vast majority of respondents have come to consider continuity as continuity in care and not per se as care by a specific GP. From that perspective, collaboration has not affected engagement because being a committed GP does not imply 24/7 availability. On the contrary, having a close colleague to whom you can transfer your patients during holidays or absence in general is regarded as a positive thing for service delivery. For example, for one GP having a duo-practice this was the main reason to bring in a third colleague. Another respondent mentions that it is not always easy for instance when you leave on a holiday while one of your patients is terminally ill but as a GP you simply have to make choices.

More collaboration between direct colleagues within group-practices of all kinds does not directly increase professional engagement. The interviews do give indications that regional collaboration via the after hours clinic does increase professional engagement. One respondent mentions that during a strike in October 2011, collaboration via the after hours clinic made it possible for many GPs not to abandon their patients and still travel to Amsterdam to protest against governmental policy.<sup>27</sup> Another respondent mentions that the teamwork in these clinics increases collegiality. In answer to a question about professional engagement of Dutch GPs, this respondent says:

'Yes, I think so. Not everybody, but we are a close-knit group. The after hours clinic has contributed a lot to that. Every time you work in a different team. Thirty times a year, ten years long every time a different team. That is great!'

For the engagement with patients the after hours clinic has not been a positive development. I have already discussed this in paragraphs 7.2.4 and 7.3.4, but what it comes down to is that GP care provided via after hours clinics is generally regarded as very impersonal. Whereas GP care consists out of a medical technical side and a social side that supplement each other, the respondents

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<sup>27</sup> The strike referred to took place on October 6<sup>th</sup> 2011. On that day several thousand GPs, POHs and assistants protested against the reclaiming of 132 million Euro by Dutch minister of Health, Welfare and Sport Edith Schippers. Later, this amount of money had been lowered to approximately 100 million Euros.

emphasize that this latter side is almost completely lacking in the after hours clinic. After all, you do not know the (demanding) patients that come to consult you. In paragraph 7.4.2, I mentioned that patience has become rare in the GP practice. Instead, there is an emphasis on medical-technical action. This is not just because of standardization pressures, this has also to do with the customer behaviour of patients which is especially notable in the after hours clinic.

‘The patient clearly become more of a customer. Some people are not prepared to wait. They pay a premium so if they have a question today, they want an answer today as well. Postponing care no longer happens. Partners who both have jobs want to know whether they can go to work the next day whenever their child is ill. They go to the after hours clinic. It happens a lot. The after hours clinic has professionalized and has become very customer and service focussed. (...) The only one that regards it as an emergency service these days is the GP who works there. (...) In our current economy, I can understand it. Everything goes ten times as fast as before. If you have a problem, and you know there is a solution, you just go for it! After all, you do pay your premium.’

The same respondent mentions that in the beginning this was experienced by many GPs as really annoying. However, resistance seems futile and the respondent characterizes it as fighting a losing battle. All in all, the after hours clinic has increased professional engagement, however it has made engagement with the patients more superficial.

#### ***7.4.5 Vertical organization: healthcare groups & multi-disciplinary care***

The development of healthcare groups and multi-disciplinary care has not affected the engagement of GPs with their patients. Some interviews show a tendency towards indicating that multi-disciplinary care implies an increase of engagement. After all, the GP can be regarded as the ‘director’ that manages the entire process of primary care that is being provided to a patient. However, based on the interviews it is impossible to conclude that this really matches the experiences of the respondents.

When it comes to engagement with the profession, the interviews show much more reference points. Many respondents emphasize that changes within the vertical organization of GP care, and especially the formation of healthcare groups and the organization of multi-disciplinary care, has made engagement very complex. In paragraph 7.1.3, I quoted a respondent stating that GPs are forced to clump together in new organizations. These are the healthcare groups. The quotation continues as follows:

‘(...) New organizations with a management layer that makes it possible for us as GPs to do what we always did and that is taking care of people with type two diabetes. So the health insurer buys diabetes care of [organization x] and consequently we carry it out and receive money via [organization x]. It is an entire structure to do what we always did.’

This GP is not the only one. Many others paint a similar picture.

‘It is because of economization. We have to receive money and deliver quality. And that has to be streamlined. An office has been founded for that and it has a secretary, and it has a

quality coordinator and a measurement unit that retracts information from the HIS and so on. Not just for diabetes but also for COPD. We have created a huge infrastructure. (...) In the past you had the LHV with local departments that coordinated the contact with hospitals and the like. If you knew what was going on in the local members meeting, you could follow what was going on. Now there are so many organizations. Everyone has its own goals and has to maintain itself. (...) All sorts of different offices, with different secretaries and different bosses. You simply do not know them anymore. (...) More layers have been created. An entire structure of the after hours clinic, an entire structure of the healthcare groups. (...) I went to a GP fair recently. The number of organizations that exist because of us scares you!

As follows from the quotation above, the number of forums in which GPs can play an active role has increased dramatically. According to several respondents, this discourages getting involved: it takes time, it is complex and splintered and the influence you have is rather limited. Because of this, many GPs do not feel called to be very active for their profession and adopt an attitude of 'wait and see'.

#### **7.4.6 To conclude**

Economization has not really led to a different understanding of GP engagement. GPs can be committed both to their patients and to their profession. The former is about knowing the patient in its context. The second is usually regarded as fulfilling some sort of an advocacy role. The remuneration system with its mixed capitation fee and fees-for-services has not changed the commitment of GPs to their patients. It deserves notice that the reimbursement of GPs by health insurers is not something patients are informed about. Furthermore, the remuneration system has also not changed the involvement of GPs with their own profession. One small remark is that commissions that have a reimbursement, seem to be more popular among GPs.

The guidelines have not affected GP engagement with the patients either. It seems it has only slightly increased the engagement of GPs with their profession. The guidelines have become the norm. They form a sort of benchmark for a GP's own practice and that of their colleagues. The delineation of GP care by the system of codes and indicators on the other hand has had an effect on GP engagement. Note well, not on the understanding of what GP engagement entails, but on 'practicing' engagement. The most prominent factor that hinders engagement is the delineation of the time a consultation should take. A consultation is set to ten minutes. Twenty-one respondents experience this as a huge time pressure that is harmful for the social side of GP care. The importance of time as factor should not be underestimated for the quality of GP care. Patients come in with vague complaints and formulating a proper diagnose takes time. It seems as if the entire system is aimed at finding a medical-technical cause for a certain complaint pattern and neglects the social side of the GP profession. Moreover, time in the sense of patience is also pressured while 'patience' is one of the best medicines a GP has. The system of codes and performance measurement has had no direct influence on the professional engagement of GPs.

Changes in the internal organization of GP practices have not led to a different understanding of GP engagement. In order to safeguard their engagement with their patients several GPs do not delegate all simple tasks to assistants and POHs. After all, these simple tasks sometimes provide an excellent opportunity to inquire about a patient's health in general or that of his family members.

Developments within the horizontal organization show a more diverse picture. It turns out that a difference of opinion about what 'continuity' entails causes some GPs to regard collaboration as an impoverishment and others as an enrichment for GP engagement with his patients. Many GPs have become less strict in defining continuity as 'continuity in care provided by a specific GP'. Instead, they have come to define it more as 'continuity in care' and they have become less reluctant in referring patients to direct colleague for example in order to be able to work part-time. Collaboration within group-practices does not affect professional engagement, but the teamwork in the after hours clinic does make the profession more closely. Simultaneously, the after hours clinic has not been a positive development for the engagement with patients. GP care provided via these clinics is generally regarded as impersonal because GPs do not know the patients and many patients adopt a consumer attitude. Many GPs have resigned themselves to this superficial kind of engagement that they believe is harmful for the quality of their care provision.

Developments within the vertical organization of GP care have not affected the engagement of GPs with their patients. However, they have affected the engagement of GPs with their profession. Many respondents feel as if they do not see the wood for the trees. Nowadays, GPs can be involved in many forums. Several respondents feel discouraged to be involved in any of them. After all, they do require a substantial time investment, but their influence is experienced as rather limited. Consequently, engagement has become a bit more engagement from the sideline.

