

The development of Demand-driven care as a new governance concept

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Abstract

Demand-driven care is oriented towards an empowerment of patients/consumers through a redistribution of responsibilities and control among government, healthcare providers, insurers and patients. Different normative approaches can be distinguished in the discussion about the implementation and development of demand-driven care. The economic approach is aimed at competition and consumerism. The democratic approach of demand-driven care focuses on shared social responsibilities and accountability between the actors involved.

In practice both approaches don't get full meaning. The characteristics of sub-sectors within the healthcare system, institutional inertia and conflicting interests hamper a real shift from supply-oriented towards demand-oriented health care.

Keywords: demand-driven care, consumerism, democracy, accountability

Introduction

In several countries health care systems are reformed towards a demand-driven care system. Actors involved are looking for ways to replace central regulation of the provision of health care by a system based on flexible markets in which consumers can express their demands and in which the providers can meet these demands with their products and services [1, 2].

In the Netherlands (and other Bismarck systems) government, providers and insurers have traditionally formed a triangle in which health care was delivered. With the introduction of the concept of demand-driven care, however, a new party is being introduced, namely the patient/consumer/insured⁴. The patient has, of course, always been present in health care systems, but usually as a passive party. Societal developments and government policy bring about change and patients nowadays become a countervailing force against the traditional actors involved. To accommodate the demand, suppliers and insurers will have to become more responsive towards the needs and wants of the patients. To accomplish this, they will be given more freedom to act according to their new responsibilities.

But what will all those developments concerning the introduction of demand-driven care eventually mean for the positions and roles of managers, professionals, insurers and patients?

In the discussion on the meaning of demand-driven care a distinction can be made between the normative elements, which focus on the desired situation, and the practical consequences of the implementation of demand-driven care. Furthermore several approaches of demand-driven care can be distinguished. Each of these different approaches is characterized by a different vision on the roles and responsibilities of managers, professionals, insurers and patients. A distinction can also be made between demand-driven care in different sub-sectors of the health

⁴ These different appellations will be used interchangeable in this paper

care system. Each sector has its own characteristics concerning the type of patients, type of care and financial and organizational context.

The different approaches of demand-driven care will be discussed both on a theoretical as well as on an empirical level. In the exploration a distinction between long-term and short-term care will be made and the following research questions will be addressed:

Which conditions are perceived to be necessary to implement demand-driven care?

How do initiatives with regard to demand-driven care work out in long-term and short-term care? How can differences and similarities in the developments of demand-driven care between long-term and short-term care be understood? What does this mean for the roles and positions of the actors involved?

Demand-driven care: defining the trend

Demand-driven care is the concept that incorporates the empowerment of the patients in the co-ordination and organization of healthcare [3]. Different definitions are applied to capture the essence of demand-driven care. A central element of all definitions is the focus on the patient perspective: the needs and interests of patients should become a central element in the organization and delivery of health care. This should lead to a health care system that can deal with the growing and differentiating demand for care. Subject of debate however are the questions who should determine the content of the patient perspective and the extent to which the perspective of the patient should be determinative for health care organization and delivery. The distinction between 'demand-oriented care' and 'demand-driven care' is used to clarify the different views.

Demand-oriented care refers to a situation in which the traditional actors (government, insurer and provider) remain in control but focus more on the needs and demands of the patient/consumer. Illustrative for this view is the definition

applied by the Dutch government to describe a demand-driven health care system: A system of organization and finance, which is oriented towards the wants and demands of clients. In a situation of demand-driven care, the patients are in control and coordinate the delivery of health care in accordance to their needs [4]. The definition used by The Dutch patient/ consumer federation (NPCF) is in accordance with this view: “provision determined by the demand, in which situation the patients actually have the means to effectively determine the provision” [5].

