

Priced, Not Praised: The Effects of Economization on the  
Professional Identity of Dutch General Practitioners

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**Abstract**

The increasing dominance of economic discourse, principles, reasoning and values –often termed economization or marketization – across society and social relations is worthy of our attention. In this study, I explore whether and how economization has affected the professional identity – including excellence, ethics and engagement – of General Practitioners (GPs); I want to determine whether recalibration of the social contract between GPs and society is needed. I interviewed 22 GPs and 5 GP care experts. I determined that economization has not had a substantial impact on GPs' understanding of their professional identity. At the core, the meaning of excellence, ethics and engagement remains unchanged. Small shifts are observed in excellence and ethics. Excellence is now more about following the NHG-guidelines, offering specialized GP care and striving to collaborate with colleagues. The notion of ethics has expanded to include entrepreneurial responsibilities. I argue that the modest effect of economization can be attributed to the creativity of the general practitioners. In spite of strong market pressures, they find and create discretionary spaces that allow them to act in accordance with their professional values.

## Introduction

The demand for healthcare in the Netherlands is booming. Over the next decade, demand will increase sharply (VWS, 2007: 39).<sup>1</sup> This increase also counts for General Practitioner (GP) care whereas the number of consultations is expected to rise from 114 million in 2007 up to 170 million in 2020 (VWS, 2007: 38). Not surprisingly, political and societal debates on healthcare have become dominated by its costs (cf. Hilhorst, 2004: 20).

This focus has resulted in an interesting tension for the medical field. On the one hand, medical professionals, like GPs, are expected to be driven by a strong professional logic, honouring the values of the healthcare domain.<sup>2</sup> On the other hand, societal and managerial emphasis on an economic logic – ‘*economization*’ – has changed the world in which GPs have to carry out their responsibilities (e.g. Jansen, Kole, and Van den Brink, 2009). How does working in such an environment affect a GP? After all, according to Freidson (2001), the professional and economic logic are often at odds with each other (see also Kuhlmann & Saks, 2008: 4-5). In this paper I examine whether and how economization affects the professional identity of GPs.

This study contributes to the ‘market and moral’-debate by focussing on the professionals – the GPs – themselves (see also WRR, 2012: 59 ff.). In the remainder of this introduction I focus on the Dutch healthcare system, GPs, and the central concepts *economization* and *professional identity*. Next, I present the analytical framework, followed by this study’s methodological considerations. After that, I present my main findings and, in conclusion places the results in a broader perspective.

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<sup>1</sup> The costs are expected to rise 63 percent from 3,920 Euros per person in 2007 up to 6,300 Euros in 2020.

<sup>2</sup> In this paper, I use the definition of *domain* and *field* of Feldman, Csikszentmihalyi and Gardner. Domain is the ‘organized body of knowledge about a particular topic’ and field refers to the group of people that work within the same domain (1994: 20).

### *The Dutch healthcare system and its 'gatekeepers'*

After more than twenty years of political debate, the Dutch healthcare system was radically transformed in 2006 with the introduction of a new insurance system based on managed competition (Schäfer, Kroneman, Boerma, Van den Berg, Westert, Devillé & Van Ginneken, 2010: 13; see also Commissie Dekker, 1987; Dwarswaard, Hilhorst & Trappenburg, 2011: 390; Enthoven & Van de Ven, 2007: 2421 ff.; Helderman, Schut, Van der Grinten, & Van de Ven, 2005).<sup>3</sup> Under the banner of liberalization, government has withdrawn partly from the healthcare 'playing field' and created a comprehensive legislative framework to offset market failures (Van der Grinten, 2007: 227 see also Boot & Knapen, 2005: 213-216; Putters, 2002: 6-7; Van Heurck, 2003: 147).<sup>4</sup>

Within the system of managed competition, GPs are the 'gatekeepers'. They are generalists who can treat people for a wide range of relatively small problems and they can write referrals for patients who need secondary care (i.e. hospital care) (Boot & Knapen, 2005: 102; Schäfer et al., 2010: 23; Van den Berg, 2010: 11; Van Dijk, 2012: 10, 13).<sup>5</sup>

### *Economization*

The role of the professional in Dutch society has changed considerably due to many different managerial, societal and internal pressures like commercialization, competition, digitalization,

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

<sup>4</sup> The most important acts are the Health Insurance Act (Zorgverzekeringswet), the Healthcare Market Regulation Act (Wet Marktordening Gezondheidszorg), and the Healthcare Allowance Act (Wet op de Zorgtoeslag) (Van de Ven et al., 2009).

<sup>5</sup> Of all contacts between GPs and patients, approximately 96 percent are handled within the general practice, and only the remaining 4 percent is referred to secondary/other care (Van den Berg et al., 2005: 133; Van den Berg, 2010: 12). On January 1, 2011 there were at least 9,891 active GPs in the Netherlands (NIVEL, 2011: 8 ff.; NIVEL, 2012a; see also Van den Berg, 2010: 11).

individualization, New Public Management (NPM), and standardization (see Groenewegen & Hansen, 2007: 61 ff.; Pollit & Bouckaert, 2004: 90; Schnabel, 2004; SCP, 2004: 51-65; SCP, 2011;; WRR, 2012: 21, 49 ff.).<sup>6</sup> A complex interplay of multiple pressures has led to *economization*, which refers to the increasing dominance of economic discourse, principles, reasoning and values.<sup>7</sup> Markets with their emphasis on contracts and financial incentives have become increasingly important as coordinating mechanisms within society, at the possible expense of values and norms (De Waele, 1999: vii; see also RVZ, 2004: 153 ff.; Van Hout and Putters, 2004: 130).