## 7.5 Pre-conditions

In chapter 4 I have distinguished several 'pre-conditions' that are essential for the care provision of GPs. After all, a GP does not provide care in a vacuum. A GP can only do 'good work' if society grants him to possibility to do so. Based on the application of social contract theory within medicine, Cruess and Cruess have formulated expectations about society (2008: 585-586). These expectations form the basis for distinguishing four pre-conditions. Between the lines, all these pre-conditions have already been touched upon in this chapter. In this paragraph, I will pay concise attention to them one by one.

### 7.5.1 Autonomy

Autonomy is about the discretionary space GPs have to take independent decisions themselves and not feel restricted by external forces. When asked whether GPs nowadays still feel as if they have such space to take decisions, the majority of the respondents says they are autonomous to a certain extend but their autonomy has been put under pressure. When it comes to medical decisions, practically all GP say they in general can still do whatever they think is best. One respondent expresses it by comparing GPs to specialists. From that perspective, it stands out that GPs have relatively much freedom to determine a medical approach they wish to follow. Nevertheless, they do experience a lot of pressure in the organization around the GP care process. This pressure comes from policymakers, politicians, health insurers and patients.

'I think I am still autonomous. I try to do what I have to in order to contribute to the health of a patient. However, I do notice that over my shoulder the health insurer is watching. Literally via material controls. It is a strong accountability pressure. The patient has become more of a consumer to a certain extend. There is this permanent crap coming from the government.

(...) I do see pressure on our practices. (...) It is all ‘you no longer determines what is happening, I determine that and you have to be transparent in your doings.’ (...) This pressure comes from all parties. (...) It is becoming less free and more binding.’

In general, GPs still have the room to exercise judgement, but it has become less self-evident because of an ‘umbrella of controlled obligations’ that sometimes hinders professional decision-making about medical matters. Many GPs fear that in the near future GP practice equals carrying out protocols.

### **7.5.2 Respect & status**

Throughout this chapter, attention has been paid to the increase in customer behaviour by patients. The majority of the respondents confirms that patients have become more like consumers. They demand more services and seem to be more self-centred. In itself, the consumer behaviour of patients is not always problematic. Being more demanding and critical does not automatically imply that a patient disrespects his GP. However, it becomes problematic whenever patients show little patience and basically want their GP to do whatever they say, whether it be writing a referral or prescribing an antibiotic. All GPs regularly come across such behaviour, especially in the after hours clinic. These patients show little respect for the GP as a professional (and sometimes even disrespect the GP as a person).

‘You come across people that treat you as dirt! They do not see you as care professional. People who think ‘you do whatever I ask’. It is getting worse. The lack of respect people sometimes have for you is astonishing. (...) Aggression. People who consider it to be normal to disturb you for every little something they have. (...) The norms are fading. Now people sometimes think: ‘I do not care whether you have studied for it, I want an x-ray of my knee so you make sure I will have on.’”

However, most GPs emphasize this to be a minority. The vast majority of patients that come to consult them definitely does *not* show such inappropriate behaviour. Especially with their own patients, GPs have a very strong relationship with trust as its fundament. The mutual respect between them is generally large but the nature of this respect has changed over the past few decades. This has everything to do with a change in status. GPs do not consider themselves hierarchically superior to their patients. All GPs emphasize that the relation they have with their patients is being characterized by equality. This is clearly expressed by the fact that many patients are on familiar terms with their doctor. Most GPs feel perfectly comfortable with this equal relation because it shows that as a GP ‘you are firmly grounded in society’.

‘Nowadays, the profession is more regarded as a job. Even when someone addresses me as [first name] in the waiting room, I still feel respected. Whether I think it is inappropriate depends upon the situation itself. Apparently, someone really feels comfortable so I do not mind. Sometimes I do think ‘you should not say it like that’. For example, when someone shouts loudly across the waiting room ‘I want to talk to you’. Then I would say, ‘You mean ‘doctor, can I have a word with you?’”

On the whole, all GPs do come across consumer behaviour more often. As one GP puts it, there is a clear emphasis on the rights people have, but not on the duties that come along. In most cases, this is not a problem because it does not automatically lead to disrespect. In general, the status of the GP profession has decreased but all GPs consider this to be something positive: the relationship with their patients is characterized by equality.

Above, I have discussed the respect and status in relation to the patient, which is the 'bottom-up side'. How about the 'top-down side' of society, that is the government? It deserves notice that all respondents feel disrespected by the government. The majority even to a great extent. This has a lot to do with the reclaiming of millions of Euros to which I will pay more attention in the next paragraph. It also has to do with the important role of health insurers in the current healthcare system. One respondent says the power balance has 'completely shifted towards the health insurer'. Most respondents feel distrusted by the government and believe they are being messed around with. One respondent exclaimed during the interview:

'The way GP care and its budget are treated is a huge vote of no-confidence!'

Many respondents feel as if their profession has allowed the way it is being treated to go unchallenged for too long. They feel betrayed by the government and they have become hesitant in following all kinds of 'meaningless trial projects' initiated by the government. After all, why would you enthusiastically take on all sorts of extra tasks if you cannot count on consistent support?

'In governmental policy, not just the patient, but the GP should be central! Then you start to trust him! You should give him the power and support. The current safety system restrains us. It would also lead to dramatic cost-savings!'

### **7.5.3 Financial reward**

With the introduction of the system of managed competition, and consequently the change in remuneration of GPs, much has changed. Last year, the salary of the average Dutch GP made the headlines because the macro budget for primary care was exceeded and minister Schippers wanted to reclaim millions of Euros. This implied a claim of 20,000 Euros per GP. The entire discussion focussed on the question whether GPs had increased their income with an unreasonable amount. This thesis does *not* answer this political question but focuses on the discussion around it. After all, it was brought up in every interview, so it is definitely a main theme within GP care not to be missed.<sup>28</sup> The discussion has two important and related aspects I will discuss here: the 'boiling frog'-principle and a feeling of injustice.

Primary care is much cheaper than secondary care. Consequently, governmental policy has been aimed at stimulating GPs to expand their care provision in order to take over secondary care. In theory, this is voluntarily. In practice, several GPs have indicated that they feel pressured to go along

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<sup>28</sup> On June 23<sup>rd</sup> 2012 it was announced that minister Schippers and the GPs had reached an agreement about the budget. Basically, the minister downsized the financial penalty by guaranteeing that GPs will not face another claim for this financial year (NRC, 2012). However, this agreement was reached *after* the interviews for this thesis were conducted and therefore no further attention can be paid to it.

with these developments (e.g. healthcare group membership, multi-disciplinary care, setting up projects). The 'boiling frog' is a metaphor for the GP who has been asked over and over again to expand the scope of his care provision a little bit. All in all, many GPs have started to carry out more little tasks. Because this did not happen overnight but in the time span of many years, it has not drawn much attention to it. In retrospect, many GPs do experience an increase in workload. The extra work has also resulted in extra salary. However, the respondents differ strongly in answer to the question whether the rise in income is proportional to the increase in workload. Some GPs say this is true, others fiercely deny it by saying they have to work a lot harder for the same salary. Nevertheless, it is good to realize that even if the extra work is rewarded, this is not sanctifying.

'The financial position of the GP has improved. Not everybody will say so, but 'more income because of more work' is true: we do more and we earn more. However, I already made a good salary! I do not want to do that extra work but you simply have to!'

Already in paragraph 7.3.1, I mentioned the encouragement of waggish behaviour by GPs. Several respondents mention that somehow they try to compensate for their 'loss', for example by being very strict.

"Do more! Do more!" I used to think that the idea was 'more work is more salary'. I did not see that in reality. Then you adapt it yourself. In that case, I can decide what I am prepared to do for the nine Euros.<sup>29</sup> The patient has five complaints and if you do your best, you can solve them within fifteen minutes and code them according to the norms of the profession. However, you can also say 'I listen a bit better to one complaint and you should visit me again for the other'. You rather do not do that because the patient wants to talk about his next complaint as well and then you start to delineate things. I consider that to be too much demarcation and I would rather not do that.'