The discussion about demand-driven care can be made more explicit by distinguishing different theoretical perspectives on the necessary conditions for the successful implementation of this concept. Two important perspectives are the economic perspective and the democratic perspective, which will be elaborated later on. The care-related perspective is a third relevant perspective, which focuses on the mutual efforts of patients and providers to ensure that the patient will receive the care that best suits his needs [6]. This perspective relates to the direct doctor-patient relationship and deals with concepts like “shared decision-making”, and professional autonomy and patient autonomy. The doctor-patient relationship is considered to be important in health care, because healthcare is a “service industry”, and the realization of the services takes place within this relationship. However, to realize demand-driven care in the ‘consulting room’, certain measures should be taken in the conditioning processes, which organize and coordinate health care delivery. Therefore most attention will be paid to the participatory and economic perspective, which focuses on those levels.

The economic approach to demand-driven care

The economic approach to demand-driven care is primarily focused on a redistribution of responsibilities of the involved actors towards a market situation. In a pure market situation the providers are competitive and effectively supply services according to the wishes and expressed needs of the consumers. These consumers

are well informed and aim to fulfill their needs in an efficient way. They will influence the providers by using the “exit-option” as defined by Hirschmann, which entails that if the consumer is not content with the services offered, he will move to another provider [7]. This approach to demand-driven care is comparable with the concept of “consumerism”. The theorists of consumerism indicate that there is a disrupted market equilibrium between providers and consumers of goods and services. To give consumers more control, five crucial factors are distinguished: Access to the products, choice between products, access to information, possibilities to express dissatisfaction and adequate representation at the decision-making level [8] This would introduce a more rational and economic way of thinking in healthcare, in which consumers choose between providers on the basis of their performance.

In healthcare however it is assumed that a free market will not result in optimal efficiency in the utilization of resources and universal access to care [1]. There are several causes of market failure in health care:

- Uncertainty of the consumer about the moment when he will need healthcare;
- Uncertainty about the nature and the amount of care needed;
- Information asymmetry between consumer and supplier;
- Supplier induced demand;
- Heterogeneity of healthcare as a product;
- Healthcare as a public good [9].

Because of these imperfections the patient is not able to be or to become a rational consumer. Consequently the patient has to rely on other parties to look after his interests. Therefore, “regulated competition” is introduced in health care. The government defines the rules of the game and the insurer is placed between the provider and the patient to buy health care on behalf of its insured. The professionals (providers) are also acting on behalf of the patient in the sense that they translate

the questions of the patient into medical needs. These dependencies can be analyzed with the principal-agent theory [10].

The principal-agent relationship implies the existence of a contract under which one or more persons (the principals) engage another person or persons (as agents) to perform a service on their behalf. Under this contract, the agent takes on some of the decision-making responsibility [11].

Within this principal-agent relationship different conflicts can occur. Information-asymmetry can exist because of the reliance on the agent. Furthermore, the principal and the agent can have different goals and interests.

Within health care, four different principal- agent problems can be distinguished:

- The information asymmetry between patients and professionals with regard to medical procedures.
- The double roles of health care providers: patients want the best treatment available for their needs (irrespective of the costs) and the insurers want the provider to spend the scarce resources as efficiently as possible.
- The different interests between the insurers and the insured. The insurers want the insured to take measures to prevent getting sick, but the insured do not feel the necessity for these measures because they are insured for future healthcare costs.
- The information asymmetry between insurer and insured, about the risks of future health care costs [10].

To counteract the potential conflicts two approaches can be followed: the first one is to attempt to bring the behavior of the agent closer to that of the principal, using hierarchical chains of command. The second approach is oriented towards the output: sharing of profit and responsibilities and transference of property rights, in other words to level the interest of principal and agent [12].

With the introduction of regulated competition the government delegates responsibilities to the insurers and other parties. As a result the citizens/ patients will obtain a more direct role as principals. To equip the patients for this role, several

steps would have to be taken, with empowerment and the provision of information as key elements. By informing the patients about the services that insurers and providers are offering, information asymmetry (one of the sources of conflicts between principal and provider) will diminish. Besides information, patients are equipped to get more (collective) negotiating and purchasing power. This will give patients a more equal position as a countervailing force against the insurers and providers. With these developments the accent is shifting from a hierarchical chain of command towards a more output-oriented approach. With the introduction of market mechanisms, the interests of insurers, providers and patient are better brought into line with each other.