Economization in healthcare puts two logics in the limelight: (1) the logic of *consumerism* (bottom-up) whereas the autonomy of patients has become central, forcing medical organizations to be more customer-focused. And (2) the logic of *managerialism* (top-down) whereas management has sought to foster efficiency and effectiveness within all kinds of healthcare organizations (Van Hout & Putters, 2004: 130; see also Dwarswaard et al., 2011: 389).

### *Professionals' special role*

Gardner and Shulman argue that 'professions consist of individuals who are given a certain amount of prestige and autonomy in return for performing for society a set of services in a disinterested way' (2005: 14; see also Abbott, 1988; Freidson, 2001; see also Jansen et al., 2009: 17; Wilensky, 1964). This definition certainly counts for the professionals of medicine, commonly regarded as the profession par excellence (Trappenburg, 2011). The relation between GPs and society can be expressed in terms of a social contract that holds mutual 'legitimate expectations' – the reciprocal

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<sup>6</sup> See also Bovens, 2003: 30 ff.; Burau & Vrangbæk, 2008: 29; Castellani & Hafferty, 2006; De Bruijn, 2006: 11 ff.; Farrell & Morris, 2003: 136; Hafferty & Castellani, 2010; Hood, 1991: 4-5; Jansen et al., 2009: 18-19; Mulgan, 2003: 151 ff.; Noordegraaf, 2004: 56-57, 87; Noordegraaf, 2011; Spangenberg & Lampert, 2009: 80; Tummers, 2012: 16; Waring & Currie, 2009: 755 ff.; Van Montfort, 2008: 47.

<sup>7</sup> In international literature this is also known as 'marketization'.

rights and duties – of both GPs and citizens (Cruess & Cruess, 2008; see also Caellegh, 2001; Coulehan, Williams, Van McCrary & Belling, 2003). It is based on the mutual *trust* that the other party will live up to these expectations (Davies, 1999 in Calnan & Sanford, 2004: 92; Sullivan, 2000: 673; Van der Schee, Braun, Calnan, Schnee & Groenewegen, 2007: 57).

Trust is about ‘the *optimistic* acceptance of a *vulnerable* situation in which the truster believes the trustee will *care* for the truster’s interests’ (Hall, Dugan, Zheng & Mishra, 2001: 615). It is especially necessary in contexts with uncertainty and risk, like healthcare. Patients are highly reliant upon both the competence and the intentions of the practitioner about whom they strive to have positive expectations (Calnan & Rowe, 2008a: 2; Hall et al., 2001: 615-617). In line with Gardner’s idea of ‘ethics of roles’, professionals are expected to fulfil the responsibilities that come along with being a good GP (2011: 77 ff.). Put differently, there are expectations about the *professional identity* of GPs. If economization has affected GPs’ professional identity, it is probable that we must adjust our expectations and ‘rewrite’ our social contract.

### **Constructing the lens for analysis**

#### *GPs’ professional identity: Good Work & Preconditions*

The literature provides many different expectations about GPs. All these expectations can be arranged along the three lines of the good work concept: GPs are expected to be *excellent*, *ethical* and *engaged* (Barendsen, Csikszentmihalyi, Damon, Davis, Fischman, Gardner, James, Knoop, Nakamura & Verducci, 2011: 5; Gardner, Csikszentmihalyi & Damon, 2001; Gardner, 2007).

First, GPs are expected to fulfil the role of the competent healer who has specific knowledge (technical expertise). High standards of competence are maintained via professional self-regulation. All physicians must be transparent about their actions and decisions for which they are accountable. In other words, society and the medical professionals themselves expect GPs to do their job in a

technically *excellent* manner (see also Cruess & Cruess, 2008: 583; Parsons 1951 in Rynnänen, 2001: 33; see also Fischman & Barendsen, 2010: 31).

Second, GPs are expected to deliver their services in an altruistic, honest and morally responsible way, providing their patients with objective advice and treating them in scientifically justifiable ways. In other words, society and medical professionals themselves expect GPs to do their job *ethically* (see also Cruess & Cruess, 2008: 583; Dwarswaard, 2011: 30; Calnan & Rowe, 2008b: 61; Sullivan, 2000: 673). Ethics is not about what *is* but what *ought to be* (Aultman, 2006: 130). It can be construed as 'social responsibility' (Fischman & Barendsen, 2010: 67).

Third, GPs are expected to have work as their main object of devotion. They should be committed, showing empathy and dedication to their patients. They are expected to promote the public good and to have a strong sense of collegiality.. In other words, society and medical professionals themselves expect GPs to be personally *engaged* with their profession and patients (Cruess & Cruess, 2008: 583; Fischman & Barendsen, 2010: 107; Van den Brink, 2012: 85-86).