This already touches upon the feeling of injustice all respondents share: all of them consider the way in which GPs and GP care has been treated as highly unfair. Over the past six years, the government has encouraged GPs to expand their care provision in order to relocate services from the secondary to the primary care echelon. Many GPs have done so with the presumption that the remuneration system allows for reimbursement of the extra care they nowadays are able to provide. Many M&I-projects have been designed in collaboration with the health insurer. This increase in tasks has led to a substantial increase in sales volume. Consequently, in the fall of 2011 the government decided to claim millions of Euros from all Dutch GPs because they had exceeded the macro-budget over 2009 and 2010. This would imply a financial penalty of 20,000 Euro's per Dutch GP. Most GPs are furious about this decision.

'For years we have been asked to take over care from the secondary to the primary care echelon. We received many pats on the shoulder saying 'you can also do diabetes care'. In hindsight, we have taken on a business risk for which we often were not yet paid. After all, there were no definite price agreements with the insurers. We carried out everything and

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<sup>29</sup> Approximately nine Euros (8,78 Euros) is the reimbursement for a normal consultation.

then the minister comes in blandly saying that the budget has been exceeded and that it will be reclaimed from our salary. This is a huge frustration for many GPs.'

The frustration is not about the height of a GP salary. In fact, practically all respondents emphasize that the average GP salary has increased. As already mentioned, it is debatable whether this matches up the increase in workload. However, the governmental claim is experienced as a complete destruction of legal security. After all, GPs have been asked to become more entrepreneurial but now, many feel betrayed because afterwards it turns out they were not allowed to make profit. A profit most respondents claim not to have. The government is widely regarded as an unreliable partner and many GPs have become a bit anxious for policy initiatives.

'As a beginning GP who recently has a mortgage, you can become very anxious of all those policy experiments. It is very intense and insecure. Government is very whimsical. At the end of the year I know how I have been doing. I do not get a salary.'

Most of the respondents are not very good entrepreneurs. Some hesitatingly admit it themselves, others try to cover it up by saying that they hate doing 'managerial stuff'. Especially for the older GPs, the changes of that past decade have been very drastic. Many GPs like to play it safe and consequently, taking on 'business risks' by investing in things like group-practices and task rearrangement is often experienced as a serious burden. By 'changing the rules while playing the game', government has put itself in GPs' bad books.

#### **7.5.4 Role in policy making**

In answer to the question whether the respondents still think GPs matter as a discussion partner in policymaking, a diffuse picture arises. Most GPs say it is hard to estimate. A few respondents are very confident that the LHV does a good job and safeguards the position of the Dutch GP. However, the majority feels unheard by 'the Hague' and by the LHV, which according to some has become part of the elite. Several respondents are also frustrated because of their colleagues. They say that many Dutch GPs are too kind-hearted which hinders them to make the profession's presence really felt.

'GPs are [abusive language]! GPs are the only professional group that would buy a Rembrandt when it is sold at the front door! We tolerate everything! What profession agrees with a fifty hour workweek?!'

Based on the interviews, it is not possible to conclude whether the position of GPs as negotiation partner has actually changed. Nevertheless, I have already mentioned that practically all respondents feel disrespected and messed around with by government. The respondents think GPs are nowadays taken less seriously and in that sense they experience the influence of GPs as professional group on the policies that are being implemented as diminishing.

### **7.6 Realizing your professional identity**

In the last four paragraphs, I have paid extensive attention to the different elements of professional identity in relation to the different 'tokens of economization'. Paragraph 7.6.1 presents the main findings (table 7.1). In paragraph 7.6.2, I will pay a closer look to how we can understand these findings.

### 7.6.1 The professional identity of GPs

The most important findings of the empirical part of this study are put in table 7.1 organized along the dimensions of the conceptualization of the professional identity of GPs. For an extended version of the table, see appendix V.

<i>Economization &amp; Professional identity of GPs</i>	
<i>Excellence</i>	<p>GP excellence has a medical-technical and a social side. Economization seems to focus solely on the medical-technical side. Nevertheless, this has not changed the understanding of GP excellence as having these two sides.</p> <p>This study shows that the majority of the interviewed GPs regard several developments that have clear signs of economization as a slight improvement of medical-technical excellence. The fee-for-service encourages expansion of care provision, guidelines provide hold, task-delegation enables specialization, efficient collaboration facilitates inter-GP consultation, and multi-disciplinary care improves care provision for chronically ill.</p> <p>This study shows no indication that GPs have come to consider the social side of their profession as less important. The emphasis on the medical-technical side works as an obstructive factor, especially when the respondents have no room to manoeuvre: the codes and indicators they have to use to 'show' their 'quality' and the after hours clinic where they feel pressured to provide care.</p>
<i>Ethics</i>	<p>GP ethics can be envisioned as a model with rings of responsibility. According to the respondents, the patient forms the core of this model, followed by 'the self' and macro-responsibility. In general, the understanding of ethics as putting the patients interests before everything else, followed at a distance by the others responsibilities has remained unchanged. The remuneration system has not changed this model, nor has the increase in standardization. However, this latter <i>is</i> experienced as a vote of no-confidence and hinders GPs to fulfil their responsibilities towards their patients. Task delegation did have an effect: it has added a ring of entrepreneurial responsibilities. Besides, also the after hours clinic has affected the respondents' sense of responsibility whereas they have become less reserved in following the demands of the patient. Multi-disciplinary care has not affected the understanding of ethics, but several respondents emphasize the restricting character of this kind of care.</p>
<i>Engagement</i>	<p>Engagement concerns two relations: between GPs and their patient, and among GPs as a professional group. The former is about knowing the patient in its context. The second is usually regarded as fulfilling some sort of an advocacy role. Economization has not led to a different understanding of GP engagement. In reality, some economization developments impede engagement and others foster it. The most important observation is the restricting influence of the delineation of services within GP care. Except for one, all respondents strongly emphasize they nowadays have great difficulty to be as involved with their patients as they consider necessary. A second important observation is the 'double role' of the after hours clinic. On the one</p>

	hand, the teamwork increases professional engagement. On the other hand, there is no social bond between the GP and the patients that comes to consult him at the clinic.
<i>Preconditions</i>	Most respondents mention they are <i>autonomous</i> : they have the discretionary space to take independent decisions. Nevertheless, most of them do experience pressure because of all kinds of organizations and an ‘umbrella of controlled obligations’. <i>Respect &amp; status</i> have changed. The respondents experience the vast majority of consultations by patients as pleasant. Sometimes, patients can have a strong customer attitude and be very demanding. In most of these cases, they can be very rude to GPs. This happens much more often in the after hours clinic than in the respondents’ own practices. After all, they know their patients. More problematic is the perceived respect shown by government. All respondents feel disrespected by the government that is regarded as unreliable. This has everything to do with the <i>financial reward</i> GPs receive. Foremost, practically all respondents are happy with their salary and many say their income has increased due to the managed competition system. However, they add two elements that put it in another perspective: many of them experience an increase in workload and the respondents differ strongly in answer to the question whether the rise in income is proportional to the increase in workload. Furthermore, all respondents in a sense feel betrayed by government who has encouraged GPs to take on extra tasks and has billed them for it afterwards. Most GPs find it hard to estimate whether the role of GPs as discussion partner in <i>policymaking</i> has changed in the economized environment.

Table 7.1 – Economization & professional identity of GPs: the main findings

### 7.6.2 ‘Is’ and ‘ought’

The results presented in table 7.1 show something interesting. For all three elements of professional identity, I have mentioned that ‘the understanding’ of the specific element has not really changed in its essence. With regard to excellence, this means the respondents have not come to consider ‘GP excellence’ as solely medical-technical quality. They consider the social side to be at least fifty percent of ‘GP excellence’. With regard to ethics, this means the respondents do not set other interests and responsibilities right next to patients’ interests. Responsibility towards the patient is followed on a distance by responsibility towards ‘the self’. With regard to engagement, this means the respondents define engagement in the GP-patient relation as knowing the patient in its context and in relation to the professional group as fulfilling some sort of an advocacy role.