From the discussion above it can be concluded that the patient has two different roles within a situation of regulated competition. At the one hand he/she has to become an informed and efficiently behaving consumer, but in the situation where he is not able to fulfill that role according to the economic criteria he will have to become a critical agent who controls the insurer and the suppliers in their roles as agents. If the market works well, the insurers and the providers are supposed to act as suppliers in the purest economic sense. They have to compete mutually and they are assumed to be responsive to the needs and demands of the demand side of the market. Also it will no longer be necessary for the insurers to act as an agent for the insured.

The democratic approach to demand-driven care

In the section above it was stated that competition, in the mere sense of the word, would not work in health care. Regulated competition is therefore assumed to be the best alternative. Furthermore Pickard [13] argues that consumerism is not sufficient to sharpen the clarity of representative government, as an instrument for citizen participation in decision-making. In that it relies on a very limited view of citizenship

and on a very individualistic relationship between consumers and service providers. This is the reason why other perspectives on demand-driven care are formulated.

The participatory perspective follows the reasoning of the democratic approach and deals with the field of tension between individual and collective interests within the modern welfare state. Giddens, one of the leading authors of the theory of civil society, argues that in the future, interventions of the state will always go hand in hand with responsibilities of the public organizations (civil society) and individuals. The state should act as a facilitator. Van der Veen argues that in the Dutch welfare state developments are already moving in this direction [14].

The concept of citizenship focuses on the role of the citizen in the new welfare state. Citizens should be made aware of their responsibilities towards the public interest. Within the public domain they should account for their actions and they should also call upon others to account for their actions [15].

A distinction can be made between active and passive citizenship. Passive citizenship emphasizes the privacy and the importance of individual opinion in relation to the sacredness of the family as an institution. Active citizenship focuses on the rights of the citizen to be heard, to make choices and to exert influence over services, however he has also the obligation to be involved in some way in the processes that are established on behalf of this purpose [16]. The concept of citizenship corresponds with the "voice-option" as defined by Hirschman in which clients directly influence the providers' policy [17].

The 'ladder of participation' that Arnstein gives can help to clarify the voice-option. The ladder has the following steps: citizen control, delegated power, partnership, consultation and information giving. North and Werkö reject information giving as a discrete form of participation but elaborate on partnership and consultation. They discriminate between institutional and informal constituencies, the degree to which the consulter is accountable or can be held accountable to those consulted, and the degree to which agendas are controlled. Furthermore they make a distinction

between consultation processes that contribute to a particular decision or process and those that exist solely to enhance the awareness of either the consulted or the consulter. Finally, North and Werkö consider the volitions of participants to be an important addition. This refers to the willingness of participants to sacrifice goals in exchange for future reciprocities and their openness to alternative (lay) perspectives [18].

The participatory perspective of demand-driven care is in accordance with the movement from vertical accountability towards horizontal accountability. The development from governing to “governance” represents a greater collaboration between government and non-governmental actors in different networks. Responsibilities shift from central government to local government and from government to non-government actors. Insurers, providers and patients/ citizens obtain more freedom to organize and develop health care [19]. Insurers and providers should act as social entrepreneurs and account for the use of collective goods.

In order to accomplish this transition, the participation of patients in the organization and coordination of healthcare should be promoted. Through legislation (Dutch) government is trying to institutionalize the participatory role of the patient. Within the democratic approach the agent role of insurers and providers is further explored. Decentralization of government responsibilities and tasks is aimed at reducing the role of the government as a director of the health care sector. Insurers, suppliers and lower governmental bodies should take over that role [20].

The normative approaches that have been distinguished are summarized in the schedule below. Regulated competition, as part of the economic approach, is presented separately because of its distinctions and importance in the discussion about the possibilities of market competition in health care.

