

Level of Professionalism Matters: Comparing Consequences of Performance-based Contracting for Transparency and Autonomy

MSc. Rosanne Oomkens

Paper written for the 8th ESPAnet annual conference 2010 in Budapest, Hungary

** September 2-4 **

- Draft version, please do not quote -

Interdisciplinary Social Science
Utrecht University
P.O. Box 80.140
3508 TC Utrecht
R.F.Oomkens@uu.nl



Universiteit Utrecht

Introduction

For those working in public services the experience has been one of “permanent revolution” (Clarke & Newman, 1997: iv). Broad scale of institutional changes, which are based on New Public Management (NPM) principles, focused on managerialism, liberalization, decentralization, transparency, demand-orientation, outsourcing, performance measurement and the introduction of independent and compound supervision. The concept of ‘marketisation’ also entered the policy arena during this wave of reforms, including competition and privatization (Pollitt, 1993; Dunleavy & Hood, 1994, Exworthy & Halford, 1999). Public service providing organizations are increasingly run as ‘quasi-businesses’, attempting to introduce output-structured incentives and performance measurement by using performance indicators (Clarke & Newman, 1997). Measurement “enables the establishment of tight, objectified links between objectives, means, outputs and outcomes, and thus the establishment of *transparent* administration” (Noordegraaf & Abma, 2003: 853).

The NPM framework promotes a stricter division between policy and administration, which is facilitated by the use of (short-term) contracts between the service provider and the service purchaser (Dunleavy & Hood, 1994; Clarke & Newman, 1997; Denhardt & Denhardt, 2000; Lane, 2001). Contracting is a new way of governance that organizes state or third-party control on professional work through monitoring, auditing, performance indicators, evaluation and benchmarking (Clarke & Newman, 1997). These “contracts only have meaning if they are made operational by way of performance indicators” (Duyvendak, Knijn, & Kremer, 2006: 23). Performance indicators generate evaluative information that will enhance transparency.

However, the market-like developments were not introduced without striking a blow as the call for transparency and the advent of performance measurement seem to touch upon the nature of professions and professional work. Performance measurement can indeed spur transparency of activities, but many authors claim it also has (unintended) negative side-effects such as an increase in monitoring costs or reduced professional autonomy (e.g. De Bruin, 2001). Van Thiel and Leeuw (2002) even doubt whether performance measurement leads to an insight in professional work since the “performance paradox” (p.271) they observe indicates a weak relation between the performance indicators and the performance itself, for example because professionals can sabotage the indicators. So, it can be questioned if performance measurement, which is one of the most crucial aspects of contracting, even enhances the visibility of professional work.

Studies on NPM-reforms tend to focus on changes in managerial roles and on efficiency gains while overlooking the consequences for the public sectors’ professional workforce. Recently, literature shows a wide and vested interest in changes in professional work and autonomy of professionals working in the public sector due to the introduction of market-oriented reforms (e.g. Van den Brink *et al.*, 2005; Bovens & ‘t Hart, 2005; Tonkens, 2008). Especially the effects of performance measurement are not unnoticed as professionals are evaluated based on measurable, quantitative outputs. The tendency in the scholarly literature is that performance indicators have constructed a measurement culture in the public sector that undermines professional autonomy, innovation and discretion (Newman, 2001; Duyvendak, Knijn, & Kremer, 2006). Some even argue that the principles of NPM colonize professional work (Broadbent & Laughlin, 2002). Or, as Diefenbach (2009) asserts: “NPM seems to be less about empowerment and more about the infantilization of employees” (p. 904). However, few studies have tested the

consequences of market-oriented reforms on professional work and autonomy empirically. Studies on professionalism are often only inclined to the positive value of professional autonomy rather than unraveling the complexities of professional autonomy in public services. It remains unclear *how* professional work changes and if professional autonomy is truly eroded because of market-oriented policy reforms including performance-based contracting and hence performance-measurement. Also, literature on professionalism predominantly focuses on full professionals such as doctors, engineers and lawyers. Research on less developed professions is underdeveloped, while a comparison of distinct professional groups can offer unique insights in the field of social policy change, public governance and the sociology of professions.

