Health Care Analysis, Vol. 13, No. 3, September 2005 (© 2005)
DOI: 10.1007/s10728-005-6450-z

Fighting Sectional Interests in Health Care[1]

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In the 1970s policy making in the Netherlands took place in sectoral networks, consisting of professional interest groups and like minded civil servants, advisory councils, mp's and departmental ministers. In this article the author examines whether such a sectoral policy network still exists in Dutch health care by comparing past and present data on the background of civil servants, mp's and departmental ministers. Next she describes the political fight against the health care sectoral network, which has gone on for decades. She concludes that the health care sectoral network has been severely weakened, although it remains to be seen whether this will lead to a substantial reduction of health care costs, which was one of the main reasons why politicians fought against sectoral interests in the first place.

KEY WORDS: health care reform; iron triangles; fight against professionalism.

INTRODUCING THE IRON RING OF SECTIONAL INTERESTS

In 1974 two political scientists, Joop van den Berg and Henk Molleman, published a book, entitled *Crisis in Dutch politics* (Van den Berg and Molleman, 1974). According to the authors Dutch politics in the nineteen seventies (and in the fifties and sixties for that matter) suffered from a disease which might be called the "supremacy of sectoral interests." Each ministerial department consisted of civil servants, trained in one or another professional specialty, and catered for a special clientele. Many members of parliament could be considered sectional specialists, who would feel loyalty toward what one might call their sectional constituency. Departmental ministers would usually also be recruited from the

[1]This paper was presented at the conference Professionals between People and Policy and at a seminar organized by the Utrecht School of Governance. Paul 't Hart was a valuable discussant.
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world of sectional interests. Thus, a minister of agriculture would probably have studied at the agricultural university in Wageningen. In parliament he would meet members of a standing committee on agriculture, who would have studied similar topics at the same university. At his department he would be surrounded by civil servants from the same background. No wonder pressure groups representing farmers' interests would feel very welcome in governmental headquarters, where they were often offered permanent seats in advisory councils as well as the means and the money to take care of their members' interests.

Although agriculture used to be the prime example of a tight policy network catering for a specific group, according to Van den Berg and Molleman, these tight sectoral networks existed in other areas as well, notably in education and health care. In the field of education sectional interests were mostly "teachers' interests" or "school interests"; in the field of health care sectional interests were taken to be "doctors' interests" or "providers' interests." Many authors, politicians and policy makers assumed that providers' interests did not necessarily coincide with pupil's interests, students' interests and patients' interests. And even if these interests did coincide there might still be a problem, if parents of pupils, students and patients had to evaluate this from a more general citizen's perspective. The supremacy of sectional interests was considered a disease, because it led to ever rising costs, to be paid by the government (or, obviously: the tax or social premium payer). Too many actors cherishing sectoral policy interests would harm the general interest, which was not so adequately represented in the political arena. Politicians would be tempted to give in to one sectional interest after another and forget to weigh these interests and to list priorities according to general ideological principles. Van den Berg and Molleman pictured Dutch politics as a weak centre surrounded by an iron ring of sectional interests.

Van den Berg and Molleman were not the only ones to complain about the supremacy of sectional interests in the Netherlands. A then notorious state committee chaired by former junior minister Vonhoff argued that policy making in the Netherlands took place in two worlds: the strong world of sectional interests on the one hand and the weak world of the general interest on the other (Vonhoff committee, 1980). Political scientist and former minister of Home Affairs Ed van Thijn characterized the Dutch political system as a republic of thirteen separate departments (cf. Andeweg, 1995). Nor was the alleged supremacy of sectional interests a peculiar Dutch phenomenon. There is quite a lot of more general, international literature about iron triangles, policy communities, policy networks (cf. Bovens, 't Hart, and Peters, 2001, p. 18; Klijn, 1992; Klijn, 1994; Smith, 1993; Marsh, 1998; Rhodes, 1997) and departmentalism (e.g. Kavanagh and Richards, 2001). The supremacy of sectional interests seems to be a widely recognized difficult problem for policy makers.