In the periphery of two elements, the professional identity of GPs does show some signs of economization influence. With regard to excellence, the majority of the respondents have come to understand medical-technical excellence as following the NHG-guidelines, offering specialized GP care and striving to collaborate with colleagues. With regard to ethics, an extra ring of entrepreneurial responsibilities is added. These responsibilities can sometimes be at odds with the preceding ring, the macro-interests. With regard to engagement, the respondents show no signs of a different understanding due to an economization influence.

None of the preconditions that are essential for the core of the GP professional identity are truly compromised because of economization. Except for one respondent who experienced his autonomy being limited too much, none of the respondents experienced any of these preconditions as pressured to the extent that they no longer can carry out their work as a GP.

This seems an answer to the main question of this study: despite the economized environment having an economic logic, the GP as a professional having a professional logic has not really changed his identity. However, leave it that way would not do justice to the empirical reality I have encountered and which is also shown in table 7.1. The understanding of what the professional identity of GPs entails does not automatically imply that GPs can exercise their profession in line with their professional identity. There is an important extra dimension that is the intermediary between the economized environment and the professional identity of GPs: the way they act.

As discussed in chapter 5, doing and thinking are two different dimensions that can differ. I distinguished three possible reactions of GPs to economization: adaptation, alienation and resistance. Above, I argued GPs have not really changed their professional identity besides some changes in the periphery. This means that we cannot speak of adaptation of the respondents. Instead, many respondents show clear signs of alienation *and* resistance. As mentioned in table 7.1, economization seems to focus solely on the medical-technical side of GP excellence. Since the respondents have not come to consider the social side as less important, they have to 'fit in' this social side themselves which is especially hindered by delineated codes and indicators. The usage of the ICPC-codes is compulsory. Moreover, whereas many respondents are affiliated to a healthcare group and involved in multi-disciplinary care project, they are obliged to work with indicators in order to show their performance. In this context, many respondents have come to speak of 'bureaucratic hassle'. Basically, they fill in the forms they have to and they provide all information which is required but it has become a 'paper reality'. As one respondent puts it (see paragraph 7.2.5):

'Anyway, we are obliged to found all sorts of new organizations and that brings along a lot of meetings and overhead. For that we need all sorts of new forms and we need to register patients and we need new protocols that subsequently nobody looks into. We do use those protocols, but the physical things of course you do not use. These are neatly in a folder for when someone comes in to check it of course.'

Moreover, the respondents experience the delineation of all GP services via codes, indicators and other norms as a sign of distrust in their intentions and capabilities and as a hindering factor for fulfilling their responsibilities towards their patients. In particular, the limited time of the consultation is an often mentioned factor. One respondent even mentions that he would have sincere doubts to take the physicians' oath again if he could do it all over again.<sup>30</sup> The same respondent even doubts whether he wants to stay a GP (see paragraph 7.4.2).

'The pressure has increased. I have almost no time to take a moment's rest in order to consider other options. The story behind a complaint is very important. Now there is an

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<sup>30</sup> The Hippocratic Oath

overdone striving for efficiency. The norm practice has 2,350 patients. It is impossible to provide care the way I want it! You are confronted with your own frustration! If this continues, I will decide to have less patients, or I will quit my job.'

Besides alienation that refers to a discrepancy between how a GP wants to act and has to act, there are also clear signs of resistance. In this case, GPs break the rules in order to act in accordance with their professional identity. As we have seen, sometimes GPs are prepared to break the rules if they think this is best for the patient (see paragraph 7.3.2).

'Every now and then I do not really mind to call something a 'medical necessity' while the criteria do not really define it as such. I choose for the patient and not for the health insurer.'

This does not only happen with prescribing medicines. It also happens when a GP considers it to be necessary for the care provision to call a patient and document it as if the patient himself had called. Moreover, as we have seen earlier, the system every now and then encourages mischief. One GP strikingly phrases both alienation and resistance by describing how he deals with economization pressures:

'Even when the world is upside-down, you go on. You do the things you are required to do. I do not feel like 'fighting windmills'. If I arrive here in the morning, I need to feel like going for it. You need to organize your own job satisfaction. You must accept things that are not good. You should stay practical. Putting up with these things sometimes means not to follow the rules. (...) It is a bit professional pride. Everything must be fair. The patient is the most important person! Professional honour, pride, is the driving force behind \*\*\* years of being a GP. I do worry about all these things but it is not the core.'

## 7.7 Conclusion

In this chapter, I have discussed the empirical results of this study. Based on the conceptualization of professional identity of GPs (see chapter 4), I have paid attention to the five tokens of economization (see chapter 3) in order to answer the fourth subquestion.

### 4) *How do Dutch GPs experience economization in terms of their professional identity?*

The empirical part of this study shows that economization has not influenced respondents' understanding of the core of the professional identity of GPs. Excellence has both a medical-technical and a social side. Ethics can be interpreted as a model with rings of responsibility with the patient as its core, followed by 'the self' and macro-responsibility. Engagement concerns two relations: between GPs and their patient, and among GPs as a professional group. The former is about knowing the patient in its context. The second is usually regarded as fulfilling some sort of an advocacy role. Nevertheless, economization has influenced the periphery of excellence and ethics. With regard to excellence, the majority of the respondents have come to understand medical-technical excellence as following the NHG-guidelines, offering specialized GP care and striving to collaborate with colleagues. With regard to ethics, an extra ring of entrepreneurial responsibilities is added. None of the preconditions that are essential for the core of professional identity is compromised.

Although the 'tokens of economization' have not led to a different understanding by the respondents of GPs' professional identity, they have influenced the work of the respondents. A diverse picture is painted when it comes to the different elements of professional identity. Sometimes they tend to strengthen a certain factor, and sometimes they seem to compromise it. The most important ones that strengthen GP medical-technical excellence are the expansion of GP care provision and the NHG-guidelines. The most important ones that seem to weaken GP excellence are the codes and indicators that claim to focus on quality, but in fact solely focus on the medical-technical side of GP care, and the after hours clinic where the social side of GP care does not play a role. The most important one that strengthens ethics are the (voluntary) NHG-guidelines that offer a hold to fulfil the responsibility to a patient to provide the best care possible. The most important ones that weakens ethics is the emphasis on medical technical 'curing' instead of 'helping the patient along' which is much more reasoned from patients' interest. The most important one for engagement is the after hours clinic which fosters professional engagement due to the working in teams. Simultaneously, it is also the most important one that weakens engagement: personal engagement of the GP with the patient is nearly impossible due to the impersonal character of the relation between them.

The fifth subquestion is about the 'action' dimension: perhaps the professional identity of GP has remained unchanged for the most part but what about their actions?

5) *How do Dutch GPs deal with economization in their daily practice?*

The empirical part of this study shows clear indications for both alienation and resistance. The actual actions of GPs seem to be an important intermediary between the economized environment with its economic logic on the one hand, and the professional identity of GPs with its professional logic on the other. Economization is experienced as focussing solely on the medical-technical side of GP care. It neglects the social side that is equally important. Consequently, GPs need to 'fit in' this social side themselves, which is not always possible, mostly due to time pressure. Many GPs follow the rules they must follow without attaching any value (and meaning) to it, creating a 'paper reality'. In this sense we see alienation among GPs. Furthermore, GPs sometimes break the rules if they consider that to be just according to their professional identity (e.g. when it is in de patient's interests). In this sense, GPs show resistance.

# Chapter 8

## *Valuing the GP*

In this study, I have focussed on economization and professional identity of GPs. This chapter forms the tailpiece containing the conclusion, a brief look at the limitations of this research and the discussion section.

## 8.1 Conclusion

Over the past few decades, an economic logic has become more dominant within our society (see also WRR, 2012). An economic logic is often said to be at odds with a professional logic like that of General Practitioners (GPs) as medical professionals (e.g. Freidson, 2001). This thesis looks into this theme whereas it aims to examine whether and how economization affects the professional identity of GPs. The central question is:

*What are the effects of economization on the professional identity of GPs and how can we understand these possible effects?*

Professions and professionals are facing both exogenous and endogenous pressures. Together these pressures form a complex interplay. Economization refers to the complex interplay of multiple managerial and societal pressures that put forward the logics of consumerism and managerialism. On the one hand, this complex interplay is partly induced by an economic logic. On the other hand, the same interplay of pressures seems to strengthen the economic spirit of the age itself, creating a vicious circle. Especially in relation to healthcare, the term 'economization' is frequently used (e.g. Hilhorst, 2004). Especially since the introduction of managed competition within healthcare, it has come to play an important role in this sector.