Traditionally, professionalism literature emphasizes the power of NPM-proponents to change the conditions of professional work and to even erode professional autonomy (e.g. Freidson, Van den Brink), while overlooking the power of path-dependency. The institutionalist perspective, contrarily, suggests that earlier pathways of governing public service provision have created the instruments used and approaches taken today, making it likely that policy changes are based on path-dependency. Within this perspective professionalism is often viewed as an important determinant for the existing pathway (Bureau *et al.*, 2009; Ackroyd, Kirkpatrick & Walker, 2007). In the past, occupational groups have been able to “influence the kind, pace and structure of provision” (Perkin, 1989: 344). As a result, professionals frame the structure and activities of the organizations they work in. Based on this strand of literature, one could also argue that highly professionalized groups (characterized by a high level of autonomy) should be able to mediate attempts that are aimed at reducing their discretionary power. Therefore it is important to bring in theoretical perspectives based on institutional change theory as well.

The emphasis of the present paper is the NPM-based health care reform of performance-based contracting. In health care there is a shift from passive purchasing – whereby a predetermined budget is followed or bills are simply reimbursed retrospectively – to strategic forms of purchasing – in which proactive decisions are made about *which* health care services should be purchased or contracted, *how* and from *whom* (WHO, 2000). “For decades, the prevailing pattern of resource allocation has been either totally non-contractual or contractual with all physicians and hospitals” (Figueras *et al.*, 2005: 199), and now there are signs that care purchasers are slowly moving towards selective and differentiated forms of contracting. Health care providers always have received a global budget by which decisions had to be taken about the allocation of financial resources. However, the extent to which they are held accountable for their performance (costs and quality) is far greater, more detailed and more strictly monitored than ever before.

Research question and hypotheses

Based on the theoretical framework described above the following research questions and hypotheses were developed:

Q1. Does performance-based contracting enhance the transparency of professional work activities?

Hypothesis 1: Performance-based contracting will lead to an increase in transparency about the type of work that is done and how the work is being done, but there will be a weak relation between the performance indicators and the performance itself.

Q2. Are the consequences of performance-based contracting for professional autonomy different for distinct professionals groups and how can this be explained?

Hypothesis 2: Performance-based contracting will lead to a greater reduction of professional autonomy among home care workers than among medical specialist, because they have a lower ability to control and mediate social policy changes.

The paper focuses on two health care sectors in the Netherlands that have to deal with similar imperatives for policy changes (cost control, increased efficiency, patient-awareness, transparency and rigid market mechanisms): hospital care and home care. The aim is to detect whether the path taken is similar or different in the two sectors and how the professionals working in the sector are affected in terms of transparency of activities, work tasks and autonomy.

In the present study medical specialists have been selected as a highly professionalized group and home care workers as a less professionalized group. The position of medical specialists has traditionally been strong in the Netherlands with specialists enjoying considerable institutional autonomy and exclusive jurisdiction within the health care system (Kruijthof, 2005). Also, specialists have a strong sheltered position in the labor market as their professional title is legally protected. Moreover, specialists have a strongly formalized training program which is controlled by the occupation. This strong position is also common in other European countries such as the United Kingdom, Denmark and Germany. A unique characteristic of the Dutch hospital care sector is the self-employment of the majority of medical specialists. Only in Belgium, Luxembourg and the United States the self-employment of specialists is a common practice (Lindert et al., 1999). The position of home care workers in the Netherlands has traditionally been much weaker. "Home care workers have problems in maintaining their professional status and their occupational uniqueness" (Knijn & Verhagen, 2003: 12). In Denmark, the Netherlands and the United Kingdom the degree of institutionalization and professionalism of home care workers is stronger than in France, Belgium and Germany. In the first cluster of countries home care nurses work on a salaried basis instead of a fee-for-service basis; their autonomy is *not* limited by medical referrals; and home care organizations require qualifications and credentials (Knijn & Verhagen, 2003).

