Societal Neurosis in Health Care

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In 1994, Michael Power, a chartered accountant and lecturer in accounting and finance at the London School of Economics, published an intriguing essay, entitled The Audit Explosion. Power argued that the growing multitude of audit procedures had changed the nature of service delivery. People and organizations that were consistently being audited - such as hospitals, schools, water companies, laboratories, and various industries - start thinking differently about their own activities; they start looking at their work from an auditor's point of view. They focus on the measurable and quantifiable aspects of their work. Auditors generally do not see what is going on in daily practice; they do not sit in the class room, do not visit hospital wards, and do not read master theses written by students. Instead they evaluate the organization's plans, programs, and evaluations; they tend to monitor systems of control, they look at the paper world created by the organization for auditing purposes.

Auditing, according to Power, has developed into `policing of policing'. An organization that wants to survive an audit has to invest in reporting, monitoring, and policing, rather than in improving performance. Unfortunately, the audit explosion has not led to more trust in service delivery. Instead, there seems to be a `regress of mistrust'. If those engaged in service delivery cannot be trusted, why should one trust the experts, managers, and accountants involved in policing them? Ultimately "the performances of auditors and inspectors will themselves be subjected to audit" (Power 1994: 13). This regress of mistrust may have something to do with the fact that the audit explosion has brought about "a shift from professions the public trusts more - such as doctors, police and teachers, to a profession the public trusts less (the accountants) at the instigation of a profession the public trusts least (the politicians)". (Power 1994: 35)

Onora O'Neill has made similar observations and complaints in her BBC lectures on trust (O'Neill 2002). Similar observations were also made by the British political philosopher Graham Lock in an essay about the demise of the Netherlands. In Locke's phraseology the quest for ever more audits, control, and accountability has turned into some sort of disease, that can be called societal neurosis or hyper-rationality. Lock describes the phenomenon as follows:

just like the neurotic who washes his hands a thousand times a day, our hyper rational society, under the political disguise of so-called responsibility,
cannot stop producing ever more refined instruments to measure and control itself a thousand times a day. (Lock 2005: 207)

Power, O'Neill, and Lock seem to have discovered an important insight. However, they tend to focus on general trends in society. In this chapter I would like to investigate this phenomenon close up by focusing on one particular policy sector, i.e., health care in one specific country, i.e., the Netherlands. By doing so, I hope to achieve a better understanding of the underlying logic that leads to societal neurosis or the audit explosion. I also hope that an in-depth analysis may give us some clues to how to put a stop to this audit explosion, or - put more appropriately in this chapter on health care - whether and how societal neurosis can ever be cured. Building on the work by Tonkens (Tonkens 1999 and 2003), I will describe the developments in Dutch health care, starting with the democratization movement in the 1970s and concluding in the full-blown societal neurosis of the 21st century. In the last section of this chapter, I will reflect on a possible cure for this (hopefully not lethal) disease.

The First Stage of Societal Neurosis: A Call for Patient Rights and Institutional Democracy

The seeds of societal neurosis can probably be traced back to the 196os and 1970s, an era in which a large part of the population turned against authority figures representing "the establishment" including teachers, mayors, policemen, politicians, and doctors. It remains an open question whether the seeds of democratization could have evolved into something other than an audit explosion, hyper-rationality, or societal neurosis. I would like to think that they could have, but social scientists cannot turn back the dock and start their social experiments afresh.

In health care, the revolution of the 196os started in psychiatric wards. You may remember the movie ONE FLEW OVER THE CUCKOO'S NEST (1975), based on the 1962 novel by Ken Kesey. Former prison inmate, Randle P. McMurphy, as played by Jack Nicholson enters a psychiatric ward and challenges the authority of Nurse Ratched. Health care social movements have questioned

medical authority, either because they did not respect authority in general or because they had witnessed various forms of abuse of that authority, such as corporate doctors who hide information regarding conditions in the asbestos industry, or medical researchers who conduct dangerous medical experiments involving unsuspecting patients (Brown & Zavestoski 2005). Despite this origin of resistance against medical authority there has also always been a close, almost natural alliance between patients and doctors. Patients who want to be cured need doctors, doctors have been trained to take their patients' interests seriously and generally earn an income by doing so. Governments who establish a goal of reducing medical resources usually, meet with fierce resistance from both patients and doctors (Blank & Burau 2004; cf. also Freeman 2000).