	Economic view	Regulated competition view	Democratic view
Manager	Competitive and innovative provider	Competitive and innovative provider	Social entrepreneur
Professional	Competitive and innovative provider	Agent for the patient, and competitive and innovative provider	Social entrepreneur
Insurer	Competitive reimbursement insurer	Agent for the patient, and competitive reimbursement insurer	Social entrepreneur and director of care

Patient	Rational consumer	As much as possible rational consumer and principal for professiona l and insurer	Responsible citizen
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Context of implementation

The above-mentioned views are normative approaches to the way demand-driven care should be implemented and the way responsibilities should be divided between actors. However, to understand the way in which demand-driven care gets its meaning in practice, the context in which it is implemented should be incorporated. To give more insight in this context Hemerijck and Helderma [21] analytically separate the provision logic and the institutional logic. ‘... the provision logic of a specific social policy area is intimately related to the particular ‘task contingencies’ of the delivery of collective good and public service, i.e. housing and health care.’ Hemerijck and Helderma reason that the provision logic is concerned with questions of the processes of production, distribution, allocation, financing, pricing, consumption, and reproduction of differentiated social goods or services [id.]. The institutional logic refers to state traditions and the organization of (civil) society. In this light the following aspects are relevant: administrative strategies, decision-rules, policy styles, state-society interaction [id.].

Within the framework of the provision logic of health care, the distinctive characteristics of health care as a market have already been discussed. Firstly

through pointing out the different elements of market failure and secondly through discussing the different principal-agent problems that can occur.

The extent in which the distinctive characteristics are expressed can however vary across the different sub sectors of health care. It is, for example, reasoned that acute patients, will be less capable to coordinate their own care than patients with a physical, chronic condition [22].

Focusing on the institutional logic, the administrative institutions of Dutch health care have been characterized as a sector with a tradition of self-governance and risk avoidance/solidarity, financed through a mixed insurance system and a private execution of public tasks. In the Netherlands the financing of medical care takes place within a mixed system of public and private insurance. This system is divided in three compartments. The first compartment is the general exceptional medical expenses Act (AWBZ). The second compartment is the statutory public health insurance based on the Health insurance Act (ZFW), the Access to health insurance Act (WTZ) and private insurance. The third compartment is supplementary (private) insurance and will be out of scope for this paper

The fact that health care is largely considered as a public good also implies an extensive influence of social norms, values and developments like individualization and empowerment. The private execution of public tasks leads to a mutual dependence between private and public actors. The Dutch government has a constitutional responsibility to guarantee the access, efficiency and quality of health care, but it is dependent on private actors to fulfill these obligations. These characteristics of Dutch health care make it necessary to take into account the presence of (in)formal institutions and networks [23].

Developments in health policy

In 2003 a next step was set in the reform process with the beginning of the "Modernization of the AWBZ". Central objectives were:

- Free choice of provider for the patient;
- Functional indication instead of indication based on the existing provider;
- Market competition;
- Free choice for patients between care free at point of delivery and a personal budget to buy care themselves.

Four years earlier, in 1995, the project to modernize the curative care was introduced. In this process four central themes could be distinguished:

- The providers are better equipped to negotiate with the insurers;
- The demand side of healthcare (patients and insurers) is being strengthened. For which the insurer plays the role of risk bearing director of care;
- The government takes responsibility for protecting public interest.

Besides sector specific policy, some relevant general policy measures were also taken.

To strengthen the position of the patient the Dutch government has written several policy documents. The latest policy document 'Met zorg kiezen' [24] formulated five elements in patient empowerment:

- An adequate legal status of patients;
- Current, accessible and reliable information for patients on the quality of care;
- Independent, accessible and reliable counseling and guidance for patients;
- Individual and collective purchasing power for patients;
- The presence of a collective negotiating power, which is representative for the patients and acts transparent.

Different measures have already been taken to execute these elements. Examples of this are legislation to strengthen the position of patients within the doctor-patient

relationship, but also to establish a negotiating power within organizations (patient counsels). Furthermore the purchasing power of patients in long-term care has been strengthened with the introduction of personal budgets

Demand-driven care in the different sub sectors

In the exploration of the provision logic in health care a distinction is made between long-term care and short-term care. When the (institutional) situation of the two sectors is confronted with the different approaches of demand-driven care, several considerations come to light. On the basis of these considerations several hypotheses can be formulated about the potential meaning of demand-driven care in the different sub sectors:

- The characteristics of the patients in both sectors differ and this could influence the implementation of demand-driven care. It can be reasoned that consumerism has the highest chance of success in the long-term care, because patients have a longer experience with their illness and are therefore better capable to express their needs.
- As far as the democratic view is concerned, it can be reasoned that participatory democracy plays a larger role in long-term care. The financing system in the first compartment is payroll-tax based, in contrast to the second compartment where there is a much more direct individual payment through premiums. This could mean that in the discussion about the preservation of the social security state, and in relation to this the civil society, the first compartment is more subject of debate than the second compartment. Furthermore patients in long term care will be more able to take responsibility for the use of collective means, because they are better equipped to estimate their need for care and fulfill those needs with alternatives (volunteers, family). Finally the discussion about citizenship is more present in long-term care, because social participation is considered an important factor in the lives of elderly and chronically ill and the delivery of care should facilitate this.

- The fact that patients in short-term care usually lack experience enlarges their dependence on professionals to interpret their needs. Furthermore the care is much more complex to understand in comparison with long-term care and therefore it is much more difficult to make a comparison between different providers. This leads a situation of information-asymmetry. It can therefore be reasoned that the role of the professional as an agent is much stronger in the short-term care. Moreover professionals in long-term care do not have such a distinctive position in the organization of care in comparison to specialists in hospitals who can refer to their professional status and professional autonomy.
- With regard to the role of the insurer it can be argued that it will have a more active role in short-term care than in long-term care because the insured can switch between insurance organizations. This is not the case in long-term care (there is only one regional care office). This will make the insurers in short-term care more motivated to meet the needs and demand of their insured with regard to the care they purchase.
- In contrast it can be reasoned that the role of the insurer in the healthcare delivery market will diminish if competition is more developed in health care. In the current health care system government assigned the insurers the role of agent for their insured, because it is presumed that they have more knowledge of health care and they already had a strong position. The question is whether their role as agent is sustainable in an increasingly competitive healthcare market.
- When both approaches are considered, it can be concluded that they allocate different roles and responsibilities to the actors involved. The Dutch government applies both approaches in the development towards demand-driven care. It remains to be seen how this will work out in practice. It can be argued that the different approaches are hard to combine. The economic approach appeals to more businesslike relationships between the different actors involved. Mutual competition, exit-options and performance are the central elements in this approach.

In contrast the democratic approach appeals to mutual responsibility and accountability. Not individual interests but the collective needs of society are the central focus. The process gets more attention, especially the participation of citizens. When both approaches are applied this could lead to conflict and tension. Particularly the roles of the insurer in both approaches are hard to combine. In a market situation they are stimulated to meet the individual needs and demands of individual insured, but within the democratic approach they are jointly responsible for the assurance of collective needs.

An empirical exploration

To explore the development of demand-driven care and the implications for the different actors involved, four case studies were performed. Two case studies were performed in the long-term care and two in the short-term care. In each sub sector one case was situated within the social insurance system and one case was a more commercial initiative. The commercial initiatives were included to explore the way that demand-driven care is developed in the activities of more entrepreneurial actors. Because these initiatives are still exceptions, the analysis will focus on the two cases within the context of 'regular health care delivery'.

A Dutch Hospital

The short-term care case is a Dutch Hospital, which is reorganizing towards a demand-driven organization. The aim is to create an organization that is no longer a collection of different professions, but which will be built up from different consumer groups, in order to realize continuity in healthcare. This case is representative for a more general development in Dutch healthcare.

The reorganization is an initiative of the management, but in the development towards the new organization, the medical specialists maintain their central positions in the hospital. The specialist determines the content of the medical care and the

specialist also gets explicit responsibilities in the role as chairman of the project groups. The initiatives primarily stem from the hospital management, but different regional actors are (to a certain extent) involved in different stages of the process. The hospital is not confronted with a situation of competition, because they are the only hospital in the region.

The roles of different actors

In the process towards the new hospital organization different actors were involved. They all had their own roles and positions. Furthermore different expectations and opinions exist about the roles of different actors in the new situation of demand-driven care.

Management had the role of initiator. A few professionals in the organization even perceived demand-driven care to be a management-instrument. Management was triggered by a sense of urgency and government policy to engage into the organizational development. It responded to a question of the central government about the hospital of the 21st century to get permission to build a new hospital building. In cooperation with an external advise organization the management designed the concept of organizing the care around patient groups.