In the present paper the NPM-based reform of performance-based contracting is considered to be an exogenous reform; the calls for health care reforms mainly came from *outside* the fields of hospital and home care. So, even highly professionalized sectors such as hospital care are considered not to be immune for externally-driven change. Medicine and home care work are assumed to be institutionalized professions that are able to mediate reforms. So it is hypothesized that a distinct pre-existing institutional setting, in which professions are considered to be institutions, leads to different outcomes in terms of changes in professional work.

Professional autonomy

In the current paper "a professional is a member of a profession, which is an occupation with specific features" (Kruijthof, 2005: 42). These features are derived from Freidson's definition of professionalism. Freidson (2001) describes the concept of professionalism by using five criteria that are all logically linked to one another. According to Freidson professional work concerns *exclusive* work domains of (abstract), specialized and discretionary skills and knowledge. This *exclusivity* enables professionals to claim autonomy or jurisdiction in their work, but this exclusivity also makes

it *necessary* to provide the professionals with exclusive jurisdiction because it concerns highly complex work that can only be carried by those who studied for it. These skills and this knowledge have been obtained during years of education which eventually allows the professional to use the title of doctor or lawyer. The many years this person has studied creates an exclusive and thereby special status in the labor force.

Professional autonomy is about decision making in the work context based on internalized professional norms and expert knowledge, but it is also about the freedom to decide on the practice and content of work and the way the quality of work is controlled (Van der Wee, 2000). Autonomy is often considered to be a key aspect of professions, “which renders them power in relations” (Kruijthof, 2005: 40) with other groups inside and outside the professional organization. Power refers to “the capacity to get decisions and actions taken and situations created which accord with, and support, one’s interests” (Dawson, 1996: 169). The power of professionals includes self-regulation and professional autonomy and is based upon certain exclusivity and on trust granted by society, as Freidson (2001) argues. But, “public trust also requires accountability. (...) Professions get public trust and exclusive rights in return for quality professional work and accountability” (Kruijthof, 2005: 45). So the contract between society and professions is reciprocal: trust is granted, but society demands accountable professionals in return. The relationship between professionals and society, including citizens but also financing bodies, is characterized by interdependency. By nature, professionals have to balance between their autonomous position and their independence with the external environment (Abbott, 1988). In the present context of stronger demands for accountability and transparency through performance measurement it is important to acknowledge that these claims result from a *lack of trust* in professions and *increased trust* in market-like (the supply and demand mechanism) and managerialist solutions (performance indicators), in order to solve problems of lack of efficiency and the lack of client orientation in the public sector. A lack of trust in professions means the legitimacy to act autonomous is at least questioned or even damaged. Society wants professionals to be held accountable for their practices in order to keep up or restore the level of trust. It remains questionable how this affects professional work autonomy.

In the literature the concept of professional autonomy is often poorly conceptualized, overlooking its multiple dimensions and its complex character. Coburn (1999) distinguishes corporate autonomy from individual autonomy; the first applying to a profession as a whole and the latter applying to individual professionals. Whereas individual autonomy is linked to freedom from organizational constraints and the freedom in decision making in the work context based on internalized professional norms and expert knowledge, corporate autonomy refers to occupational control over the entry into the profession, over the standards of work and over the quality of work performed by professionals (Batey & Lewis, 2000). By contrast, professional work can also be controlled by the government, consumers or third parties.

Schulz and Harrison (1986) make a distinction between three dimensions of professional autonomy: clinical autonomy (control clinical decision-making), economic autonomy (control prices and incomes) and political autonomy (controlling context in which work takes place). A downside of this notion is that the clinical autonomy only accounts for medical professions, not for less professionalized groups such as home care workers or youth care workers. Therefore, I suggest to

partly reframe the dimensions of autonomy into: input, process, output, political and economic autonomy.