Oudenampsen (1999), Rijkschroeff (1989), Stüssgen (1997) and Verkaar (1991) have analyzed the origins of the patient movement in the Netherlands. According to Verkaar, patient organizations in those days employed four strategies:
1. the substitute care strategy, directed at the replacement of regular care by other forms of treatment offered by the patient organization (think of Alcoholics Anonymous which organizes group sessions
and group support as an alternative to the regular counseling agencies for substance abuse, or of patient groups that favor alternative treatment);
2. the protest strategy, aimed at the abolition of certain parts of the health care system (e.g., the Dutch organization for psychiatric patients, the Cliëntenbond, was opposed to psychiatric care in general
and electroshock therapy in particular; following the ideology of the anti-psychiatry movement they argued that many mental patients should not be viewed as patients in the first place because their conditions could be viewed as an appropriate response to a sick society);
3, the improvement strategy, aimed at transforming the regular health care system; and
4. the additional care strategy, which - as the word suggests - was meant to supplement the regular care offered by the medical system.

The government, almost from the very beginning, looked upon the patient movement favorably (Nederland and Duyvendak 2004; Nederland, Duyvendak and Brugman 2003). Of course, this warm welcome may have been due to a true commitment to the goals and interests of the patient movement. However, it may also have had something to do with the fact that the government had been engaged in a frustrating battle with medical specialists over their incomes (Trappenburg & De Groot 2001). Politicians may have seen the patient movement as a possible ally against the medical elite. The first two strategies employed by the patient movement seemed truly promising in this respect.

The first strategy (opting out of the health care system and turning to self-help instead) seemed to concur with money-saving government concepts such as `family care' and `neighborhood care' instead of more expensive professional help. This may have been one of the reasons why patient organizations were readily included in the policy-making process. Patient organizations were granted representation in the sickness fund council and the National Council for Public Health. They were asked to regroup in regional platforms, which were to be paid by the provinces. These regional platforms could delegate patient representatives to meetings with the local governments in which matters such as provisions for the handicapped and community care were being discussed (Oudenampsen 1999). Rijkschroeff describes how representatives of the patient movement were overwhelmed by government requests to participate in all sorts of advisory bodies, councils, committees, and advisory meetings with the government. `Once you get in, it seems that one participation activity leads to another'. (Rijkschroeff 1989: 13).

The second strategy employed by patient organizations (which aims to redefine the status of patients and the abolition of certain kinds of treatments) may have contributed to the introduction of legislation about patient rights, such as the Law on the Medical Treatment Contract (the WGBO, which codified principles such as the right to be informed about one's medical treatment, the principle of consent and the right to refuse consent) and the Law on Forced Admittance to Psychiatric Hospitals, the BOPZ. The BOPZ replaced the former law on the mentally insane, which had stated that psychiatric patients could be put away against their wishes if this was for their own good. Under the BOPZ regime, patients could not be locked up in a psychiatric ward unless they were a danger to themselves or others.

Those patients who were still committed to a psychiatric hospital (against their wishes or voluntarily, because their conditions were too serious to live outside the confines of a hospital ward) strove for institutional democracy. Client and patient councils were installed, at first in mental health

care, but later also in homes for the elderly and homes for the mentally disabled (usually the mentally retarded inmates of these homes were represented by their parents).

In 1996, a law that forced health care institutions to establish a client council strengthened the position of these client councils. Institutions that had never had a client council before (hospitals and organizations for short-term out-patient psychiatric care) were required to establish one as well. The client councils were given a voice in important issues concerning care. They went beyond merely dealing with the daily lives of patients within the facility (food, atmosphere, outings, parties and so on), they also became involved in discussions concerning such complicated issues as mergers with other institutions, management's vision on the future, new building projects, complicated financial reports, and so on.