The specialists traditionally have a strong position in hospitals. Also in the reorganization process of this hospital, the professionals (medical specialists) have a central place. The medically indicated need of patients is the central focus of the process redesign. Service elements are also important but more supplementary.

The professionals primarily gave input about the criteria that had to be satisfied by the new organization. They used their knowledge of and experience with patients as their reference point. Therefore it was not felt necessary to communicate with the

patients about their needs concerning the content and process of their medical treatment.

The patients were involved in different ways. There was a client council in the hospital that was informed about the developments. With regard to the development project of the new hospital, panel groups were organized in which patient organizations also participated. A representative of the regional general patient organization felt that the patients were not sufficiently representative due to the number of representatives and because she felt she lacked the specific knowledge required for the sufficient representation of the needs of patients regarding the new hospital building. The panel groups were not involved in decision-making concerning the new building, but mostly gave information about their ideas and needs for the new hospital. In the development of the medical processes no patient organizations were involved.

The regional general patient organization was, just like other regional actors, informed about the developments.

In the regional network patient organizations were also not involved. They were informed and are asked for advice on different projects, but they were not involved in decision-making. They were not involved because it was considered that they could not bear the same financial responsibilities as the other actors.

The director of the hospital expressed his wish for the regional general patient organizations to put more pressure on him, because he felt they were not truly present.

The insurer, who is the primary contractor of the hospital, was very much focused on the regional situation, because of its main work area, which equaled the working area of the hospital. The insurer was primarily a financier. It was not involved in policy decisions of the hospital. It felt like a director and a partner of regional

providers of care. It was also involved in the regional health care network but it was aware of its different, more controlling, role in comparison of the other actors. That was sometimes perceived to be difficult because other actors also said that the insurer became more and more a partner and not just a financier. The insurer tries to be critical towards the hospital by also threatening to give insured the possibility to get care abroad if the hospital cannot provide it satisfactorily.

There was also a regional representative of the other insurers who have only a small number of insured in this region. The regional representative was more critical towards the developments of the hospital and sometimes felt shut out because of the strong relation between the regional insurer and the hospital. The regional representative saw his role towards the hospital more as a critical buyer of care.

Elderly care

The long-term care case was a collaboration between a nursing home organization and a home care organization to provide extensive care at home, in order for elderly people to live at home longer instead of living in a nursing home. The development was primarily an initiative of the nursing home, but the home care organization was involved from the beginning onwards. This development was at first implemented at residences for elderly connected to the nursing homes. At different locations this development was implemented in a different way.

The roles of different actors

In this case also different actors were involved. Besides providers, patients and insurers, housing corporations and local government were involved. The roles and positions of these parties are outside the scope of this paper and will not be discussed.

The nursing home is a result from a merger of several nursing homes in the region. Before the merger several nursing homes had already started developments of nursing home care at home. There were different layers of management both at the nursing home and in the home care organization. The lower management (in the nursing home that was the manager of a location) primarily implemented the project. At a more central level there was a bureau of innovation. This bureau also discussed the possibilities of demand-driven care with management and also explicitly discussed the meaning and definition of the concept.

The home care organization was involved in the organization of the project because the nursing home care is dependent on them, to deliver part of the care. Furthermore the home care organization had an interest in the survival of the nursing home as a partner. With the introduction of a function-based indication system, the relation between the nursing home and the home care organization was hardened. They became potential competitors, but chose initially for collaboration.

The professionals that were involved in this project are primarily nurses. Head nurses (floor managers) were involved in the implementation process, but primarily the nurses were only involved as executing personnel.

In comparison to the hospital professionals the nurses were not a party with whom management has to negotiate. There was more hierarchy.

However it was recognized that floor personnel is important in the final implementation of demand-driven care. Therefore education of personnel was seen as an important step.

The clients (primarily elderly) had different roles in the process. At an individual level, clients were expected to keep control over the organization of their own care. They were supposed to be able to organize their own care, if necessary with help from a care coordinator.

Elderly organizations at a regional level and the regional general patient organization were not involved with the project. They were informed only.