The specific answers to the questions evoked by the three elements of Good Work – What is technically excellent? When is the work carried out ethically? And when are you personally engaged? – constitute a relatively stable image of what it takes and means to be a good GP.

Nevertheless, I want to add another dimension. A social contract has by definition a reciprocal character. Consequently, there are not just expectations about the role of GPs, but also about the role of society. Although this study focuses on expectations about good GP work, it is only possible for GPs to realize these expectations when society itself (however construed) lives up to specific expectations as well. I cannot exclude in advance that changes in the expectations about society's role affect the expectations about the professional identity of GPs. For example, a societal development like heightened individualization could lead a patient to adopt a customer attitude,

which could affect the status ascribed to a GP. As a result, a GP might reformulate his role as being more of a service provider than of an authority. In order to keep this consideration into account, I consider several elements as preconditions for good GP work. Based on Cruess and Cruess, these preconditions are autonomy, respect and status, financial rewards, and the role GPs play in the development of health policy (2008: 585-586). Together, the three elements of good work (excellence, ethics & engagement) and the preconditions form the conceptualization of professional identity (see figure 1).

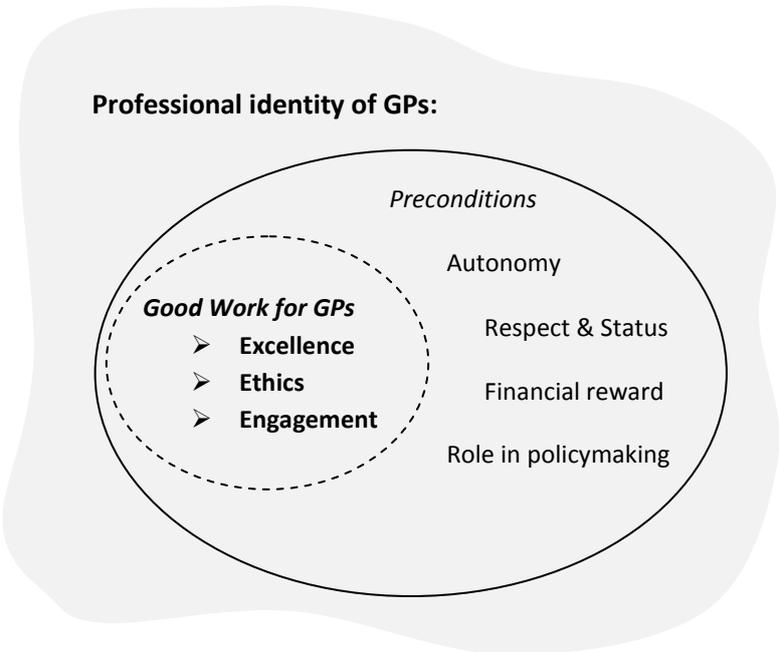


Figure 1 – Conceptualizing Professional Identity: Good Work as the core

*Tokens of economization*

Within excellence, ethics and engagement, I focus on three developments in healthcare that are prompted (partly) by a managerial and consumer logic and/or that have strengthened the tendency towards these logics . Note well, this is not an exhaustive list and none of these developments can be regarded as purely the result of economization (they may well reflect factors like scientific

developments and GPs' work-preferences). Moreover, they are not completely separate but influence each other. That is why I call them *tokens of economization*.

The first is the revision of the *remuneration system*. GPs are financed via a mixed structure of capitation fees and fees-for-service. For practically all treatments, fees are fixed (Van Dijk, 2012: 13 ff.).<sup>8</sup> The reimbursement of costs goes via the digital system GPs use (HIS).

The second is the development of a system of *evidence-based guidelines (NHG-guidelines), codes (ICPC-codes) and indicators* that serve to standardize GP care and to measure performance for transparency purposes (Groenewegen & Hansen, 2007: 61 ff.; NHG, 2012; Van den Berg et al., 2005: 33; see also Van Doorn, Bouma & Braspenning, 2009; Westert, Van den Berg, Zwakhals, Heijink, De Jong & Verkleij, 2010:21-22; Wiegers, Hopman, Kringos & De Bakker, 2011: 27).

The third is the *internal, horizontal and vertical reorganization*. First, GPs often delegate tasks to high-educated support staff so that the medical practitioners can optimize their practice (Ebbens, 2002: 463; Groenewegen & Hansen, 2007: 58-59; Van den Berg et al., 2005: 29 ff.; Wiegers et al., 2011: 31; see also RVZ, 2002). Second, GPs collaborate more often which has led to more group-practises and all kinds of partnerships within specific districts. The rise of the after hours clinic ensuring 24/7 care is an important development in this context (Groenewegen & Hansen, 2007: 57 ff.; Rijnierse, Bastiaanssen & Westerhof, 2011: 7; Wiegers et al., 2011: 25 ff.). Third, regional healthcare groups – consisting out of many different kinds of primary and secondary care providers – are formed, among others to negotiate with health insurers and to provide integral care

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<sup>8</sup> Except for those that are part of a certain segment – the Modernization & Innovation (M&I)-services – which are freely negotiable with health insurers (see also Dwarswaard, 2012: 143; Karssen, Schipper & Jurling, 2009: 41 ff.; NIVEL, 2012b; NZa, 2011; Peek, 2010; Rijnierse et al., 2011; Van den Berg et al., 2005: 35;; Van Ginneken, Schäfer & Kroneman, 2010: 25)

(Adviesgroep Ketenzorg, 2012; NZa, 2010: 15-17; Wiegers et al., 2011: 27, 44 ff.; see also NMa/NZa, 2010: 7; NZa, 2010: 19 ff.).