According to many commentators and researchers a lot of things have changed in Dutch politics between 1974 and 2004. The once famous policy network consisting of agricultural pressure groups and like minded civil servants and politicians (commonly referred to as the green front) has been declared dead

or at least powerless (cf. Bekke and De Vries, 2001). Other policy networks are sometimes assumed to have withered away during the ongoing attacks on the welfare state in the eighties and the nineties, when politics was taken to reclaim its own responsibility. Peters did detailed research on power and decisionmaking in the Netherlands. She investigated three different policy areas: envrironmental planning, child care and policing. She found no traces of an iron ring of sector specialists steering the decision making process in these areas (Peters, 1999).

In this article I will look into the policy network surrounding health care in the Netherlands. I intend to investigate two competing hypotheses, to wit:

Hypothesis 1: Everything has changed since Van den Berg and Molleman wrote their exposé. Iron triangles no longer exist, more particularly: there is no such thing as an iron triangle for health care at the beginning of the 21st century.

Hypothesis 2: The iron policy network surrounding health care is still very much alive in 2004. The analysis of Van den Berg and Molleman is still an appropriate tool to explain the goings on in Dutch health care politics.

In section 2 I will discuss empirical phenomena that support the first or the second hypothesis by taking, so to speak, snapshots of the situation with regard to the power of sectional interests in health care in different periods between, roughly, the nineteen fifties and the 21st century. In section 3 I will use a video camera instead of a photo camera in order to describe the *process* of health care policy making. I will discuss the way sectional interests in Dutch health care have been fought against over the past twenty-five years. I will try to find out whether the battle against sectional interests was won, and if so, by whom exactly. By providers? By politicians? By patients? By citizens?

THE HEALTH CARE POLICY NETWORK PAST AND PRESENT

A sectoral policy network as described by Van den Berg and Molleman typically consisted of five different actors: pressure groups, advisory councils, civil servants, members of parliament and departmental ministers. Let us take a closer look at each of these actors.

Pressure Groups

If we look at the position of pressure groups in Dutch politics in general we are immediately struck by the declining power of labour unions since the beginning of the nineties. Employers and unions were held responsible for the welfare state crisis that had followed the economic crisis in the eighties (Kuipers, 2004). The neocorporatist tradition that used to characterize Dutch social policy seems to have been in decline ever since. The present coalition cabinet has embarked on another large scale welfare reform project in which the unions do not participate. Apparently the unions cannot rebuild their position.

However, if we look at the position of pressure groups in the alleged health care policy network, things look differently. One might argue that the government seems to be following a divide-and-rule strategy here. Since the nineteen seventies patient groups have been granted quite a lot of money and facilities, so as to strengthen their position vis-à-vis other interest groups such as organisations of health care insurers, health care providers and health care professionals (Oudenampsen and Steketee, 2000). The pressure groups in the health care policy network have become more diverse, and therefore, perhaps, easier to manage for politicians with an eye for the general interest.

ADVISORY COUNCILS

In 1996 parliament passed a law, dubbed the desert law. The desert law was meant to transform the jungle of advisory councils surrounding Dutch central government into a desert with a few lonely palm trees. Although the desert law led to some changes in the world of advisory councils, such as the disappearance of councils consisting of both pressure groups representatives and independent scientists, the current situation cannot be characterized as a desert. Some advisory councils were abolished, others were transformed (for example: the National Council for Public Health was renamed the Council for Public Health and Care and some council members were replaced by others), merged with other councils, or trimmed down, but they did not disappear. A quick look at the list of advisory councils on the government website (*www.overheid.nl*) will suffice to draw this conclusion. There are 36 councils listed on the website. This may be significantly less than in the true heydays of advisory councils (apparently, in 1980, Dutch central government was surrounded by no less than 296 advisory councils, cf. Van Delden, 1983), but some of these advisory councils were created after the desert law was passed. Thus, in the health care area there is the Council for Health research (founded in 1996), and the council for societal development (founded in 1997).