In addition to the law on institutional democracy in health care (the WMCZ); patients were given the legal right to complain about their health care professionals to a complaints committee.

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 common fight against disease, but as actors who have their own interests and their own agendas, who must be compelled to listen to their patients and clients. All these measures (the codification of patient rights, the representation of patients in advisory councils and institutional councils and the right to complain) seemed to turn patients against health care professionals.

Many political scientists have described the phenomenon of `iron triangles' or `policy networks'. Decisions with regard to certain policy areas are often taken in `policy communities' consisting of powerful pressure groups, advisory councils, civil servants and politicians who feel close to the involved pressure groups. Thus, in many countries, agricultural policy used to be made in a policy community dominated by farmer pressure groups, and civil servants and politicians with agricultural backgrounds. Social security policy was made in policy communities dominated by unions, employers associations and civil servants and politicians with a background in either one of these two groups. Likewise, health policy used to be made in a policy community dominated by health professionals' interest groups (cf. Van den Berg & Molleman 1977, Smith 1993, Rhodes 1997, Marsh 1998). Politicians have not limited themselves to reserved participation in these policy communities. They have time and again also tried to undermine these communities by employing other types of civil servants (cf. De Haan & Duyvendak 2002) or by recruiting and appointing other politicians (who would not feel any connection to the department they were chairing, because they did not have a background in farming, the workers' movement or the health sector), for instance. Politicians have also managed to undermine policy communities by opening them up for other interest groups by, for example, inviting consumer interest groups in the agricultural community. Thus patient-consumer groups were invited into the health policy community, on the implicit condition that they would not serve as allies to the medical profession (Kjaer 2004). This seems to have been the case in the Dutch health care sector.

As noted above, the Dutch patient movement (or rather: the patient organizations) did not just employ negative strategies against the medical profession, but they also sought to improve, supplement, and support current health care, and these strategies (in terms of the aforementioned analysis by Verkaar involving the improvement and additional care strategies) seemed to warrant much more co-operation with health care professionals. However, during the 19gos, these strategies would gradually be curbed and forced to go in another direction. Instead of fostering the natural coalition between patients and professionals, these two strategies (like the oppositional strategies discussed before) would be turned into weapons against professionals as well. An early sign of this phenomenon was the so-called Quality Law, introduced in 1996. This law required that care providers develop a quality system and produce annual quality reports, which were to be submitted to patient organizations and health insurers, who would then have to judge the care providers' attempts to improve the quality of care (cf. Casparie et al. 2001).

The alleged conflict of interests between professionals on the one hand, and patients and their organizations on the other, was only exacer
bated with the new plans for the marketization of health care, which will be discussed in the next section.

The Second Stage of Societal Neurosis: The Quest for High-Quality Care on the Cheap

During the ig8os and early 19gos, politicians in European countries interested in health care were mostly busy finding ways to contain costs. In the words of health care policy expert Richard Freeman:

`Beginning at the end of the 1970s, an epidemic of reform swept the health systems of Western Europe'. (Freeman 2ooo: 66). In the past, health care policy had been very consensual. Equal and universal access suited both doctors, patients, employers and taxpayers, that is "both users and providers and those who ultimately paid for it." (Freeman 2000: 77). Since the 1g8os, however, all this has changed. The downward pressure on fees and other health expenses led to the introduction of managers in hospitals, who would try to meet targets, cut back on resources, and interfere with clinical autonomy. Of course, there had been health care managers in the past, but their powers were always limited. Traditional health care managers were inclined to solve problems and maintain their organizations, rather than institute major changes (Harrison 1999). But with the introduction of `the cost containment imperative', managers were given much more influence in the goings on of health care organizations.

Similarly, the impact of politics in the health care systems grew substantially. Politicians consciously aimed to reform their health care systems. Since it did not seem politically viable to boldly announce that health care was just going to get for the worse, for both doctors and patients alike, governments in many countries tried to depict their reform policy as essentially motivated by the patient interests (Freeman 2ooo). Hence, the cutbacks in health care were accompanied by the introduction of patient councils, patient charters, and endless procedures for quality control and cost containment under the heading of New Public Management. Patient advocacy groups seem to have been manipulated to foist health care reforms on an unwilling public (Dibben & Higgins 2004, also Freeman 2000).