### **Research design**

In this study I explore whether and how economization has affected the professional identity of GPs. After all, if their professional identity has changed, it undoubtedly requires an adaptation of the social contract between GPs and society. A research approach that is open to GPs' subjective perceptions of values and contexts is required. Consequently, this research belongs to the interpretative tradition and has a qualitative research design (see Coghlan & Brannick, 2010: 41 ff.; Flyvbjerg, 2001: 42 ff.; Morgan & Smircich, 1980: 494 ff.; Van Thiel, 2007: 41 ff.). I do not aim for statistical generalization. Instead, this study aims at analytic generalization: it strives to find a particular set of general results that can contribute to broader theory (Yin, 2009: 43).

### *Data collection*

I conducted 25 in-depth semi-structured interviews with 19 GPs and 5 experts and one small focus group with 3 GPs (Baarda, De Goede & Van der Meer-Middelburg, 2007). The questions/topics for the GP interviews were derived from the theoretical framework presented above. 17 Interviews were held face-to-face in order to take into account the social context and 2 interviews were held telephonically. The 3 respondents from the focus group worked in the same health centre. The interviews and the focus group lasted on average 1 hour and 10 minutes. In hindsight, the number of GPs I needed to reach the point of *saturation* was 19 (Boeije, 2005: 52). All interviews were recorded, and though strict confidentiality was guaranteed, each respondent gave permission to be listed.

At the end of the last ten interviews, I shared my preliminary impressions, ideas (and codes) with the respondents as a 'member check'. In order to overcome socially desirable answers, I used a technique from the Good Work project by consistently focussing first on the 'abstract colleague'

before turning to the ‘self’ (Fischman & Barendsen, 2010: 13). In order to examine the plausibility of conclusions, I consulted 3 experts before *and* 2 after the data collection (cf. De Graaf, 2007: 62; see also Van Thiel, 2007: 165-167). To avoid a single source of bias (e.g. nostalgia for the past), I interviewed GPs of differing gender, age, kind of practice and region.

The respondents for this study were found via different organizations/networks. 6 GPs were found via CAPHRI (Maastricht University), 4 via the Professional Pride Foundation, 4 via Tranzo (Tilburg University), 4 via friends and family, 2 via ‘snowball sampling’ and 2 via e-mailing/calling their general practice. Towards the end of the research process, I was able to select my respondents more carefully. Three characteristics seemed to be important: gender, age, and kind of practice (cf. Dwarswaard, 2011: 50-52). Since I aimed to find out whether economization has affected the professional identity of GPs, a strong representation of older GPs who might have experienced an economization of environment seemed appropriate (cf. Dwarswaard, 2011: 50) (see table 1).

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

Table 1 – Overview respondents (GPs) (n=22)

### Analysis

Although I did *not* transcribe the interviews verbatim due to strict time limitations, I wrote an extensive report on every interview. In order to stay as closely as possible to the respondents’ own

words, all reports were typed while listening to the recorded interviews. For all quotations used in this report, I replayed all the recordings to make the translated quotations as accurate as possible.

These reports were analyzed in line with the coding procedure as proposed by Boeije which is based on a grounded theory approach (2010: 106 ff.). First, all reports were divided into fragments. Each fragment was ascribed a certain code based on its essence/message by using the Nvivo 9 computer program (see also Bazeley, 2007). Nvivo 9 allows to retrieve relevant fragments that are attributed to a specific code during the analysis. This step is called 'open coding'. During this phase, in order to prevent bias no selection of codes or fragments was made. Second, rather than the fragments, the codes became central. All codes were looked at again and they were compared in order to judge whether synonyms were used. The resulting codes were put onto an ordered "code tree", which distinguished between main and sub themes. This phase is called 'axial coding'. Third, associated fragments of the codes were related to each other so as to make sense of 'what is going on'. This final phase is called 'selective coding'.

During the axial coding phase, the three tokens of economization were identified. In the selective coding phase, these tokens were related to each other and to the Good Work framework in order to see how each of them affected excellence, ethics and engagement. The structure and content of the following findings section is based on this last phase.

## **Findings**

The findings of this study are presented along the lines of the Good Work framework.

### ***Excellence***

#### ***Remuneration system***

Dutch GPs are remunerated not just via a capitation fee, but also via a fee for every operation/service. The respondents generally regard the idea behind the fee-for-service payment as

honest: doing more, means earning more. Consequently, this incentive has encouraged GPs to expand their care provision, making GP care more comprehensive. However, in reality, many respondents experience the fee-for-service system as 'crippled'. First, the system is solely aimed at medical-technical care provision. However, this is only half of GP excellence. The other half is the subjective experience of patients themselves about the care they receive. All respondents state that a good and strong relation between a GP and his patient is essential for the quality of GP work. That is why many respondents attach great value to the capitation fee. After all, this practice allows them to act in the interest of the social side of their profession without having a price tag attached to everything they do.