In this thesis, I focus on GPs who fulfil a central role in the Dutch healthcare system. The GP can be regarded as the gatekeeper whose specialism is generalism. Patients can visit their GP as soon as they (think they) have health issues. GPs can treat patients for all sorts of non-specialist problems and when they believe specialist care is required, they can write a referral. Economization did not leave GP care untouched. In order to operationalize economization, I have focussed on five developments I call 'tokens of economization'. These developments are have occurred due to a managerial and/or consumer logic, or they strengthen such logic(s). These developments are the remuneration system; standardization via guidelines, codes and indicators; internal task rearrangement; increased collaboration on district level including the rise of the after hours clinic; and the development of healthcare groups and multi-disciplinary care.

Whereas GPs are seen as the gatekeepers of our healthcare system, this study adopts a functionalist view on professionals: they fulfil a function within our society. By adopting a functionalist perspective on professionals, we can speak of a social contract between medicine and society (i.e. government and general public). A social contract implies mutual expectations. For GPs, these expectations are about the role they have to fulfil, or more abstract, on how they should *be*. In other words, these expectations are about their professional identity: about the quality of their work (excellence), about their intentions (ethics) and about their commitment to their work in general (engagement). This may evoke the impression that professional identity is something independent but in fact, it has a contextual nature. Consequently, four preconditions are added: autonomy, respect & status, financial reward, and role in policymaking.

In answer to the first part of the main question (i.e. *what are the effects of economization on the professional identity of GPs ..?*) this study shows that the respondents have not come to a radically different understanding of their professional identity. In the core, excellence, ethics and engagement are still regarded from a professional logic. Excellence has both a medical-technical and a social side. Ethics can be interpreted as a model with rings of responsibility with the patient as its core, followed by 'the self' and macro-responsibility. Engagement concerns two relations: between GPs and their patient, and among GPs as a professional group. The former is about knowing the patient in its context. The second is usually regarded as fulfilling some sort of an advocacy role. The preconditions are all met, by which I mean that practically none of the respondents experience any of these conditions as compromised to an extent that it becomes impossible to carry out their work. Whereas the core has remained unchanged, economization has had an influence on the periphery of excellence and ethics. With regard to excellence, the majority of the respondents have come to understand medical-technical excellence as following the NHG-guidelines, offering specialized GP care and striving to collaborate with colleagues. With regard to ethics, an extra ring of entrepreneurial responsibilities is added.

Does this mean that economization largely passed by GPs? The answer is no. The 'tokens of economization' might not have changed the understanding of professional identity, they certainly influence the work of the respondents. Sometimes they strengthen a specific factor of professional identity, and sometimes they are at odds with one. With regard to excellence, the economization factors that strengthen GP medical-technical excellence are the expansion of GP care provision and the NHG-guidelines. Those that weaken GP excellence are the codes and indicators that claim to focus on quality in its entirety but in fact solely focus on the medical-technical side of GP care. The other is the after hours clinic where the social side of GP care barely plays a role. With regard to ethics, the (voluntary) NHG-guidelines that offer a hold to fulfil the responsibility towards a patient to provide the best care possible seems to strengthen it. On the other hand, ethics are weakened by the emphasis on medical technical 'curing' instead of 'helping the patient along' which is much more reasoned from patients' interest. With regard to engagement, the after hours clinic is both most positive and most negative. It is positive in the sense that GPs have to work in teams and consequently are more involved in their profession. It is negative in the sense that they have no personal relation with the patients that come to consult him (and as discussed, the social bond as part of the social side is fifty percent of GP excellence).

The second part of the main question (i.e. ... *how can we understand these possible effects?*) asks how we can understand the fact that apparently the professional identity of the respondents does not really change but simultaneously economization does influence their work . The answer can be found in the actions of the respondents: between the economic logic of the tokens of economization and the professional logic of their professional identity the way in which GPs act forms a sort of intermediary 'buffer'. Many GPs find the room to act in line with their professional identity besides 'doing what they have to do' according to their economized environment. When GPs are supposed to act in line with economization principles and these actions simultaneously are at odds with their professional identity they experience a conflict. In many cases, they are obliged to follow the rules

and have no space to manoeuvre. In these cases, they just do what they are being asked to do, in order to get it over with. Often, this is experienced as a bureaucratic hassle creating a 'paper reality'. All in all, it is a huge frustration for most GPs to feel compelled to spend time to do various 'nonsense things'. For example, providing all sorts of medical data like blood values that in itself do not necessarily say anything about the quality of their care. In this case, GPs show signs of alienation: they feel obstructed to act in a way they feel they should act according to their professional identity. Sometimes when they experience a conflict, they do have room to manoeuvre. In reality, this means that they resist the economization pressures by breaking the rules in order to preserve their professional identity. For example, a GP calls a patient in order to inform about a patient's health condition but will administer the telephone call as if the patient had called the GP instead of the other way around.

## 8.2 Limitations

As with practically all scientific research within the social sciences, it is hard to design and carry out the perfect study. Before turning to the last paragraph, I think it is honest to briefly mention at least three limitations. Firstly, although I have interviewed several experts in order to prevent complete 'blindness of others', this study provides a one-sided image of the Dutch GPs. Note well, this was a deliberate choice. Secondly, many of the respondents that wanted to cooperate turned out to have a research/study affinity: many are GP educators, one works at a university and one works at a research institute. Perhaps this implies that the 'commercial GPs' were not included in the group of respondents. Thirdly, in this thesis I have put emphasis on the collective dimension of professional identity. For future research, I think it is a good idea to incorporate more room for individual differences. For example, politically seen some GPs were very right-wing oriented, while others had a clear preference for left-wing political ideas. This influences the way people think about market principles.

## 8.3 Discussion

In this discussion section, I will pay attention to the societal and academic embedding of this study. I want to raise several important points (of concern): the poor and damaged relationship between GPs and the government, the drawbacks of the after hours clinic, the relation with the studies of Dwarswaard (2011) and Van Dijk (2012), trustworthiness, and internal regulation.

In the result section, I have mentioned many GPs are deeply aggrieved by the way in which the government has treated them. Since it has not led to a change in professional identity, I did not focus on it in the conclusion. However, it does matter from a societal point of view. Over the past six years, the respondents have felt called upon to act in line with governmental preference to relocate services from the secondary to the primary care echelon. This was not philanthropy, GPs would get their efforts reimbursed via the remuneration system. The decision by government to reclaim millions of Euros was experienced as a stab in the back. Let me be clear, I cannot answer whether GPs have earned too much money or not. However, the entire process has implied a very worrisome blow to the confidence in the relation between government and GPs. Something we must keep in mind is the observation that most respondents – and probably GPs in general – are not very good entrepreneurs. Some have hesitatingly admitted this themselves, other respondents simply

mentioned to hate doing 'managerial stuff'. Although there is diversity between GPs, many like to play it safe and now feel left alone because the government is experienced to have 'changed the rules while playing the game'. Since GPs fulfil a pivotal role in our healthcare system and seem to have a fairly big sense of responsibility for macro-interests, a conflict situation between government and GPs is undesirable. After all, it would not turn the macro-costs for the better when GPs no longer feel a shared responsibility to guard those. The recent agreement between minister Schippers and the professional association is an important first step in healing the wounds.

After hours clinics in the Netherlands have become strong institutions on their own. Practically all respondents like the structure it offers them. Via the after hours clinic, they are able to lead a more regular life compared to the 24/7 availability of the past. Nevertheless, this study shows that the after hours clinics have become too much of a commonplace. It is no longer regarded as an emergency clinic and people tend to come in 'as if they went out to do some groceries'. The patients that come to have a consultation at the after hours clinic are usually complete strangers to the GP. The social bond between patient and GP, that is considered as very important for GP excellence, is completely lacking resulting in unnecessary service delivery. Practically all respondents consider the after hours clinic in this respect a dangerous undermining of the Dutch GP system. It may not come as a surprise that recently it made the headlines that seventy percent of Dutch GPs is in favour of a compulsory deductible for consultations at the after hours clinic (Volkskrant, 2012). It is advisable to conduct more research to the impact of the after hours clinic on the provision of GP care.