Let us take a closer look at what happened in the Netherlands.

The health care system in the Netherlands was neither a tax-financed national health service (as in the UK or Scandinavian countries) nor an outright, premium-based social insurance system (as the Belgian or German systems). Until zoo6 the Dutch health care system consisted of three layers. Long-term institutional care (in a psychiatric hospital, a geriatric ward, or an institute for the mentally disabled) was financed by means of a social insurance system, which covered the entire population. Less-expensive care for chronically ill, elderly, or handicapped patients was also included here. `Ordinary' hospital care, visits to general practitioners, midwives, and various other provisions broadly classified as `cures', were financed differently for different segments of the population. This second layer of the Dutch health care system consisted of two parts. Roughly two-thirds of the population was legally obliged to pay income-based health care premiums. Health care funds provided cures or care in kind for these citizens. The remaining one-third of the population (mostly those with higher incomes) could choose a private health insurer. There were some elements of solidarity built into the private insurance section of the second layer. Private insurers had to offer less healthy clients whom they might otherwise refuse a so-called standard package. These high-risk clients were required to pay high premiums for this standard package, but these premiums in no way fully covered their health care costs. The healthier privately insured clients had to pay a solidarity bonus on top of their premiums to make up for the losses incurred by private insurers as a result of their chronically ill or otherwise extremely expensive clients. The third layer in the Dutch health care system was very small and consisted mostly of non-essential medical provisions, which people could do without or might choose to pay out of pocket, should they desire to.

How could one reduce expenses in this kind of a system?

In actual political practice, three different policy instruments were employed to reduce health care costs, all of which could be classified as supply-side instruments.
1.   Everything that could be budgeted was budgeted (hospital budgets, budgets for certain operations, macro health care budgets).
2.   Medical doctors were strongly encouraged to make and follow professional guidelines. Following a report by the Health Care Council, in which the council argued that there were far too many differences between doctors about what kind of treatment or medicine should be prescribed under what conditions, the profession was asked to make medical practice more 'evidence-based!.
3.   Certain provisions were taken from the collective insurance health care packages because they were not considered to be evidence based, or because they were not meant to remedy a truly pathological condition (e.g., physiotherapy was deemed to be not evidence-based and involuntary infertility, albeit it very tragic, was not considered a handicap or a disease, hence fertility treatments were largely thrown out of the collective insurance packages).

These three policy instruments were very effective; the percentage of the gross national product spent on health care rose from 7.0% in 1975 to 8.7% in 1998 (Blank & Burau 2004), which was a very moderate increase, for example, compared to the US (from 7.2% to 12.9% in the same period).

However, despite this apparent success in actual policy, and despite the fact that the OECD considers supply-side measures a much more effective way of cost containment than demand-side measures (Blank & Burau 2004), the political rhetoric tended to move in another direction. In 1986, the Dutch government had installed an ad hoc committee chaired by Philips business tycoon Wisse Dekker to consider the future of the health care system. The Dekker Committee in its 1987 report 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 the insurance packages they offered. Thus, health care providers who did not meet professional standards or who charged too much for their services, would be disqualified by the insurers and lose their clientele. The idea of making (mildly) profit-oriented insurers assume the health care costs has never really left the political agenda since the Dekker Committee's reports, although their plans were not implemented as such.