- Input autonomy: autonomy over input refers to control over the structural conditions of work and the workplace, such as the required level of personnel or the presence of certain quality monitoring systems.
- Process autonomy: autonomy of the process of work refers to control over the patients'/clients' diagnosis and/or control over the process of care provision and control over the time spend on a treatment or on a particular form of care provision; so it refers to control over the way professionals' carry out their work (*how*).
- Output autonomy: autonomy over output refers to control over the total number of treatments/hours of care provided. In short, it indicates control over the *volume of* and *budget for* care that is to be provided.
- Corporate political autonomy: political autonomy refers to jurisdiction or decision-making power in the field of social policy development. It indicates the ability of a profession to mediate or shape social policy development.
- Corporate economic autonomy: economic autonomy refers to control over the price/tariff of care that is provided.

This distinction in different dimensions of autonomy is a useful instrument in order to unravel the mechanisms at work when the consequences of contracting for professional autonomy are considered. It helps to create a more nuanced view of these complex mechanisms.

Health care systems & contracting: international perspective

In order to understand the structural context in which performance-based contracting takes place in the Dutch hospital care and home care sector, a brief overview of the international context of the health care systems and developments of contracting will be presented. Such an outline will enable foreign readers to distinguish the elements in this paper that might be of value outside the Netherlands.

The Dutch health insurance system is divided into three so-called compartments. The first compartment consists of a compulsory social health insurance scheme for long-term (chronic) care, which is regulated in the Exceptional Medical Expenses Act (*Algemene Wet Bijzondere Ziektekosten*, AWBZ). The AWBZ is mainly financed through income-dependent contributions. The second compartment also consists of a social health insurance system covering the whole population for 'basic health insurance'. Under the new Health Insurance Act (*Zorgverzekeringswet*, 2006), all residents of the Netherlands are obliged to take out a health insurance. The system is a private health insurance with social conditions operated by private health insurance companies. The third compartment consists of complementary voluntary health insurance, which may cover health services that are not covered under the AWBZ and Zvw schemes, including prevention and social support. These are mainly financed through general taxation (Schäfer et al., 2010). So unlike other health care systems, such as the UK and Scandinavian countries, the Netherlands do have a collective instead of a *public* health service. Although it is a universal system, because of its compulsory character, it is based upon private purchasing companies and private (not yet for

profit) providers. This hybrid construction both deviates from the tax-based structure of the United Kingdoms' Beveridgean health care system as well as from the work-related 'Bismarckian model', found in Germany, Belgium and France.

Both the Dutch hospital care and home care sector can be characterized as mature organizational fields with private (non-profit) ownership and regulation through political-administrative decisions. Considerable changes in governance structures from 2001 onwards paved the way for more market mechanisms. For a proper operation of market forces it was important that in hospital care health insurers and care providers had the freedom to negotiate with each other about prices, volume and quality. For that reason a system of variable and performance-focused payment and financing based on Diagnosis Related Groups (DBCs) was introduced (the so-called B-segment¹). Every year health insurers and care providers negotiate about the price, quality and quantity of the care performances in the B-segment (OMS, 2007b); since 2009 34 percent of hospital is subject to free prices. So, there is no tariff regulation in the price and volume competitive B-segment. The costs of medical specialists contrarily, so their honorarium, are fixed. These rates have been set by the National Health Authority (NZa). In terms of production freedom, the NZa does not set a production or volume ceiling within the B-segment. In order to enable price competition, hospital care had to be defined in terms of 'care products'. Therefore, DBCs have been introduced. The combination of diagnosis and treatment results in a single rate that is charged by the hospital.