Elderly people were represented at different regional networks in which regional actors came together to discuss future developments of (elderly) care. However they were not part of the regional care network in which health care providers make future policy. The elderly were highly organized in different organizations, and were supported by local welfare organizations (they were part of the responsibility of the municipality).

The insurer in this case was mostly involved in the project as financier of the regular care. The project was developed without the insurer, but now there were conversations about the financing of the project. A cluster director of the nursing home saw the care office mostly as facilitator.

The insurer put a lot of effort in the communication with the client (organizations). It had regular meetings with the client counsels of the care organizations. And it only gave financial support to projects in which the client perspective was taken into account.

Some care organizations felt that the insurer was putting the interests of the patients to much in first place and that it forgot the interests of the providers.

Analysis

The empirical cases show the following roles of the different actors:

	Hospital	Elderly care
Manager	Innovative provider	Innovative provider
Professional	Principal of medical needs patients	Executer of care
Insurer	Partner of providers, financier/ facilitator and director	Agent for the patient, financier/ facilitator
Patient	Individual: patient; Collective: informed	Individual: director of care; Collective: informed and partner of care

When confronting this schematic overview with the normative approaches discussed earlier in this paper it becomes obvious that the competitive element of the economic view is almost fully absent. In the long-term case, incentives for competition are present but providers choose to collaborate instead. The hospital is not confronted with direct competition, because they have a monopoly position in the region they attend to. The care office in the long-term care case has a critical position towards the providers as financier and also tries to incorporate the patient perspective in its

policy. The providers however see the insurer more as a financial facilitator than as a buyer who encourages competition. In the short-term care case the insurer is mostly a partner and facilitator of the hospital, but it also tries to be critical towards the hospital. The insurer feels the tension between sharing the responsibilities with providers and acting as a critical buyer as a representative of the insured.

At an individual level the patients in both cases are not really considered as rational consumers by the providers. In the case of elderly care an appeal is made to their competence as directors of their own care, but the exit-option is not really expressed. With regard to the democratic view the cases show that mostly insurers and providers both coordinate and collaborate the delivery of health care in their region and the use of collective means. They do that from their appointed tasks and responsibilities from the central government.

The patient organizations and elderly organizations try to become a partner in the development and organization of care, but they are not considered as full partners by the other actors, considering the fact that in both cases the patient organizations are not part of the regional care networks. They are primarily considered as a source of information and as an actor that has to be informed.

In both cases the providers (managers and professionals taken together) are innovative, because they are reorganizing their organization and products. The incentives to be innovative are originate both from central government and from social developments. Changes in regulation and financial arrangements that are made by the central government urge providers to reorganize and their change strategies. On the other hand, providers feel pressure from clients, especially in the long-term case, where clients express their expectations with regard to the services that are provided. It was argued that developments in healthcare are influenced by the context in which they are introduced. This context is partly shaped by policies that form the formal institutions. In the perspective of regulated competition it is presumed that government states the rules of the game. The Dutch government has

executed several policy measures to fulfill that task, but the necessary conditions are not yet fully developed. For the democratic perspective on demand-driven care central elements are decentralization, participation of citizens and mutual responsibilities. Even though regulated competition is the central element in health policy, Dutch government has also introduced several measures to strengthen mutual responsibilities and participation of the citizen. An example for this is the law for patient counsels in healthcare organizations. The participation of citizens in both short-term and long-term care, however, is limited to receiving information and giving information. This shows that formal institutions are not determinative for the way developments occur. In the case of participation it is presumed that patients are not able to carry the same responsibilities as providers and insurers. There is no sense of mutual dependency.

Another example for the limited influence of formal institutions is the way that the providers in the long-term care reacted to the introduction of functional indication, which made competitions between different providers possible. They choose not to compete with each other but to structure their collaboration. A feeling of mutual dependency and the present possibilities to escape competition and maintain collaboration within the “new” context was the reason for this decision.