In addition to the Dekker proposals, government ministers felt that, if a system of managed competition were adopted, there had to be a larger role not just for the insurers but also for the various patient organizations. They should be allowed to evaluate medical performance and advise insurers about whom to contract under what conditions. However, in order to be up to this particular task, patient organizations first had to be strengthened and professionalized. Patient advocacy groups have been explicitly encouraged to merge with consumer groups and to behave as consumers, in order to perform the role they should play under a new public management regime. Patient organizations were invited to participate in top conferences on the quality of medical care, they were asked to reflect about and discuss reform plans with the government. In order to be able to fulfill this task patient organizations were heavily subsidized by the so-called Patient Fund (introduced in I996). Many organizations were newly created, while many other organizations could afford to hire professional staff. At the national level, the NPCF (the National Platform for Patient and Consumer Organizations) developed into a large organization, staffed by a number of employees.
Patient organizations were strongly encouraged to fall back on two strategies that they were familiar with: Focus on the improvement and possible expansion of regular medical care. However, they were no longer allowed to use these strategies in close collaboration with medical professionals. It was somehow taken for granted that medical professionals would not be willing to think about alternative treatments or improved care on their own. It was accepted that they very much needed material incentives and external controls. Patient organizations and insurers were the ones who could provide this, according to the government. The ongoing development towards evidence-based medicine and the traditional forms of disciplinary control within the medical profession (disciplinary law and the health care inspection) were deemed to be not enough to guarantee quality care.

Henceforth, professionals would have to become more open and transparent regarding their actions, they would have to admit mistakes, register their every move, and duster their movements into a multitude of indicators involving, for instance, the number of patients suffering from decubitus in their hospital, the number of operations which went slightly wrong, the amount of pain suffered by patients after their operations, the number of high-tech medical instruments in their hospitals and so on and so forth. Representatives of patient organizations and health insurers would then compare the scores of hospitals, hospital departments or even individual doctors and judge performance based on these comparisons.

The almost infinite amount of storage space on the Internet has made it possible to save a multitude of lists of performance indicators and the professional scores given these indicators. Not only patient organizations and health insurers can use this information; individual patients can also access it as well.

Many professionals obviously end up complaining about the administrative and bureaucratic overloads thrust upon them, but these complaints always sound slightly suspicious because a professional who does not want transparency obviously has something hide.

Recent (2004-2005) reform plans, launched by Health Minister Hoogervorst, but still very much inspired by the Dekker report, expected a scenario of health care providers continuously busy delivering data on the quality of care they provide, and a coalition of eager insurers and well-informed patient organizations who decide whom to contract at what price for what kind of services (cf. TK 27807, no. 22 and TK 28439, no. 7). Moreover, Hoogervorst emphasized that the Quality Law will be further amended in the future, to make it even stricter on care providers (EK 29 763, no. 22).

Societal neurosis thus starts with democratization and then takes a turn for the worse via new public management reforms that involve bureaucratic marketisation.

The Third Stage of Societal Neurosis: Hyper-Control

Under the new health care system, health insurers and patient organizations will have to monitor and control the performance of doctors and other medical professionals. However, individual patients (or, as the market rhetoric would prefer: individual consumers or clients) will basically not choose doctors or hospitals. They will instead have to first choose a health insurer. This means that they will have to be able to compare the insurance packages offered by the various health insurers. Ideally they should be able to compare the prices, the quality of the total package, and the insurance conditions of different insurers such as the percentage of co-payments. Hence, it is paramount that the insurers provide information about their performance histories and their future policies, like medical professionals had to do before. These data will have to be evaluated - like the medical performance data - by patient organizations, but they are certainly not the only ones who will be called upon to monitor the insurers. The Dutch Senate recently organized a meeting with relevant actors involved in the implementation of the new health insurance system. During this meeting Roger van Boxtel, chairman of the board of directors of a large health insurance company, neatly summed up the institutions that will monitor his organization in the future: monitoring by patient organizations, but also supervision by the Financial Market's Authority (AFM), the Dutch central bank (DNB), the Dutch Authority on Competition (NMA), and the future Health Care Authority (Zorgautoriteit, the present CTG).

Eric Fischer, of the Insurers Federation, expressed his concern about all these monitoring and control authorities. In his opinion, these organizations were staffed by policymakers, that is by creative people who continuously need to demonstrate their worth and thus continue to invent ever better, more advanced, and more refined monitoring methods. Fischer believes that there should at least be some time left to actually do one's work (EK 29762/29763, proceedings of a hearing, 29 April 2005, 12).