Of course the number of advisory councils does not in itself say anything about their power. Resarch on the factual influence of advisory councils has led to various conclusions about their past and present position (Peters, 1999, p. 51, cf. also Boot and Knapen, 2001, pp. 294–295). Politicians may decide to ignore council reports, they may question the expertise of council members, and they may openly regret to have listened to council's advice. With regard to health care, all three strategies have been practiced in the past six months. Thus, in 2004 the minister of health has announced that he would not follow the Council of Public Health and Care on the subject of the so-called no claim benefit, which will grant patients a yearly premium if they have not used any health care services in that year. The minister announced that he would adopt the no claim system, regardless of the council's wishes. The junior minister for public health decided not

to listen to the Health Council's recommendations regarding prenatal screening. She suggested that members of the Health Council committee who had drawn up these recommendations had listened too much to a British expert who would benefit personally, should the screening programme be adopted (*de Volkskrant*, 10-6-2004). And when the minister of Health decided to follow the health council's recommendations with regard to the wooping cough vaccine for toddlers and decided to import a new vaccine from abroad, he publicly regretted this, saying that he had spent an enormous amount of money, just to prevent a few baby tears, because there was nothing wrong with the old vaccine other than that it seemed to make babies cry harder (*NRC Handelsblad*, 1-9-2004).

On top of all these symptoms of decline of advisory power, politicians have grown into the habit of asking paid outsiders for "independent advice." They install ad hoc committees chaired by famous managers or business entrepreneurs, and they hire advising agencies to produce visions and reports on difficult questions. Thus, they can organise to have a large number of different recommendations, from which they can pick and choose. It is not unlikely that it would be easier to steer a commercial advice agency in a certain direction than an old-fashioned advisory council which typically consisted of unpaid or underpaid participants. Travel expenses and attendance fees are peanuts compared to what commercial agencies charge by the hour (cf. Daalder, 1993, pp. 36–37).

The Civil Service

During the 1970s and 1980s numerous reports and plans were made in order to fight the bureaucratic evil of departmentalisation and the supremacy of sectional interests in the civil service, but in practice things stayed very much as they were.

However, in 1995 the Dutch civil service was enriched with what was called the "algemene bestuursdienst" (the "general civil service"). Henceforth higher civil servants would have to leave their department after a period of five years. Thus, they would become loyal to the public interest in general instead of cherishing their own narrow departmental hobbies. About 800 higher officials fall under this regime now (the bureaucracy of the Dutch central government consists of somewhat more than 100 000 civil servants). (Cf. *www.algemenebestuursdienst.nl*). Obviously this is not a very high percentage, but these are all higher officials and one may assume that they are the ones who determine the contents of policy proposals. Research has shown that interdepartmental mobility has increased since the introduction of the general civil service ('t Hart and Wille, 2002; Van der Meer & Raadschelders, 1999; cf. also Kickert, 2002, ch. 4).

Members of Parliament

Van den Berg and Molleman argued that sectoral interests would be warmly welcomed in the Dutch house of commons. Parliament has a number of standing

Table I. Members of Parliament Specializing in Health Care with a Background in the Health Care Sector

Period	Number of mp's with health care background
1946–1960	11
1960–1977	19
1977–1994	26
1994–2004	34 (28)

Note. The information on mp's can be found on www.parlement.com; a biographical archive developed by the parliamentary documentation centre of Leiden University.

committees, each taking care of a policy sector or policy area. According to Van den Berg and Molleman the members of these committees were often drawn from different societal sectors (farmers or scientifically trained agricultural specialists in the committee on agriculture, teachers or university trained pedagogues in the committee on educational policy and so on). Hence one would expect doctors, nurses and pharmacists in the standing committee on health care.

In the following Table I I have listed the number of members of parliament with a health care background from 1946 till 2004. I have included all mp's with anything remotely resembling a health care background. Some mp's were doctors or nurses, others were managers in a sickness fund or home care organisations, still others had been a doctor's assistant for a number of years before embarking on a long political career. I have included all of them and still the number of mp's with a health care background is not impressive.

Some additional comments are in order, to qualify the numbers in the table.