In the first chapter, I mentioned two Ph.D. theses about the same theme as this study. One of Dwarswaard (2011) and one of Van Dijk (2012). Whereas the former has found a change in professional ethics, the latter has found GPs to be rather insensitive for financial incentives. This study seems to take a middle stance that leans towards the latter. On the one hand, inappropriate behaviour does occur and there have been slight changes in the professional ethics and in the professional identity as overarching concept. Within GP care however, we are talking about exceptions and we should be careful to label them as guiding principles. In line with Van Dijk, this study has found no indications that GPs have become very money focussed which leads us to the discussion on trustworthiness.

In the introduction, I mentioned the debate on the trustworthiness of Dutch GPs. The quotation I used as opening even mentions GPs to be drugged by money. This study is not statistically generalizable to all Dutch GPs. However, it is important to note that I have found no real indication for GPs being 'drugged by money' on a large scale. Commercialism does occur within the GP profession but most respondents emphasize this to be very exceptional. The majority of GPs have chosen their profession not solely for having a good salary. It is a tough job that brings along huge responsibilities that sometimes even concern matters of life and death. It would be unfair to depict the entire profession as moneygrubbers. Of course, this does not imply they do not want an honest salary. With regard to trustworthiness in general, the conclusion of this study that the professional identity of GPs has not really changed is important. We can expect GPs to be as excellent, ethical and engaged as we did in the past. I do not proclaim 'blind trust', but I definitely do not encourage the current situation of distrust.

This brings me to an important point. Before the introduction of managed competition Hilhorst (2004) and Putters (2006) put emphasis on organizing supervision external of the profession instead of internal professional self-regulation. Six years after the healthcare system reform it turns out that many professionals experience the external supervision as crippled. The work of a GP is very individual. After all, each patient is different and requires a tailor-made approach. All respondents experience the convulsively trying to increase uniformity and to measure 'quality' as negative for GP care. It would be a good idea to aim future research not at increasing external supervision, but to find out chances possibilities to organize and increase internal supervision in an economized environment. Perhaps insights from the GoodWork project and literature about excellence, ethics and engagement might prove useful. This is also what the title of this thesis is all about: nowadays GPs seem to be values. Not in the sense of appreciation ('praised'), but in the sense of expressing everything in terms of an economic logic ('priced'). I was in fact quite surprised to find out that many respondents only feel appreciated by their patients and definitely not by the government or the health insurer. Perhaps this is a bit strange. After all, GPs are the spindle in our healthcare system and moreover, a sign of appreciation like a compliment does not even cost any money.

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# Appendices

## I. Introductory letter sent to respondents [in Dutch]

*This letter was slightly adapted for each respondent to 'match' his/her specific circumstances*

Interview verzoek voor scriptie

Laat ik mij eerst even voorstellen. Mijn naam is Wiljan Hendrixx (23) en ik ben momenteel bezig om af te studeren van de onderzoeksmaster bestuurskunde (UU, TiU & EUR). Mijn scriptie schrijf ik over de professionele identiteit van huisartsen. Dit is vooral ingegeven door de kop van een column in de Volkskrant van vorig jaar: 'Huisartsen zijn al beneveld door geld' (prof. Evelien Tonkens, <sup>1</sup>). Deze kop greep mijn aandacht vast en riep vele vragen bij mij op (Hoezo beneveld? Hoe zit het met de vertrouwensrelatie tussen patiënt en huisarts? Etc.). Bovenal besepte ik erdoor dat ik als bestuurskunde student eigenlijk relatief weinig afweet van uw beroep als huisarts en de ontwikkelingen binnen uw professie. Dat terwijl de huisarts in de wetenschappelijke literatuur vaak bestempeld wordt als de poortwachter van het Nederlandse gezondheidszorgsysteem. Reden genoeg om door middel van mijn scriptie meer te leren over uw interessante beroep.

In mijn scriptie richt ik mij op het toenemen van economisch denken. Ofwel, 'economisering'. Denk hierbij aan marktwerking, maar ook aan de 'patiënt' die zich steeds meer opstelt als 'klant'. Ik heb de indruk dat door deze economisering van alle kanten aan u als huisarts getrokken wordt. Door verzekeraars, beleidsmakers, toezichthouders, patiënten, collega's, noem maar op. Maar wat betekent deze economisering voor de professionele identiteit van de huisarts?

Om meer te weten te komen hierover, zou ik u erg graag willen bevragen over hoe u als huisarts deze 'economisering' ervaart (of juist niet ervaart). In totaal richt ik mij op een diverse groep van ongeveer 25 huisartsen. Met divers bedoel ik gevarieerd in leeftijd, geslacht en werkverband. De interviews duren niet langer dan een uur. Ik ben niet gebonden aan kantooruren, dus voor of na werktijd is voor mij meestal geen probleem. De vragen die ik zal stellen gaan over 'professionele identiteit'. Hierbij ga ik in op mogelijke veranderingen in expertise, ethiek en betrokkenheid met daar omheen factoren als respect en autonomie. Wanneer mijn onderzoek is afgerond krijgen de deelnemende huisartsen uiteraard een exemplaar.

Bovenal ben ik ontzettend benieuwd naar uw huisartsenperspectief op de ontwikkeling van uw eigen professionele identiteit in het licht van een toenemend economisch denken. Ik zou u als huisarts vriendelijk willen verzoeken en van harte willen uitnodigen om deel te nemen aan mijn onderzoek. Mijn contactgegevens zijn tel.: (\*\*\*) & mail (\*\*\*). Vooral via mail ben ik zeer goed bereikbaar. De interviews zijn vertrouwelijk en uw bijdrage wordt anoniem verwerkt. Het onderzoek is niet in opdracht van een organisatie/opdrachtgever, maar geïnteresseerde meelezers zijn Tranzo

(onderzoeksinstituut naar zorg & welzijn, Universiteit van Tilburg; <sup>2</sup>) & Stichting Beroepseer (stichting ter bevordering van trots en kwaliteit van professioneel werk; <sup>3</sup>).

Eventuele vragen vooraf beantwoord ik uiteraard graag. Bij voorbaat hartelijk dank.

Met vriendelijke groet,

Wiljan Hendriks

1 <http://www.volkskrant.nl/vk/nl/6268/Evelien-Tonkens/article/detail/2447462/2011/05/11/Huisartsen-zijn-al-door-geld-beneveld.dhtml>

2 <http://www.tilburguniversity.edu/nl/onderzoek/instituten-en-researchgroepen/tranzo/>

3 <http://www.beroepseer.nl/>

## II. Topiclist [in Dutch]

### Topiclijst interviews huisartsen

#### Introductie

- a. Algemene introductie (naam, studie, onderzoek (*professionele identiteit van huisartsen in tijden van economisering (wat doet dat nu met de professie?)*)), onderzoeksopzet: interviews, duur & opbouw interview, toestemming vragen voor opname (vertrouwelijk & anoniem).
- b. Er is geen goed of fout! Alleen zoveel mogelijk denken in het licht van 'economisering'
- c. Hebt u vragen vooraf?
- d. Wat is uw achtergrond? (leeftijd, studie, werkzaamheden, type praktijk/werkverband + hoeveel uur, hoe lang al huisarts)

#### Algemeen

1. Waarom heeft u gekozen voor huisartsgeneeskunde?
2. Spreekt dat u nog steeds aan?
3. Wat vindt u leuk aan uw werk, en wat niet?
4. Welke bedrijfsmatige beslissingen hebt u in de afgelopen 10 jaar genomen?
5. Wat zijn volgens u de belangrijkste ontwikkelingen die van invloed zijn op de huisartsenprofessie van – laten we zeggen – de afgelopen 10 jaar?
6. Wat merkt u van 'economisering'?
  - a. Marktwerking: overheid & verzekeraar?
  - b. Veranderende burger: van patiënt naar klant?