There does not seem to be much chance that these complaints will be resolved, however. Hoogervorst has emphasized that the health insurers definitely have to be controlled and monitored by these various authorities (EK 29763, 9o). Moreover, they will have to provide data to the Institute for Public Health and Environment (the RIVM), which will organize surveys in order to acquire data on patient satisfaction, that can subsequently be published on the internet so that it can be used by (potential) clients (EK 29763, 95).

Given the fact that they were the ones who advocated transparency and comparable data with regard to medical practices, it would be inconsistent for insurers to argue that insurers themselves should not have to conform to the same types of rules and regulations.

Meanwhile, we can sum up an impressive list of tasks for the patient organizations:
- they must staff client councils if the patients of homes and hospitals do not volunteer for these councils (staffing these councils has been a problem almost from the beginning and still is, cf. Rijkschroeff i989; Casparie et al. 2001);
- they must monitor the quality reports of the health care organizations and must continue to do so in the future when the law will become even more exacting;
- they must participate in all sorts of meetings with policy makers on the local, regional and national level;
- they must monitor the performance of care providers (nursing homes, hospitals, homes for the mentally retarded, general practitioners), and discuss what to do with this information with health insurers;
- they must monitor the performance of health insurers, in order to be able to advise their members and other patients on insurance packages and optimum treatments.

It is not surprising that the representatives of patient organizations invariably react to new proposals by demanding extra money from the government. They cannot perform all these tasks with a bunch of volunteers; they need a highly educated, trained and paid staff to meet all these demands. Hence, an important element in the Minister of Health's new plans is the empowerment of patient organizations in order to enable them to perform their ever-expanding roles (EK 29 763,13; TK 27 807 no. 22). The special fund which distributes subsidy money to patient organizations (the former Patient fund) will receive a large budget. However, this money does not come cost-free - there are strings attached to this subsidy package. Patient organizations will have to show how they intend to perform their new tasks and will have to prove that they actually did so afterwards. The minister intends to produce "as much results as possible for care users". And here we definitely enter the phase of hyper-control. The patient organizations will not only have to spend a huge amount of time, money and effort monitoring the quality of care, and evaluating professionals' and insurers' performances, they will have to become equally transparent themselves about their own plans and performances. The special fund

that distributes the government's money to patient advocacy groups has drawn up a complicated set of rules and guidelines involving performance areas and indicators for patient organizations (cf. for the new rules and regulations).

And there is no escaping it. If a patient Organization decides to disregard the special fund and the government's stipulations and look for money elsewhere, for example, in the pharmaceutical industry, it would be suspected of having compromised its objectivity and of being `unduly influenced' by the industry. Recently, the special patient Organization subsidy fund organized research concerning money flows between the pharmaceutical industry and patient organizations (DGV 2005). The researchers found that a lot of patient organizations had indeed received money from the pharmaceutical industry in one form or another, and they were appalled by the absence of policies in many patient organizations that dealt with this subject. Some patient organizations were totally opposed to pharmaceutical industry sponsorship. Others saw no problem whatsoever with any form of sponsorship. The vast majority thought sponsorship was potentially warranted under certain conditions, which many of them apparently tried to formulate on a case by case basis (Shall we ask pharmaceutical company X to donate money for our conference? What if they want to be present then and distribute leaflets or gadgets? Do you think it would be all right to have an article written by a researcher connected to the pharmaceutical industry in our journal? Do you think we should charge them for that? Or shall we send the article to our advisory board and let a doctor referee it? And so on.) Most patient organizations prefer this modus operandi. They want to remain autonomous and make their own policies in this area, as in many others as well. The researchers are highly suspicious of this approach, however. They argue that patient organizations should come together and work out one code of conduct concerning sponsorship. This ought to be a code with strict conditions, in order to minimize the chances that individual organizations interpret the code as they see fit. This code should at the very least apply to all organizations receiving public money from the special fund. The researchers add ominously: "A code of behavior without active supervision on compliance is mere window dressing. Therefore, conditions should be created and a means should be developed to monitor pharmaceutical companies and patient organizations to ensure they abide by their code of conduct. It must also be possible to impose sanctions, preferably performed by an existing organization" (DGV 2005,37)

The director of the special fund thought it might be a good idea if the pharmaceutical industry simply donated a lump sum of money, which could then be redistributed to the patient organizations by an independent organization (Bouma & Brandt 2005).