For the extramural AWBZ market, including home care, the regional care office (representing the insurance companies) possesses full freedom in deciding with whom they want to enter into a contract with; there is no duty to contract all providers. The health insurer that runs the care office is usually the market leader in that region. The government regulates the budgets of care offices. Care offices receive a budget comprising of administration costs, this compensates the costs the care office makes because of negotiations with care providers, and a budget for care costs. Care offices do not run the risks for these care costs. In an attempt to provide care offices with more stimuli to purchase efficient care, the regional contracting headroom was introduced in 2004. Contracting headroom limits the costs of care the care office is allowed to make; it is the maximum budget of the care office. When the contracting headroom is exceeded, care offices fetch back the overrunning costs pro rata among the care providers who have increased their production compared to the year before. Nonetheless, the vitality of the AWBZ market is hampered because of the existing budget guarantees for care providers (RIVM, 2008).

Contracting in hospital care and home care: international perspective

European health care systems have faced major challenges in recent years, including quests for cost containment, increasing efficiency and an emphasis on clients' preferences. The challenges faced by European countries are diverse. But despite differences, common trends are signified. The concept of contracting has entered the policy arena in many European countries (Figueras *et al.*, 2005). Contracting is a way to enable regulated competition between health care providers. It concerns purchasing health care, but entails more than simply allocating financial resources;

¹ For the purpose this paper the focus will be merely on the price, - volume, - and quality competitive B-segment and not on the remaining A-segment, in which the introduction of market principles has been limited.

contracting refers to both the contracting policy as well as to the contractual agreement between the health care purchaser and health care provider in which specific agreements are made concerning quality demands, registration and accountability, production volume and tariffs.

Some Western and Eastern European countries have already exchanged integrated command-and-control models of (semi-)publicly operated health care service for purchasing based models. In these models public, semi-public or third party purchasers of (health) care are kept organizationally detached from care providers. The social-insurance based health care systems (Bismarckian models) have a background in separating purchasing/contracting and provision through contractual relationship. However, in the past contracting was a passive process including overall budget ceilings and only minor financial incentives. Presently contracts are contestable, focus on price and efficiency and the exercise of contracting is sometimes selective and includes the use of performance indicators. An important factor here is introduction of competition between health insurers. This reform was first discussed in the Netherlands, by the Dekker Committee in the 1980s'. Together with Germany and Austria, the Netherlands take a frontrunner role in the development of performance-based contracting (Figueras et al., 2005).

Methods

In what follows we now explore how contracting is shaped in two sectors (hospital care and home care), how contracting affects transparency of professional work and on how two professions – medicine and home care work – have mediated the development of contracting *and* how their work and professional autonomy is affected by performance-based contracting. The analysis draws on data collected during 41 semi-structured interviews with health care professionals, managers and purchasers of care, a content analysis of the purchasing documents of three regional care offices, a content analysis of the DBC contracting manual and a secondary analysis of the contracting policy of health insurers². Furthermore, policy documents, white papers and existing reports (NZa, ZN, RVZ) on purchasing and contracting in health care have been studied. The interviews generally lasted for 45-70 minutes and were conducted in 2009 and the beginning of 2010.

Findings

The Dutch case: hospital care and home care

Performance-based contracting is the driving force of the Health Insurance Act that was introduced in the Netherlands in 2006. The governance changes in the Dutch hospital and home care sector have been a response to similar imperatives (cost control, increased efficiency, patient-awareness and transparency and 'more market'). However, analysis shows both sectors differ in the path that has been taken. In both sectors the nature of change has been coercive since legislation and executive powers were used to introduce the new policies. Regulatory agencies such as the Dutch Healthcare Authority (NZa)³ play a directive role. Nonetheless, there are considerable differences between the contracting instruments and techniques used in both sectors. Table 1 summarizes the most important differences and similarities.

² Data collected by the Consumentenbond (2008).

³ The NZa is the supervisory body for all the healthcare markets in the Netherlands.