- In 1956 the number of seats in parliament changed from 100 to 150; one might say that the number of health care mp's in the first period is lower than could be expected for that reason.
- The statistics on the last period deserve some clarification too. In 2002 the Dutch election results were very much influenced by the murder of Pim Fortuyn, who intended to run for parliament but was killed one week before election day. Fortuyn had asked a number of medical specialists to run for office and they had accepted a place on his list. When Fortuyn was dead, the people on his list decided to go through without him. Twenty-six people of the Pim Fortuyn list were elected in parliament, three among them were medical specialists. However, the Pim Fortuyn group soon fell apart because of a number of internal fights over leadership and strategy. The three medical specialists on the list did not get much of chance to become parliamentary health sector specialists and they were not re-elected in 2003. One former nurse was a member of the older people party, a one issue party that fell apart soon after entering parliament. Three other

mp's with a medical background left their parliamentary group and did not manage to do very much at all, hence we might subtract 6 mps from the 34 listed in the last period, but that would still leave us with 28 mp's with a health care background in the last ten years. If there ever was a representation of a health care policy network in parliament we cannot say that it withered away during the 1990 and the first four years of the 21st century.

– On the other hand, it is striking to see how many former mp's, who did not have a health care background but became health care specialists while in office, end up in health care policy organizations on leaving parliament. This might indicate that the health care policy network is good at recruiting people who know their way in the government. Although this seems a plausible thought, it cannot be stated as a matter of fact, because there is another equally plausible explanation for this phenomenon. Reigning politicians often do their best to find suitable jobs for their predecessors; places in health care quangos might be deemed eminently suitable in this respect. A simple analysis of biographical data cannot determine which of these two theoretical explanations would be justified.

Departmental Ministers

The last but certainly not least important member of a sectoral policy network would be the departmental minister. According to Van den Berg and Molleman he or she would typically be recruited from the policy sector (same training or university, similar professional background, acquaintances in the sectoral pressure groups and so on).

In the following Table II I have listed all departmental ministers and junior ministers with a health care background at the department of public health (or, more precisely: at the department then responsible for public health, since public health has been reshuffled from one department to another a number of times).

It is questionable whether Mrs. Ross-van Dorp, the current junior minister, would qualify as someone with a proper background in health care. She was trained as a doctor's assistant, she worked at a doctor's office for a few years, but after that she became a teacher, studied Chinese and started a political career as personal assistant of a member of the European parliament. But even if we were to disregard Ross-van Dorp, this would not imply a major change for the general picture. Since the 1950s, apart from several notable gaps in time (twenty two years, rather evenly spread over the last fifty odd years), the general rule for coalition negotiations concerning ministers of public health seems to have been to recruit either a minister or a junior minister with a health care background.

Table II. Ministers and Junior Ministers of Public Health with a Health Care Background

Period	Minister	Junior minister
1951–1956		Muntendam (medical doctor)
1956–1963		
1963–1967		Bartels (home care, preventive health care)
1967–1971		
1971–1973	Stuyt (medical doctor)	
1973–1977		Hendriks (sickness fund)
1977–1982		
1982–1986		Van der Reijden (sickness fund)
1986–1989		Dees (pharmacist)
1989–1994		
1994–2002	Borst-Eilers (medical doctor)	
2002–present		Ross-van Dorp (? See below)

Note. The information on ministers can be found on www.parlement.com; a biographical archive developed by the parliamentary documentation centre of Leiden University.

Summing up.

- With regard to health care pressure groups we cannot conclude that they have become less powerful overall. Patient groups have been made more powerful over the years and this development will continue in the near future, if it is up to the government.
- The jungle of advisory councils has been trimmed, but it has not been transformed into a desert. There are some indications that advisory councils are not as powerful as they used to be, because politicians seek advice elsewhere (commercial agencies) and can choose to ignore bits of advice that they do not want to hear.
- Higher officials in the civil service have to change departments after five years; hence they are probably less wedded to their departmental clientele than they used to be.
- With regard to politicians, there is no clear pattern of change in the health care policy sector. During the last fifty years a rather constant percentage of mp's have been recruited from the health care sector. There seems to be a rule that ministers or junior ministers for public health should preferably have a sectoral background, although it is acceptable to ignore that rule in coalition agreements from time to time.