Second, all respondents but one said that they felt betrayed by government. They were pushed to be more entrepreneurial, but the resulting increase in sales volume led government to an annoying practice: in the fall of 2011 the government reclaimed millions of Euros from all Dutch GPs because they had exceeded the macro-budget over 2009 and 2010. Some GPs see it as the deathblow for further investments in quality improvement. Third, GPs experience the health insurer as a force that interferes with their professional judgement and in that sense impedes excellence: "The power of the health insurer increases. They set requirements for the healthcare they purchase. They want to see what it is exactly you are doing, but it is the individual GP against the big organization." Finally, to the discontent of most respondents, the remuneration system encourages competition. However, all GPs emphasize that collaboration is the only way to improve quality and excellence: "No! Real competition prevents modernization and innovation! It decreases quality, I am convinced of that."

### *Standardization*

GP excellence is a combination of medical-technical and social quality. One respondent expresses it as being "capable and kind". Standardization via guidelines, codes and indicators focuses purely on

the medical-technical side and leave no room for the other half; those things that cannot be readily measured. All GPs regard the evidence-based NHG-guidelines as an improvement of medical-technical excellence. They have become the norm and form a strong basis for accountability purposes.

The codes and indicators, on the other hand, are experienced as totally inadequate. Whereas the guidelines are voluntarily and explicitly aim at improving GPs' medical-technical performance, the codes and indicators are compulsory for practically all GPs and serve to make quality in general transparent. All GPs consider the amount of data they have to provide to health insurers completely excessive. Some call it a bureaucratic hassle. More importantly, practically all respondents state that the data they must provide do not even come close to capturing the core of GP excellence. Every single possible operation performed by a GP is delineated and has to be classified via codes. Together with other information about individual patients (e.g. certain blood values), the coded information about GPs' actions feed into the indicators that measure GP performance. The GPs interviewed state unanimously that this is not just, because it overshoots the fact that there is an entire process attached to the provision of GP care. Recall that the majority of patients that come to see their GP are perfectly healthy. They just need to be reassured, but there is no 'target' for that.

### *Organization*

Since the introduction of managed competition in healthcare, GP practices in the Netherlands have reorganized internally, horizontally and vertically. An important internal development is the expansion of care provision and specialization of GPs, which led to task rearrangement via delegation. Eighteen respondents employed a 'practice seconder' (POH). Most GPs consider this a quality improvement but some fear this internal development weakens the strong relation between GP and patient that is pivotal for GP excellence. Consequently, several respondents do not delegate

everything. Horizontally seen, GPs have started to collaborate more, which is generally experienced as the optimal means to improve the quality of GP care. In contrast, the after hours clinics have had a perverse effect. One respondent laments: “the care is not provided by your own GP which cuts out the added value of the GP.” Whereas the personal relation between GP and patient is totally lacking, these clinics have strengthened consumer behaviour of patients drastically. Vertically seen, GPs have come to form healthcare groups providing multi-disciplinary care. Despite the extra bureaucracy that comes along, many GPs regard these groups as a means to improve quality and excellence.

## ***Ethics***

### *Remuneration system*

Encouraged by the remuneration system, GPs have come to take a critical look at their care provision. Many feel challenged to improve their care and to provide as many services as they can themselves instead of referring patients to secondary care. But has the system encouraged improper behaviour? According to nineteen respondents, large scale unethical behaviour to increase one’s income is exceptional. Three respondents argue that care provided on economic grounds is not exceptional but in fact happens regularly. The most important example of this occurs when GPs offer all patients that belong to a certain ‘risk group’ the opportunity to take a certain test. Sometimes even the added value of the results of a certain test is debateable. One GP mentions that “the commercialization sneaks in”. All respondents condemn the prevalence of self-interest and fiercely turn against colleagues who provide services without medical-technical necessity. After all, eighteen GPs mention that they feel responsible primarily for the health of the patient.

All GPs acknowledge that small scale controversies happen more frequently. When it comes to ‘the grey area’ of reimbursement, respondents sometimes grant themselves a piece of the pie. This happens firstly due to confusion. Since their entire consultation has been cut into pieces, some GPs

often find it difficult to attach the proper codes to the diagnosis and treatment that serve to get their services reimbursed. Second, some GPs interpret the rules for themselves in line with their sense of justice. For example, a GP can issue an invoice for a double consultation to the health insurer whenever it takes longer than twenty minutes. This seems straightforward, but what if a GP has managed to pay attention to several different complaints a patient has in fifteen minutes. Finally, some GPs disagree with the system and exhibit a form of protest. Some respondents regard it as unethical if you do not invest time and care in this crucial relationship. The remuneration system does not offer any room for this contingency, leading some respondents to charge a telephone consultation as if the patient had called him/her instead of the other way around. As one GP expresses it: “You get the feeling: ‘Just get lost! They want to fine me?! I will get back at them!’” Nevertheless, there is no sign that this is completely exorbitant because that would conflict with a sense of responsibility for macro-costs. The respondents feel aggrieved by the suggestion – often evoked by the government and the media – that they are money-grubbers.