#### Excellence:

7. Wat is volgens u de maatstaf om te bepalen wanneer een huisarts uitmuntend werk (excelleren) aflevert?
8. Wat zijn uitdagingen voor het afleveren van uitmuntend werk?
9. Leveren uw collega huisartsen altijd uitmuntend werk af?
10. Kunt u zelf altijd uitmuntend werk afleveren?
11. Wat merkt u van meer concurrentie?
  - a. Leidt het tot meer innovatie & modernisering?
  - b. En tot meer differentiatie?

#### Ethics

12. Tegenover wie hebben huisartsen verantwoordelijkheden?
13. In de uitoefening van uw werk, tegenover wie voelt u zich zelf verantwoordelijk?
14. Wat ziet u als de kern van uw beroepsethiek? (Eed?)
15. Bent u bij een collega ooit een situatie tegengekomen die voor uw gevoel in strijd was met uw idee van goed en fout?
  - a. Zorg niet geleverd, overbodige medische handelingen, integriteit onder druk
  - b. NB niet zozeer over controversiële issues

16. En bent u zelf ooit in een dergelijke situatie geweest?
17. Leidt economisering in uw ogen bij uw collega's tot andere afwegingen?
18. Denkt u dat het bij u zelf soms tot andere afwegingen leidt?
19. Maakt u zich over iets zorgen binnen uw werk?

Engagement (vragen 1 t/m 3)

20. Beschouwt u uw collega's als betrokken bij hun patiënten en beroepsgroep?
21. Ziet u zichzelf als betrokken bij uw patiënten en beroepsgroep?
22. Hoe zou u die betrokkenheid omschrijven? (Wanneer ben je betrokken?)
23. Heeft economisering hier iets in veranderd?
  - a. Bij uw beroepsgroep
  - b. Bij u

Randvoorwaarden

24. Kunt u handelen/zijn zoals u vindt dat een huisarts zou moeten handelen/zijn?
25. Is er iets veranderd in de ruimte die u hebt om beslissingen te nemen (autonomie)?
26. Benadert de patiënt u anders (respect en status)?
  - a. Is het respect voor u en uw oordeel veranderd?
  - b. Is het aanzien van uw beroep veranderd?
27. Heeft economisering de financiële positie van huisartsen veranderd?
28. Heeft economisering naar uw oordeel invloed gehad op de betrokkenheid van uw beroepsgroep bij het maken van beleid?

Tot slot

29. Hoe ziet u de toekomst wanneer het gaat over economisering en de huisartsenprofessie?
30. Vraag naar anonimiteit: bezwaar tegen respondentenlijst?
31. Wat vond u van het interview?

Afsluiting

## IV. Respondents

<i>Name</i>	<i>Gender</i>	<i>Age category*</i>	<i>Place of practice</i>	<i>Practice type (&amp; peculiarity)**</i>	<i>Interview length</i>	<i>Interview date</i>	<i>Type of interview</i>
<b>GPs</b>							
1. Achterbergh, D.	m	O	Amsterdam	Health centre (& Wardi Beckman Stichting)	1h 11m	03 July 2012	Telephonic
2. Breedveld, E.	f	O	Tilburg	Health centre	1h 8m	05 June 2012	Focus group
3. Brusse, B.	f	Y	The Hague	Hires o.s. out as GP	58m	31 May 2012	Face-to-face
4. De Jong, A.	m	O	Goirle	Solo-practice	1h 7m	05 June 2012	Face-to-face
5. Donker, G.	f	O	Hoogeveen	Health centre (& NIVEL)	1h 18m	11 June 2012	Face-to-face
6. Hendriks, H.	m	M	Lage-Mierde	Group-practice	57m	13 June 2012	Face-to-face
7. Hendriks, H.	f	Y	Tilburg	Health centre	1h 8m	05 June 2012	Focus group
8. Jonker, C.	f	O	Delft	Group-practice	1h 19m	06 June 2012	Face-to-face
9. Leenders, H.	m	O	Leeuwarden	Solo-practice (soon to group-practice)	53m	08 June 2012	Face-to-face
10. Maes, A.	m	O	Dieren	Group-practice (& De Vrije Huisarts)	1h 36m	08 June 2012	Face-to-face
11. Mees, K.	m	M	Tilburg	Group-practice	51m	15 June 2012	Face-to-face
12. Musterd, J.	m	M	Schijndel	Duo-practice	1h 6m	31 May 2012	Face-to-face
13. Romijn, L.	f	M	Wateringen	Group-practice (& LHV)	1h 1m	18 June 2012	Telephonic
14. Stokmans, A.	m	O	Tilburg	Health centre	1h 8m	05 June 2012	Focus group
15. Sundermann, J.	m	O	Tiel	Health centre	1h 17m	12 June 2012	Face-to-face
16. Tromp, L.	f	Y	Tilburg	Group-practice	27m	27 June 2012	Face-to-face
17. Van de Laar, F.	m	M	Nijmegen	Health centre (& research at Radboud University)	1h 11m	29 May 2012	Face-to-face
18. Van den Brand, T.	m	O	Sprang-Capelle	Solo-practice (recently to health centre & retired)	1h 15m	01 June 2012	Face-to-face
19. Van Dongen, J.	f	Y	Tilburg	Group-practice	1h 13m	14 June 2012	Face-to-face

20. Van Hoolwerff, C.	f	Y	The Hague	Hires o.s. out as GP	1h 17m	13 June 2012	Face-to-face
21. Van Veenendaal, D.	m	Y	Udenhout	Solo-practice	1h 11m	01 June 2012	Face-to-face
22. Woerdman, A.	m	O	The Hague	Group-practice	1h 19m	31 May 2012	Face-to-face
<b>Experts</b>		<b>Institutions; Expertise</b>					
De Bakker, Prof. D.	m	-	NIVEL/TiU; Structure and organization of primary Health Care		± 30m	08 August 2012	Face-to-face
De Wildt, J.E.	m	-	De Ondernemende Huisarts/Commonsense BV/De Eerstelijns		31m	21 May 2012	Telephonic
Jorna, R.	m	-	Menzis; Medical advisor quality of primary care		57m	18 June 2012	Telephonic
Spreeuwenberg, Prof. C.	m	-	CAPRHI/UniMaas/Platform Vitale Vaten; Integrated care for chronically ill		± 1h	23 May 2012	Face-to-face
Ter Braak, G.J.	m	-	Zorgpunt		39m	04 July 2012	Telephonic
Vosmans, F.	m	-	TiU; among others medical ethics		± 30m	10 May 2012	Face-to-face
* Y = aged between 25 and 40; M = aged between 40 and 55; O = aged 55 or older (cf. Dwarswaard, 2011)							
** GPs in a group-practice can still be self-employed, e.g. via a HOED structure							

## V. Overview of findings on economization and professional identity of GPs

<i>Excellence</i>	
<i>Remuneration system</i>	The respondents generally regard the fee-for-service payment as honest: doing more, means earning more. Consequently, this incentive has encouraged GPs to expand their care provision. In reality, many respondents experience the fee-for-service system as 'crippled': firstly, it is solely aimed at medical-technical care provision. That is why many respondents attach great value to the capitation fee. After all, this allows them to act in the interest of the social side of their profession without having a price tag attached to everything they do. Secondly, the government is said to use 'double standards'. GPs are pushed to do more, but not to earn more. Thirdly, health insurers have gained more influence over the medical-technical content of GP work. Finally, the system encourages competition but in reality, this barely happens because most respondents emphasize collaboration as the key to improve excellence.
<i>Standardization</i>	GP excellence is a combination of medical-technical and social quality. Standardization via guidelines, codes and indicators focuses purely on the medical-technical side. All GPs regard the NHG-guidelines as an improvement of medical-technical excellence: they have become the norm. The codes and indicators on the other hand, are experienced as totally inadequate. Whereas the guidelines are voluntarily and explicitly aim at improving GPs' medical-technical performance, the codes and indicators are compulsory for practically all GPs and serve to make quality in general transparent.
<i>Internal organization</i>	Most respondents regard task delegation as an improvement of the medical-technical quality of GP care. However, some GPs fear that it will weaken the strong relation between GP and patient. In order to offset this danger, several respondents do not delegate everything. For some patients they make exceptions in order to work on their social relation.
<i>Horizontal organization</i>	Most GPs regard collaboration as a huge improvement of quality. Medical-technically seen, GPs can consult each other. Socially seen, they can treat each other's patients if necessary. The after hours clinic is the highlight of GP collaboration. However, this is regarded as completely dreadful for the quality of GP care since the personal relation between GP and patient is totally lacking.
<i>Vertical organization</i>	Despite the extra bureaucracy that comes along with it, the formation of healthcare groups and providing multi-disciplinary care is generally regarded as positive development for GP care quality.
<b>Conclusion</b>	GP excellence has a medical-technical and a social side. Economization seems to focus solely on the medical-technical side. Nevertheless, this has not changed the understanding of GP excellence as having these two sides.  This study shows that the majority of the interviewed GPs regard several