Furthermore the empirical cases show differences between the two sub sectors of care. In the long-term care the different collective organizations that represent the interests of the elderly are much more actively involved and with a larger number than in short-term care. In the short-term care the professionals had a much more prominent role in the development of the demand-driven hospital than in the long-term care. Finally health care was confronted for a long time with strong financial regulations. These regulations are still effective but at the same time policy towards demand-driven care is implemented. The actors however are still very much directed towards financial incentives. The fact that the insurer is mostly seen as a financial facilitator shows that. This shows that informal institutions like norms and values but

also grown relationships and positions are influencing the way that demand-driven care gets meaning.

Looking at the formulated hypotheses the empirical cases show the following results. Elements of both normative approaches are present in both sectors, but are not fully developed. Consumerism is not a central element in the long-term care case, more emphasis is put on the management and improvement of care-processes. In the short-term case a market approach is present in the sense that the hospital is trying to distinguish it self by informing patients about their services. This means that the hospital is aware of the fact that patients can go to another hospital. The central processes however are not really oriented towards market competition and in the reorganization the patient is not considered as a rational consumer.

With regard to participatory democracy, the collective patients in both cases are informed about the different developments and in some cases they are also asked for input (panel groups in the hospital case) but their role, as participant is still very small. In the long-term care case the elderly are very well organized and institutionalized as an actor, but they do not share responsibilities.

In the hospital case, the professionals act as principals of the patients. This role however is mostly limited to the medical needs of patients. Professionals still have a central position in the process, because their commitment is supposed to be critical to the success of the reorganization. In the elderly care case; professionals do not have such a central position in the development of the project. They are considered as the executors of the project. Because of the complexity of the care in short-term care, there is a situation of information-asymmetry, which makes it necessary for the professionals to be involved in the developmental stage, because they have the necessary information. Furthermore professionals have a more autonomous position; some of them are not even employed by the hospital. Professionals are eager to maintain this situation. The insurers in both cases are mostly seen as a

facilitator in the sense that they are responsible for the finances. Insurers are developing their role as a director of care. They are also acting as a principal for their insured, which is particularly expressed with regard to the care office in the long-term care case. It is interesting to see that the care office is active in incorporating the patient perspective in its activities, considering the fact that it is not confronted with any form of competition.

With respect to the tension between the two normative approaches the insurer in the short-term care case feels tension between its partnership with providers and its role as critical buyer for its insured. In the long-term care case, the introduction of functional indications made competition between the elderly home and the home care organization possible. This was an incentive for both providers to have a strategic deliberation, but the result from this deliberation was to continue collaboration. This illustrates that measures from the central government, concerning both approaches, do stimulate actors to reconsider their mutual positions and relations. But the measures are not stimulating enough to radically change the existing institutional arrangements.

Conclusion

The central question stated at the beginning of this paper was focused on the meaning of demand-driven care for the positions and roles of managers, professionals, insurers and patients.

A theoretical exploration shows two approaches of demand-driven care (economic and democratic) that both describe different roles and responsibilities of the different actors involved. The policy of the Dutch central government has incorporated elements of both normative approaches and several measures derived from this policy are already implemented.

From the results of the empirical cases it can be concluded that in practice demand-driven care has not yet reached the potential meaning, argued by the two different

normative perspectives on the concept. The cases show that providers start to behave in a more strategic manner. They also become more aware of the value of insight in the 'patient-perspective'. However a large shift in responsibilities and roles has not yet taken place. Patients are still not incorporated in the decision-making process, but their possibilities to act as a rational consumer are also limited. This means that the empowerment of the patient is only developing within certain boundaries, which are still determined by the provision side of health care.

The empirical results show that policy measures are to some extent neutralized by the context in which they are implemented. Grown relations and norms and values make actors reluctant to change. A sense of urgency should be created before actors are willing to give up familiar routines. From the case studies it can be derived that this sense of urgency is built up from different elements, among other things measures of central government, pressure originating from the local situation and the pursuit of continuity of the organization.

A conclusion from these results could be that the development of demand-driven care is an uncontrollable process for the government and that therefore its potential meaning as a new governance concept is questionable. However from a more rational perspective it could also be argued that the necessary conditions to stimulate the desired behavior of the actors involved are still not present. This would mean that the insight in the dynamics between governmental policy and policy context should be used to implement the suitable measures and guarantee the essence of demand-driven care: the needs and interests of patients as a central element in the organization and delivery of health care.

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