### *Standardization*

Standardization by the NHG-guidelines has affected GP ethics. The guidelines have become the repository for the distinction between ‘right’ and ‘wrong’. Most GPs feel they have the responsibility to treat patients in line with these medical-technical ‘best practices’. Nevertheless, GPs can deviate from them whenever they believe this to be necessary. After all, the GP profession is “all about differences in nuance”.

The system of codes and indicators used by the health insurer (and healthcare group) also focuses on the medical-technical side of the GP profession and thus on ‘curing’. However, this system leaves little room for the social side of GP care. Many respondents struggle to fit their professional ethics.

According to them, their responsibilities as GPs go beyond 'curing'. They are about helping patients to get ahead. Mere medical-technical 'curing' not necessarily coincides with the patient's interests.

I have found no indications for a shift in practice: the respondents enter into conflict with the system rather than change the way they feel that they need to act: "Every now and then I do not really mind to call something a 'medical necessity' while the criteria do not really define it as such. I choose for the patient and not for the health insurer." In other words, emphasis on medical-technical matters has not changed GPs' professional ethics. Nevertheless, the system is experienced as a huge vote of no-confidence. GPs feel distrusted by government and health insurer when it comes to their good intentions and capabilities. But according to most respondents, the trust within the individual relation between GP and patient remains high.

### *Organization*

Changes in the internal organization have brought extra responsibilities for GPs: they have become managers, having a business and employing staff. With regard to the horizontal organization, the increase in collaboration between practices has not affected GP ethics, but the after hours clinic has. When the social relation between GP and patient is lacking, GPs find it is a lot harder to formulate a diagnosis, especially when patients are very demanding. GPs have become more indulgent which implies a change of their professional ethics. I have found no evidence that the change in the vertical organization by the development of healthcare groups and multi-disciplinary care has had any effect on GP ethics. It has not specifically influenced any of the rings of responsibility. The only footnote to be made, is the perceived involuntary nature of the way in which multi-disciplinary care is shaped: what counts as good care (provision) appears to be dictated by the health insurer.

## ***Engagement***

### *Remuneration system*

GPs can be committed both to their patients and to their profession. From the interviews it follows that the former is about knowing the patient in his context. The second is regarded as fulfilling some sort of an advocacy role. The interviews provide no indication that the remuneration system has led to a different understanding of GP engagement. Note that the reimbursement of GPs by health insurers is not something patients are informed about.

### *Standardization*

The NHG-guidelines have not affected the GPs' engagement with their patients. On the other hand, it seems the guidelines have slightly increased the engagement of GPs with their profession. Several respondents have been part of commissions that helped formulating these guidelines; in turn, the guidelines have become a sort of benchmark for a GP's own practice and that of his colleagues.

On the other hand, the delineation of GP care by the system of codes and indicators has had an effect on GP engagement. The most prominent factor that hinders engagement is the delineation of consultation time. A consultation is set to ten minutes. Twenty-one respondents experience this as a huge time pressure that is harmful for the social side of GP care. The importance of time as factor should not be underestimated for the quality of GP care. Patients come in with vague complaints and formulating a proper diagnose takes time. One of the respondents mentions: "Relational quality is the first thing that is being cut out. Somehow, the pressure on the practice only increases. People have more questions. Time is pressured constantly. We are too much in a hastiness mode." There is no indication as yet that the system of codes and indicators has affected GP involvement with the profession.

### *Organization*

Changes in the internal organization of GP practices have not led to a different understanding of GP engagement. In order to safeguard their engagement with their patients, several GPs do not delegate all simple tasks to assistants and POHs. After all, these simple tasks sometimes provide an excellent opportunity to inquire about a patient's health in general or that of his family members. Developments within the horizontal organization show a more diverse picture. It turns out that a difference of opinion about what 'continuity' entails causes some GPs to regard collaboration as an impoverishment and others as an enrichment for GP-patient engagement. Many GPs have become less strict in defining continuity as 'continuity in care provided by a specific GP'. Instead, they have come to define it more as 'continuity in care' leading them to be less reluctant in referring patients to direct colleagues, for example in order to be able to work part-time. Collaboration within the after hours clinic strengthens GP-GP engagement. In the words of one respondent: "We are a close-knit group. The after hours clinic has contributed a lot to that. Every time you work in a different team. Thirty times a year, ten years long every time a different team. That is great!" However, the after hours clinic has not been a positive development for the engagement with patients. GP care provided via these clinics is generally regarded as impersonal because GPs do not know the patients and many patients adopt a consumer attitude.

This study shows no indication that developments within the vertical organization of GP care, like healthcare groups and multi-disciplinary care, have affected the engagement of GPs with their patients. However, these developments have affected the engagement of GPs with their profession. Many respondents feel as if they do not see the wood for the trees. Nowadays, GPs can be involved in many forums. Several respondents feel discouraged by this development. After all, these forums require a substantial time investment, but their influence is experienced as rather limited.