No doubt the day will come when someone will suggest that we monitor the performance of the special fund that distributes the money to patient organizations, and then yet another organization that evaluates the way the special fund is being monitored by its supervising agency and at some point or other, as Graham Lock writes, we will realize that we are like the neurotic, checking and monitoring, washing our hands a thousand times a day (cf. also Engelen 2005).

Societal Neurosis: Can It Be Cured?

It is not easy to develop a cure for societal neurosis. Every individual actor who protests against transparency, performance indicators and close supervision is thus immediately under suspicion. Probably he or she has something to hide; he or she cannot live up to the performance criteria, is ashamed, and therefore does not want to confront a supervising authority.

An organization that protests against supervision and transparency will not only have to face potentially angry policy makers and controllers, it will also risk a lot of negative publicity, because many journalists will sense a cover up and will do an investigation to unearth the organization's secrets. Such journalistic scrutiny might even be worse than the controlling procedure by a regular supervising agency. Hence, an organization that wants to address the ongoing societal neurosis would have to orchestrate its own publicity, it would have to invest a lot of time in talking to journalists, explaining how the administrative burdens are piling up and then hoping that journalists understand and sympathize with their stories. This is a risky strategy indeed because inevitably things do go wrong in every organization. People are fallible, mistakes and accidents happen and the seemingly sympathetic journalist might decide to change his story and investigate further. It is not surprising that many organizations simply go along with the demands of modern times. Imagine a modern hospital or health insurance director confronting his staff. `We have to be open, transparent, and accountable, folks, and we are going to employ two new administrative policymakers who will see to it that we are; but they cannot do it alone! They will need your help. Please register and monitor your every move; make a daily routine of it. Fill in your blue forms, and don't ever forget to submit the pink forms on time. It is paramount that we survive the upcoming supervision and quality control procedures'.

In fact, the only individuals and organizations that could actually make a formidable stand against societal neurosis would be people and organizations that are totally above suspicion, that is, people who have invested a huge amount of time and effort surviving various quality control procedures. One cannot blame them for thinking, `Well, I have bent over backwards to live up to all the crazy benchmarks, performance indicators and the like. Why should others have it easier?'

Organizations and individuals who are controllers themselves such as health insurers and patient organizations have a difficult time when policymakers or policy-friendly researchers suggest that they should be watched and monitored as well. You cannot preach transparency and performance standards if you do not practice what you preach.

So what can be done? I believe there are three treatments for societal neurosis to choose from. This may sound reassuring, but these treatments are very much like medical treatments for serious diseases. The first one has severe side effects, much like chemotherapy. The second one requires that politicians, policymakers, and managers commit to a drastic change in behavior (compare the patient who is suffering from a cardiovascular ailment who has to quit smoking, change his diet drastically, and exercise daily, it can be done, but it is certainly not an easy job). The third one requires the courage and collective action of both professionals and patients. This is probably the most promising treatment, but collective action - as the sociological literature has shown time and again - can be hard to organize, and courage to defy dominant policy rhetoric and the accompanying instructions to comply is a rare quality in a consensual, corporatist country like the Netherlands. Personally I prefer a combination of the second and the third prescriptions.

The first prescription would be real marketization instead of bureaucratic marketization. Let private health insurers try to strike cheaper bargains with hospitals, let them merge with whomever they like, do not ask yourself whether this will interfere with healthy competition, do not worry about insurers who want to select a healthy and youthful clientele, do not discuss the premiums or the differences in premiums for the various categories of patients. In short, if you want to have a market, then have a market. Think about health care the way you think about haircuts. Some people get them regularly, others visit their hairdressers once a year, while others cut their own hair as they see fit. Some have their hair dyed blond, darker, blue, or purple, while others choose perms or an elegant bob. Eccentric individuals want triangles shaved into their heads. Here it is unnecessary to engage in an intricate system of quality control: If people feel their hair has been messed up, they will choose a different hairdresser next time.