Table 1 Findings

	Hospital care	Home care
Purchaser	Health insurer	Care office (representing health insurer)
Funding source	Tax-based / insurance	Tax-based / own contribution
Market form purchaser side	Oligopsony: small number of purchasers	Monopsony: single purchaser
Market form provider side	Differentiated oligopoly: many providers, heterogeneous product, high barriers to enter market	Differentiated competition: many providers, heterogeneous product, small barriers to enter market
Form of contracting	Negotiations; differentiation + selection for preferred provider contracts	Tendering; differentiation + selection
Type of contract	Combination cost-per-case and performance contracts, sometimes combined with block contract	Combination cost -per-case, block contracts and performance contracts
Status contract	Short-term, legally binding, overall soft (relational) contract	Short-term, legally binding, overall hard contracts with some relational aspects
Contract specificity	Explicit on financial issues, slightly specific on quality issues, loose contract specificity	Explicit on both financial as well as qualitative demands: tight contract specifications
Communication	Frequent communication between hospital and insurer	Minimal communication after contract award (depends on regional care office)
Payment system	Retrospective; variable prices	Retrospective; maximum tariffs
Price determination	Provider makes proposal. Price determined during negotiations	National Health Authority sets maximum. Price determined in bidding process
Quality criteria	Use of input, process and outcome indicators with a strong focus on process indicators	Use of input, process and outcome indicators with a strong focus on input indicators
Monitoring & evaluation	Strict control on administration, minimal control and no sanctions for non-compliance concerning quality parameters (only sanctions for preferred provider contracts)	External audits, sanctions non-compliance for both administration and quality parameters

In hospital care contracting occurs on the basis of negotiations between the care purchaser and the care provider. Every year health insurers and hospitals negotiate about the volume, quality and price of the hospital care to be provided within the B-segment. Hospitals negotiate separately with all of the five health insurance companies that are present in the Netherlands. Despite some isolated examples of selective contracting, the prevailing picture is that of non-selective contracting. Selective contracting means that health insurers do not contract all of the health care that a given health care provider has available, nor do they have contracts with all health care providers. Interestingly, it seems that health insurers increasingly use a tender procedure to determine which hospitals will obtain the ‘preferred provider’ contract. These contracts are selective as a restricted number of hospitals obtain the label. Hospitals hope to increase patient numbers with a preferred provider contract. Health insurers in the Netherlands also make use of differentiated contracting: parties get different contracts that differ in terms of attractiveness. For example, higher prices are negotiated.

In the home care sector, contracting takes place through tendering. Tendering is a formal competitive bidding process where suppliers compete for contracts under strict rules. In home care tendering on the basis of a bonus-malus system is most common. In this variant of tendering the price or volume, depending on the use of a price or volume method, is determined by the extent to which care providers meet the contracting criteria as set by the purchaser. In home care, care offices do not contract all care (hours) that a given home care provider has available, nor do they

have contracts with all home care providers. This means that, after the tender procedure, only a selected number of providers are offered a contract that differs in terms of attractiveness. Contract attractiveness is mostly determined by the providers' score on the care offices' contracting criteria. All care offices distinguish five categories of contracting criteria: availability/accessibility, price/efficiency, quality of care, management information/administrative organization, and client centered practice. However, the content of the criteria may differ per care office.

It appears that the form of contracting used in hospital care, negotiations between provider and purchaser, is more cooperative and flexible in nature than the contracting approach used in home care. The contracts in hospital care are more diffuse, less-specific and sanctions are softer than in the home care sector. In hospital care, in terms of consultation, I found that in this wave of reform professional associations in the hospital care sector were involved in the design of policies and instruments used, such as the development of purchasing guide used by health insurers, the DBCs and the Dutch Health Care Transparency Program (*Zichtbare Zorg*) in hospital care. In the home care sector occupational groups were also consulted, for example in the development of the quality framework 'Safe Care' (*Kwaliteitskader Verantwoorde Zorg*). But occupational groups were not consulted in set up of the collective purchasing guideline of regional care offices. Also, we found that medical specialists are sometimes part of the negotiations between health insurer and hospital, whereas the home care worker is fully absent throughout the tendering process.