### ***Preconditions***

A GP can only do 'good work' if society grants him the possibility to do so. After all, a GP does not provide care in a vacuum. Most respondents mention they are *autonomous*: they have the discretionary space to take independent decisions. Nevertheless, most of them do experience pressure because of all kinds of organizations and an 'umbrella of controlled obligations'. As one GP expresses "I think I am still autonomous. I try to do what I have to in order to contribute to the health of a patient. However, I do notice that over my shoulder the health insurer is watching. Literally via material controls. It is a strong accountability pressure." Many GPs fear that in the near future GP practice will be reduced to carrying out protocols.

*Respect & status* have changed. The respondents experience the vast majority of consultations as pleasant. Sometimes, patients can have a strong customer attitude and be very demanding. In most of these cases, they can be very rude to GPs. This happens much more often in the after hours clinic than in the respondents' own practices. After all, in these clinics, GPs seldom know the people that come to consult them: "You come across people that treat you as dirt! They do not see you as a caring professional. People who think 'you do whatever I ask.'" On the whole, GPs do encounter consumer misbehaviour. As one GP puts it, there is a clear emphasis on the rights people have, but not on the duties that come along. In most cases, this is not a problem because it does not automatically lead to disrespect. In general, the status of the GP profession has decreased but all GPs consider this to be something positive: the relationship with their patients is characterized by equality.

More problematic is the perceived attitude of government. All respondents feel disrespected by the government that is regarded as unreliable. This has everything to do with the *financial reward* GPs receive. To be sure, practically all respondents are happy with their salary and many say their income

has increased due to the managed competition system. However, they add elements that put it in another perspective: many of them experience an increase in workload and the respondents differ strongly in answer to the question whether the rise in income is proportional to this increase in workload. Besides, all respondents feel betrayed in a sense by government which has encouraged GPs to take on extra tasks and has billed them for it afterwards. In general, the respondents feel that “the way GP care and its budget are treated is a huge vote of no-confidence!” Most of the respondents are not very good entrepreneurs. Some hesitatingly admit it themselves, others try to cover it up by saying that they hate doing ‘managerial stuff’. Especially for the older GPs, the changes of that past decade have been very drastic. Many GPs like to play it safe and consequently, taking on ‘business risks’ by investing in things like group-practices and task rearrangement is often experienced as a serious burden. By ‘changing the rules while playing the game’, government has put itself in GPs’ bad books.

For the final precondition, a diffuse picture arises. Most GPs find it hard to estimate whether the role of GPs as discussion partner in *policymaking* has changed in the economized environment. Based on the interviews, it is not possible to conclude whether the position of GPs as negotiation partner has actually changed. Nevertheless, since practically all respondents feel disrespected by government, they do think GPs are taken less seriously. In that sense they experience the influence of GPs as professional group on the policies that are being implemented as diminishing.

## **Discussion**

### *The research aim revisited*

In this study, I asked about the effects of economization on the professional identity of GPs. It is not possible to generalise the findings presented above to all GPs in the Netherlands and beyond. Nevertheless, this study shows that the respondents have not come to a radically different

understanding of their professional identity. At the core, excellence, ethics and engagement are still regarded in virtue of a professional logic. In short, excellence has both a medical-technical and a social side. Ethics can be interpreted as a model with rings of responsibility with the patient as its core, followed by GPs' own conscience and macro-responsibility. Engagement concerns two relations: between GPs and their patient, and among GPs as a professional group. In general, the preconditions are all still met – practically none of the respondents experience any of these conditions as fully compromised. Still, whereas the core has remained unchanged, economization has had an influence on the periphery of excellence and ethics. With regard to excellence, the majority of the respondents have come to understand medical-technical excellence as following the NHG-guidelines, offering specialized GP care and striving to collaborate with colleagues. With regard to ethics, an extra ring of entrepreneurial responsibilities is added.

Does this mean that economization has left the GPs untouched? The answer is no. The 'tokens of economization' might not have changed the understanding of professional identity, but they have certainly influenced the work of the respondents. Sometimes they strengthen a specific factor of professional identity, and sometimes they are at odds with one.

With regard to excellence, the economization factors that strengthen GP medical-technical excellence are the expansion of GP care provision and the NHG-guidelines. Those that weaken GP excellence are the codes and indicators that claim to focus on quality in its entirety but in fact solely focus on the medical-technical side of GP care. Another consideration is the after hours clinic where the social side of GP care barely plays a role.

With regard to ethics, the (voluntary) NHG-guidelines that offer a patient the best care possible seems to strengthen it. On the other hand, ethics are weakened by the emphasis on medical technical 'curing' instead of 'helping the patient along'.

With regard to engagement, the after hours clinic is both the most positive and the most negative development. It is positive because GP teamwork strengthens involvement with their profession. It is negative because GPs typically have no personal relation with the patients that come to consult him.

I would like to add one important element that can contribute to our understanding: at issue is why GPs' professional identity has not really changed, while most GPs acknowledge that economization pressures exist in their daily work. GPs' *actions* seem to form a sort of buffer between the economic logic of the tokens of economization, on the one hand, and the professional logic of their professional identity, on the other. Many GPs find room to act in line with their professional identity besides 'doing what they have to do' according to their economized environment. Sometimes, GPs have no room to manoeuvre. In these cases, they just do what they are being asked to do, in order to get it over with. Often, they show signs of *alienation*: they feel unable to act according to their professional identity (see also Tummers, 2012).