Of course, a government cannot abandon health care altogether, there should probably be some emergency care for uninsured people who would otherwise bleed to death in the street, but one could probably stop there and leave the rest up to the people, their insurers, and the health providers.

This prescription of total marketization might cure societal neurosis, but the treatment may be worse than the disease itself. Health care is not like a haircut; we care whether people are suffering when they could be cured, in a dramatically different way than caring whether people dye their hair a hideous green. Of course, we might organize fund raising events to cough up money to help deserving patients who cannot pay, but we would probably keep having doubts about all the others that we knew nothing about.

The second recipe would consist of the government listening to sensible policy experts who now and then argue that one can definitely have too much of a good thing such as control or accountability. The Dutch scientific council for government policy recently published a report in which they argued that the public service sector was plagued by a huge number of monitoring, checking, and controlling agencies, watching their every move and discouraging all professional initiatives (WRR 2004). The council argued that the government should try to get rid of a lot of these monitoring agencies, learn to trust professionals to do their job on their own and search for different forms of accountability, such as more qualitative reports on what happened and how professionals dealt with it (in fact, very much like Tonkens, cf. her contribution to this volume and Tonkens 2003). The government could also read the chapter by Bovens and 't Hart in an edited volume on public accountability, who argue that too much accountability can be paralyzing, time consuming, and frustrating (Bovens & 't Hart 2005). Acting on those insights, however, is terribly difficult. It requires a drastic change of behavior, which could perhaps only be realized if someone (preferably an economist) could convincingly point out that societal neurosis will in the end stifle economic growth and devour huge amounts of money which might have been spent on real work in health care such as on nurses, nursing home staff, doctors and so on. Paul de Beer's analysis of managerial work (200r) as some kind of non-productive but highly

paid activity (not unlike the fake jobs we tend to give to retarded people who cannot hold a proper job because they lack the capacities for that) might be a promising start.

The third prescription is based on the fact that many health care professionals still try to perform their jobs more or less alongside or in disregard of managerial objectives. They care for their patients whether or not this results in a higher score on a balanced score card of performance indicators. Of course this may change in the future. Professionals may become cynical under the weight of an ever larger control structure that forces them to spend ever-increasing amounts of time making plans, writing them down, and evaluating them instead of dealing with patients directly. But at present, although there are probably some professionals who have turned cynical, many have not. And many patients still trust their doctors to help them as best they can; they do not seem eager to engage in a time consuming internet search for the best general practitioner, the best surgeon, or the best hospital (cf. Trappenburg 2005). They visit their family doctor, they know how hard she or he has to work and they can understand their doctor's resistance to increased bureaucratic control.

In 2005, the Dutch general practice doctors decided to go on strike after the government announced its intentions to transfer a substantial sum of money from the incomes of these doctors to that of the health insurers. The rationale behind this was that insurers could then ask them to draw up plans to improve their practices and then reward those who came up with the most promising or original improvements. It was clear that this plan would cut their incomes while placing increased ad-ministrative burdens on their backs. A strike might be interpreted as a fight of narrow selfish interests at the cost of patients who were unable to consult their GPs for several days. Dutch GPs are definitely not poor, they earn substantial incomes, so if the strike ended up being perceived as a fight for a few extra euros this could damage their reputations considerably. Despite this, they decided to go on strike and many patients seemed to sympathize with them. In fact, even the media were rather positive about their strike. Unfortunately, in the end, the doctors settled for financial compensation and dropped their other demands, which contributed to the view that they were just in it for the money after all. Still, this strategy of the bonding of professionals and their clients in the primary process may end up being a promising strategy. If professionals engaged in primary care attempt to establish coalitions with their patients (and with those patient organizations who still prefer professionals to insurers, managers, and politicians), if they stick together and simply disregard the tangle of planning and control boards all around them for a while, then common sense may get the upper hand and the protracted process of societal neurosis can ultimately be defeated.

This third treatment might work as a form of shock therapy.