	<p>developments that have clear signs of economization as a slight improvement of medical-technical excellence. The fee-for-service encourages expansion of care provision, guidelines provide hold, task-delegation enables specialization, efficient collaboration facilitates inter-GP consultation, and multi-disciplinary care improves care provision for chronically ill.</p> <p>This study shows no indication that GPs have come to consider the social side of their profession as less important. The emphasis on the medical-technical side works as an obstructive factor, especially when the respondents have no room to manoeuvre: the codes and indicators they have to use to 'show' their 'quality' and the after hours clinic where they feel pressured to provide care.</p>
<b>Ethics</b>	
<i>Remuneration system</i>	<p>Acting in the patient's interest is the main responsibility for practically all respondents, followed by their own conscience and a responsibility for macro-interests. All respondents condemn prevalence of self-interest. Large-scale unethical behaviour does occur but is highly exceptional. All respondents fiercely turned themselves against colleagues who provide services without medical-technical necessity. When it comes to 'the grey area' of reimbursement, many respondents sometimes do grant themselves a piece of the pie. This happens due to confusion, a sense of justice and as a form of protest.</p>
<i>Standardization</i>	<p>The NHG-guidelines have become the norm for the distinction between 'right' and 'wrong'. Nevertheless, they do allow for reasoned deviation. The codes and indicators focus solely on the medical-technical side of the GP profession, and many GPs struggle to fit their professional ethics within this system. Acting in the interest of the patient, does not always imply focussing on 'cure'. Focussing solely on the medical-technical side of their profession is experienced as a huge vote of no-confidence.</p>
<i>Internal organization</i>	<p>Changes on the level of the internal organization have added an extra ring of responsibilities to the responsibility scope of GPs: nowadays they many of them also have entrepreneurial responsibilities.</p>
<i>Horizontal organization</i>	<p>No indications were found that the increase in collaboration on practice level has affected ethics. However, the after hours clinic did imply a change. Many respondents criticize the customer-attitude of patients who come to consult them at the after hours clinic. Since there is no social relation between them and these demanding patients, diagnosing becomes a tough task. Many GPs no longer enter into discussion with the patients at the after hours clinic. Instead, they have become more indulgent.</p>
<i>Vertical organization</i>	<p>The development of healthcare groups and multi-disciplinary care has not specifically influenced any of the rings of responsibility. The only footnote to be made, is the perceived involuntary nature of the way in which multi-disciplinary care is shaped: what counts as good care (provision) feels dictated.</p>

<p><b>Conclusion</b></p>	<p>GP ethics can be envisioned as a model with rings of responsibility. According to the respondents, the patient forms the core of this model, followed by 'the self' and macro-responsibility. In general, the understanding of ethics as putting the patients interests before everything else, followed at a distance by the others responsibilities has remained unchanged. The remuneration system has not changed this model, nor has the increase in standardization. However, this latter <i>is</i> experienced as a vote of no-confidence and hinders GPs to fulfil their responsibilities towards their patients. Task delegation did have an effect: it has added a ring of entrepreneurial responsibilities. Besides, also the after hours clinic has affected the respondents' sense of responsibility whereas they have become less reserved in following the demands of the patient. Multi-disciplinary care has not affected the understanding of ethics, but several respondents emphasize the restricting character of this kind of care.</p>
<p><b>Engagement</b></p>	
<p><i>Remuneration system</i></p>	<p>The interviews provide no indication for a change in engagement due to the remuneration system. One remark, the reimbursement of GPs by health insurers is not something patients are informed about.</p>
<p><i>Standardization</i></p>	<p>The NHG-guidelines have not affected the GPs' commitment to their patients. It seems they have slightly increased the engagement of GPs with their profession. The delineation of the profession by codes and indicators does not change the understanding of GP engagement, but it has changed the actual involvement with patients. All respondents except for one experience especially the delineation in time as a huge and damaging pressure. Time is widely regarded as an important factor for GP care, both for diagnoses and as medicine. The system of codes and indicators did not affect involvement with the profession.</p>
<p><i>Internal organization</i></p>	<p>Task rearrangement has not influenced the understanding of engagement in both relations (GP-patient; GP-GP). In reality, it might be harmful for GP engagement with patients. In order to offset this problem, several respondents pointed out they do not always delegate all simple tasks.</p>
<p><i>Horizontal organization</i></p>	<p>Whether engagement has changed due to more and efficient collaboration depends upon the definition of 'continuity'. A few respondents impose 'care provided by a specific GP' as mandatory. Most others focus on a consistency of care provision in general. From the first perspective, collaboration damages the 24/7 availability of a GP and thus his engagement. From the second perspective, collaboration increases engagement because it enables GPs to guarantee care for their patients. On the other hand, the after hours clinic is unanimously experienced as dreadful for engagement. GPs have no social relation with the patient that comes to consult them in the clinic. For professional engagement, it is the opposite: teamwork in the after hours clinic increases professional engagement.</p>

<p><i>Vertical organization</i></p>	<p>The interviews show no indication for a change in patient engagement due to healthcare groups and multi-disciplinary care. Developments in the vertical organization in general have had an impact: the vast number of forums in which GPs can ‘show their engagement’ discourages many respondents to be involved in any of them.</p>
<p><b>Conclusion</b></p>	<p>Engagement concerns two relations: between GPs and their patient, and among GPs as a professional group. The former is about knowing the patient in its context. The second is usually regarded as fulfilling some sort of an advocacy role. Economization has not led to a different understanding of GP engagement. In reality, some economization developments impede engagement and others foster it. The most important observation is the restricting influence of the delineation of services within GP care. Except for one, all respondents strongly emphasize they nowadays have great difficulty to be as involved with their patients as they consider necessary. A second important observation is the ‘double role’ of the after hours clinic. On the one hand, the teamwork increases professional engagement. On the other hand, there is no social bond between the GP and the patients that comes to consult him at the clinic.</p>
<p><b>Preconditions</b></p>	
<p>Most respondents mention they are <i>autonomous</i>: they have the discretionary space to take independent decisions. Nevertheless, most of them do experience pressure because of all kinds of organizations and an ‘umbrella of controlled obligations’. <i>Respect &amp; status</i> have changed. The respondents experience the vast majority of consultations by patients as pleasant. Sometimes, patients can have a strong customer attitude and be very demanding. In most of these cases, they can be very rude to GPs. This happens much more often in the after hours clinic than in the respondents’ own practices. After all, they know their patients. More problematic is the perceived respect shown by government. All respondents feel disrespected by the government that is regarded as unreliable. This has everything to do with the <i>financial reward</i> GPs receive. Foremost, practically all respondents are happy with their salary and many say their income has increased due to the managed competition system. However, they add two elements that put it in another perspective: many of them experience an increase in workload and the respondents differ strongly in answer to the question whether the rise in income is proportional to the increase in workload. Furthermore, all respondents in a sense feel betrayed by government who has encouraged GPs to take on extra tasks and has billed them for it afterwards. Most GPs find it hard to estimate whether the role of GPs as discussion partner in <i>policymaking</i> has changed in the economized environment.</p>	