Sometimes when they experience a conflict between what they have to do and what they would want to do, practitioners *resist* the economization pressures, breaking the rules in order to preserve their professional identity. For example, a GP telephones a patient about his health condition but the GP will document the call as if the patient had called the GP instead of the other way around.

### *Limitations*

There are at least three limitations to my study. First, although I have interviewed several experts in order to ensure some diversity, this study provides a one-sided image of the Dutch GPs. Second, many of the respondents who wanted to cooperate turned out to have a research/study affinity: many are GP educators, one works at a university and one works at a research institute. 'Commercial GPs' may not have been included in the group of respondents. Third, in this study I have put emphasis on the collective dimension of professional identity. For future research, I think it is a good

idea to leave more room for individual differences (see also Hafferty & Castellani, 2010). For example, politically, some GPs were right-wing oriented, while others had a clear preference for left-wing political ideas. This political perspective presumably influences the way people think about market principles.

### *Discussion*

This study has raised many points. I will limit myself to the damaged relationship between GPs and the government; the drawbacks of the after hours clinic; trustworthiness; and internal regulation.

In the findings section, I mentioned that many GPs are deeply aggrieved by the way in which the government has treated them. This is highly relevant from a societal point of view. Over the past six years, the respondents have felt called upon to act in line with governmental preference, taking on tasks that used to be part of hospital service. This was not philanthropy. After all, GPs would get their efforts reimbursed via the remuneration system. The decision by government to reclaim millions of Euros was experienced as a stab in the back.

Let me be clear: I cannot answer whether GPs have earned too much money. However, the entire process has undermined the relation between government and GPs. We must keep in mind that most GPs are not very good entrepreneurs. Many like to play it safe. They now feel abandoned because the government has 'changed the rules while playing the game'. Since GPs fulfil a pivotal role in our healthcare system a conflict situation between government and GPs is undesirable. The recent agreement between minister Schippers and the professional association is an important first step in healing the wounds (NRC, 2012).

After hours clinics in the Netherlands have become strong institutions. Practically all respondents like the structure they provide. Via the after hours clinic, compared to the 24/7 availability of the past, GPs are able to lead a more regular life . Nevertheless, this study shows that the after hours clinics

are taken for granted. People tend to come in 'as if they went out to do some groceries'. The patients are usually complete strangers to the GP. The social bond between patient and GP, that is considered as very important for GP excellence, is completely lacking, often resulting in unnecessary service delivery. Practically all respondents consider the after hours clinic as undermining the Dutch GP system.

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

This brings me to an important point. Before the introduction of managed competition, Hilhorst (2004) and Putters (2006) put emphasis on organizing supervision external of the profession instead of internal professional self-regulation. Six years after the healthcare system reform it turns out that many professionals experience the external supervision as crippling. The work of a GP is highly individualized. After all, each patient is different and requires a tailor-made approach. All respondents experience the compulsion to increase uniformity and to measure 'quality' as negative for GP care. It would be a good idea to aim future research not at increasing external supervision, but

to discovering ways to organize and increase internal supervision in an economized environment. Perhaps insights from the GoodWork project and literature about excellence, ethics and engagement might prove useful. This is also the source of the title of this paper: nowadays GPs seem to be valued. Not in the sense of appreciation ('praised'), but in the sense of expressing everything in terms of an economic logic ('priced'). I was in fact quite surprised to find out that many respondents feel appreciated only by their patients and definitely not by government or health insurers. Perhaps this is a bit strange. After all, GPs are the spindle in our healthcare system: a sign of appreciation like a compliment does not even cost a penny.

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## Appendix – Respondents

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

19. Van Dongen, J.	f	Y	Tilburg	Group-practice	1h 13m	14 June 2012	Face-to-face
20. Van Hoolwerff, C.	f	Y	The Hague	Hires o.s. out as GP	1h 17m	13 June 2012	Face-to-face
21. Van Veenendaal, D.	m	Y	Udenhout	Solo-practice	1h 11m	01 June 2012	Face-to-face
22. Woerdman, A.	m	O	The Hague	Group-practice	1h 19m	31 May 2012	Face-to-face
<b>Experts</b>		<b>Institutions; Expertise</b>					
De Bakker, Prof. D.	m	-	NIVEL/TiU; Structure and organization of primary Health Care		± 30m	08 August 2012	Face-to-face
De Wildt, J.E.	m	-	De Ondernemende Huisarts/Commonsense BV/De Eerstelijns		31m	21 May 2012	Telephonic
Jorna, R.	m	-	Menzis; Medical advisor quality of primary care		57m	18 June 2012	Telephonic
Spreeuwenberg, Prof. C.	m	-	CAPRHI/UniMaas/Platform Vitale Vaten; Integrated care for chronically ill		± 1h	23 May 2012	Face-to-face
Ter Braak, G.J.	m	-	Zorgpunt		39m	04 July 2012	Telephonic
Vosmans, F.	m	-	TiU; among others medical ethics		± 30m	10 May 2012	Face-to-face
* Y = aged between 25 and 40; M = aged between 40 and 55; O = aged 55 or older (cf. Dwarswaard, 2011)							
** GPs in a group-practice can still be self-employed, e.g. via a HOED structure							