On the basis of this first analysis one cannot conclude that the iron ring in health care policy has disappeared completely, nor can one decide that the iron ring in this area is still very much alive. I think it would be fair to say that the data

seem to support the first hypothesis (decline of sectional interests) slightly more than the second.

In the next section I will take a closer look at the way politicians have fought against sectoral interests in health care policy over the past thirty years.

FIGHTING THE SUPREMACY OF SECTIONAL INTERESTS

The supremacy of sectional interests was considered a disease in Dutch politics. According to Van den Berg and Molleman the general interest (the tax payer's interest, the citizen's interest) suffered, due to the dominance of farmers' interests, doctors'interests and teachers' interests. This description of the iron ring can be interpreted in two different ways:

1. policy sectors are typically dominated by actors and professionals who take care of their narrow self-interest (i.e. their income, power and prestige) or
2. policy sectors are dominated by actors who take care of of their clients' interests. Teachers represent the interests of pupils and students, doctors and nurses represent the interests of patients. But this would still be a problem, because what people want as pupils (as parents of pupils) or as patients should not prevail over what they want as citizens or tax payers.

With regard to health care, one might say that both interpretations were taken to be true, and both appearances of the iron ring have been fought against over the past thirty years, consecutively and simultaneously. From the end of the nineteen seventies till the beginning of the nineteen nineties government has tried to freeze or diminish the incomes of medical specialists, by lowering their tariffs, and by adopting income regulations (Trappenburg and De Groot, 2001). This policy was not very successful, to put it mildly.

More successful was the attack on the professional autonomy of individual medical doctors. Following a critical report by the health council on unacceptable differences between doctors (interdoctor variation) with regard to the prescription of treatment for certain afflictions and diseases, doctors were told that they would have to abide by professional guidelines (Trappenburg and De Groot, 2001). Their work should be scientific and evidence based; hence it should be inconceivable that one doctor would prescribe a totally different medication regime than another for a patient in the same condition. The medical profession did not oppose this call for guidelines. It seemed to agree with the way they wanted to perceive their scientific expertise. For general practitioners (who were sometimes uncertain about the best way to deal with patients and complaints) it was a relief to be able to rely on guidelines and professional standards. The plea for guidelines was not interpreted as an attack on individual professional autonomy or as an infringement of medical power and prestige.

Fighting the second appearance of the iron ring—policy sector specialists are professionals who take care of their clients' interests, disregarding the tax payer and the public interest—was a long term process involving separate stages.

Divide and Rule, Part I. The Call for Patient Rights

During the nineteen seventies the call for individual patient rights and internal democracy within hospitals and long term care institutions was strongly supported by the government. Patients should be entitled to information, they should be entitled to refuse treatment, and they should be given a say in how their institutional environment ought to be organized. The quest for patients rights and institutional democracy led to several laws in the making, that were finally adopted in the nineteen nineties: a law on medical treatment contracts, which codified the patient's right to information and his right to refuse treatment (WGBO, 1994), a law that should make it more difficult to put patients in a mental hospital against their wishes and should strengthen the legal status of psychiatric patients (BOPZ, 1991), a law that would force all care institutions to install a client council (WMCZ, 1996), and a law to guarantee access to a formal complaint procedure (WKCZ, 1995). All these laws emphasize that patients have rights and claims against their doctors, nurses, care institutions and hospitals, thus picturing professionals and professional institutions not as allies in a sectoral network, but as actors who have their own agenda, and who ought to be forced to listen to their patients or clients.

Divide and Rule, Part II. Representation of Patients by (Paid) Lobbyists

The formal democratization of care institutions has given patient councils (or client councils as they are formally called) a proper say in the organization of their institution. Client councils are asked to advise on mergers between their organization and another hospital, they are asked to comment on their organization's financial report, its religious or ideological foundations, its personnel policy and several other complicated matters. It is not easy to find patients who are able and willing to study and discuss these issues. Patients who live in their own house and lead a rather normal life involving work, family or friends may not want to have to spend more time on their disease than they already do, and they will probably see time served on a patient council as time devoted to their disease or affliction. Patients who live in an institution are usually very ill or very weak (senile patients, severely mentally retarded patients, very disturbed psychiatric patients and so on). They are often not capable of acquiring the knowledge required to be able to discuss client council issues. According to the law, they can be represented by their family members, but family members have a life of their own and will not be eager to volunteer for a seat in the institution's council. They may very well choose to spend time with their loved one rather than to represent his or her interests very

indirectly in a patient council. Hence many client councils are (partly) populated by patient pressure groups staff, who are not treated in the organization themselves (Oudenampsen et al., 2000). This may have strenghtened the idea that patients should be represented by patient pressure groups rather than be taken care of by health care professionals.

Apart from this role at the meso level of hospitals and institutions, patient and consumer groups have also been granted a role at the macro level. They have been asked to collect data on professional performance and hospital output and to translate these data in accessible information (quality rankings and option menus), so as to enable future patients to choose between health care providers.

Sowing Distrust: Introducing Financial Elements in the Relationship with Professionals

Health care professionals can be paid in a number of ways. One might think of these different ways as situated on a continuum. On the one hand government may pay fees or hospital budgets out of taxpayers' money, in which case there will not be any monetary transaction between the medical professional and his or her client. On the other hand one can imagine a fee for service system, in which patients have to pay many medical treatments directly. It seems plausible to assume that at some point patients will come to see their doctors as actors with their own interests to defend as we travel from the taxpayers end of the continuum to the fee in cash upon delivery system. The introduction of co-payments in the Dutch health care system has probably strenghtened the view that professionals are not to be seen as simple allies of patients in a sectoral policy network.

Divide and Rule Part III: Introduction of Health Care Insurers as Representatives of Patients' Interests

In 1986 the Dutch government installed an ad hoc committee to reflect on the future of the health care system. The committee was chaired by Philips business tycoon Wisse Dekker (which, incidentally, already shows another attempt to fight the supremacy of sectional interests in health care). The Dekker committee argued that Dutch health care could benefit from a system of managed competition, in which health care insurers would have to play an important role in guarding the quality of care, by deciding whether or not to include one or another health care provider in their insurance packages on offer. Thus, a health care provider who would not meet professional standards or who would charge too much for his services, would disqualify himself in the eyes of insurers and thereby lose his clientele. The idea of making (mildly) profit oriented insurers take care of health care costs has never really left the political agenda since the Dekker committee, although Dekker's plans were not implemented as such. Seventeen years after the Dekker report this watch dog role for health care insurers

is one of the corner stones of the insurance reform plan of minister Hoogervorst. Apparently health insurers are to become the new allies or representatives of patients in their alleged quest for high quality care on the cheap. The fact that health insurers are far more profit oriented than health care professionals ever were does not seem to frighten policy makers. Neither are they scared by the fact that health care professionals were traditionally bound by a code of professional ethics whereas no such code exists for health care insurers. It is assumed that patients are better off alongside their insurers than alongside their medical professionals.

So who won the battle? Did this long protracted fight result in the final defeat of sectional interests in the health care sector? Let us look at three important actors and ask ourselves the following questions:

- Did medical professionals lose?
- Did politicians, i.e. representatives of the general interest, win?
- Did patients win or lose?

Did Medical Professionals Lose?

If one looks at these developments from the perspective of a gloomy professional, one might conclude that the battle was lost. Health care professionals have first been situated opposite their patients who were taken to be in need of formal legal rights, democratic representation and formal complaint procedures. In those cases where patients would no longer be able to fight their medical professionals, the medical professional would meet with patient representatives: family members or lobbyists appointed by government sponsored patient pressure groups.

Once the new health insurance system will be implemented health care professionals will also be forced to compete with one another: they will have to account for their every move, and present suitable figures to insurers and consumer pressure groups who will then prefer some of them over others. While this may lead to better performance (as the government likes to emphasize), it will surely destroy some of the spirit of cooperation that used to be characteristic of professions (cf. Freidson, 2001). The traditional spirit of professionals was to imitate and adopt one another's good practices, not to conceal them from the competition. It would be quite a change of culture to see professionals change this modus operandi in order to survive a regime of competition.

A medical professional in a more cheerful mood might point out that semi-autonomous social fields such as the health care sector cannot be turned upside down so easily (Moore, 1973). Many policy measures might remain dead letters, because professionals will still meet each other in scientific communities, train their younger colleagues and discuss new treatments and medications as a matter of course. Former politician Kars Veling left politics to become headmaster at

an inner city comprehensive. In an interview he said that a good school manager should be able to disregard most policy measures and let his school be a good school in its own way. The same might be true for health care professionals. They might be able to keep their sector afloat by ignoring insurers and politicians. Moreover, the new insurers-plus-competition-system has not been implemented yet. In the past Dutch politicians have drawn up many plans to change the health care insurance system and many of these plans were not implemented in the end. It ain't over till it's over, is the way optimistic professionals might see it.

Did Politicians Win?

The answer to this question depends very much on what should be taken as politicians' objectives. If their goal was the reduction of sectional power by changing the balance of power within the health care sector, one may conclude that they have succeeded. They may then rejoice in the gloomy professional's interpretation of events. If their goal was the reduction of sectoral costs (not a very unlikely goal given the fact that the supremacy of sectional interests was characterized as a disease because it supposedly led to ever rising costs), it remains to be seen whether they did win in the end. There are not many examples of liberalization and marketization operations that actually led to cheaper services. In fact, the opposite has also been seen to happen. If one encourages medical professionals and insurers to compete and be more profit oriented this may lead to rising health care costs, and in a welfare state context a large part of these costs will be borne collectively. If one encourages patients to take action whenever they are not content about a medical treatment, this may lead to defensive medicine. Doctors may decide to err on the safe side and order extra diagnostic tests to rule out mistakes and avoid complaints. Moreover, the introduction of performance figures, the registration of these data, and the introduction of a different billing system that must enable insurers to bargain with hospitals has been a very costly operation. There are serious reasons to doubt whether the whole operation will lower the health care budget in the end.

Did Patients Win or Lose?

The answer to this question depends on the way patients perceive their former position toward their health care professionals. Patients who were very displeased with their status in the past might consider the present situation and the future developments a considerable improvement. They have been given formal rights against medical professionals, they can influence the way health care institutions are run, and they have complaint routes to follow if they do not like the goings on. In the future they should be able to download all kinds of information from the internet which they could use to choose between health care providers (hospitals, doctors, institutes). They may consult patient pressure groups if their own expertise

is not sufficient for a good choice. And they may choose a health care insurer according to their personal preferences with regard to health care consumption in comparison to other consumer goods, that is, they may decide to spend more or less on their health insurance.

Patients who were not dissatisfied with the state of health care in the past stand to lose from the future developments. They will be asked to invest quite a lot of time and effort in a selection process in order to find good doctors, good hospitals and good insurance at a reasonable price. Some patients will not feel up to that task, because they did not manage to finish high school and simply lack the skills required for this kind of choices. Others do have these skills, but lack the time it would take to carry out such an exercise thoroughly. They do not want to trust the figures they see at face value; they know too well that statistics may have been bent or manipulated. If a hospital's quality has been made dependent on the way appendectomies are performed, the hospital might have decided to put all its cards on its appendectomy scores. This might have led to the neglect of other services. A hospital that did not redirect its efforts so as to upgrade its appendectomy figure might be better in quite a number of other things (cf. O'Neill, 2002, on the perverse effects of indicators.) In fact, a hospital that would have decided to invest almost all its time and money in direct patient care, disregarding the whole accountability circus might be an even better place to be treated. How should patients weigh all these factors?

A third group of patients may have been dissatisfied with certain aspects of patient care in the past, but would very much have preferred a raising of standards in which they would not have to participate so much themselves. Patients are not just patients and do not want to invest so much of their time to that role. They have work to do, children to care for and lives to live.

The fight against the supremacy of sectional interests in health care has been lost by professionals. Whether it has been won by politicians remains to be seen and how many patients will consider themselves winners in the end is a very open question as well.

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