Transparency of professional activities

Performance indicators

In this paragraph we deal with the question how contracting affects the extent of transparency of professional activities. Transparency refers to a set of conditions in which purchasers (in our case) are allowed *insight* in the work of professionals. But, professional work is not always clear and measurable. And do purchasers want insight in the *conditions* under which professional work is carried out, in the *tasks* professionals perform, or do they desire insight in the *outcomes* of professional work, and how are these operationalized?

Purchasers want to make the activities of professional workers transparent as professional organizations and its workers are hold accountable for their performance. By doing so the purchasing party tries to distinguish the good from the bad providers. In hospital care the performance of hospitals, encompassing both quantitative (budgets, volume) and qualitative performance, is the footing for negotiations between hospitals and health insurers. In home care, the quantitative and qualitative performance of home care organizations is the groundwork for the tendering procedure. In order to find out how the work of professionals is made transparent, we have to focus on the type of performance indicators and monitoring systems that are used. These are the means through which the concept of transparency is operationalized in the health care sector.

Currently, different sets of performance indicators circulate in the Dutch hospital care sector, for example the Basic Set of Quality Indicators used by the Dutch Health Care Inspectorate (legally

obligatory), the Dutch Health Care Transparency Program (*Zichtbare Zorg*), developed by different stakeholders such as the Dutch Health Care Inspectorate (IGZ), health insurers and the Order of Medical Specialists in order to standardize the measurement of performance (legally obligatory), the performance indicators of the Dutch Health Insurers Association (ZN), and the sets of indicators developed by *individual* health insurers. There is a lot of overlap between all the different sets of indicators. These indicator sets only contain performance indicators for a selected number of ailments. In the hospital sector health insurers make use of four types of indicators: input or structure, process, output and outcome indicators (Donabedian, 1988; see figure 1). The performance indicators that are used by insurers mainly cover input and process indicators, and to a smaller extent output and outcome indicators. This means that hospitals are held accountable for the structural conditions of their health care system, while professionals are held accountable for the way they carry out their work (e.g. use of protocols). In terms of transparency, health insurers mainly gain insight in the conditions under which professional work is performed and in the ways (methods, procedures) professionals carry out their work.

Figure 1 Types of performance indicators

	<i>Requirements, specifications</i>
Input/structural	availability of qualified personnel; implementation of systems of in-house quality management detailed structural requirements; implementation of systems of data collection.
Process	mandating of evidence-based standards (clinical practice guidelines); targets for indicators (for example, proportions of patients treated with...); minimum volume of service agreements.
Output	total care production/volume provided by an organization; budget ceilings
Outcome	targets for health outcomes/effects (for example, proportion of patients with outcome...); targets for patient satisfaction

Source: adapted table (RO) from Figueras et al., (2005)

It appears that most hospitals only live up to the additional requirements for performance measurement (so those indicators that are *not* legally obligatory) of health insurers in the case the outcomes of these indicators determine whether a hospital acquires a preferred provider contract. But even then some hospitals believe the registration of those indicators is such a tradeoff in terms of registration efforts that they do not find it worth it, as they argue that a preferred provider contract does not necessarily generate more patients. In those cases hospitals tell the insurance company that they only work in accordance with the national (obligatory) performance indicators.

For specialists the usage of indicators is an administrative burden. Moreover, they often note that the indicators do not differentiate between good and bad health care provision; this is also called the 'performance paradox'. This paradox assumes performance measurement will simply lead to symbolic behavior and it claims there is a weak correlation between the indicators and the performance itself (Van Thiel & Leeuw, 2002). For example, an indicator provides information about the required time span between two cataract surgeries for one person. The protocol sets out there should be at least e.g. 30 days between the two operations. However, if the patient has a high

amount of error, it can be unpleasant for this patient to wait 30 days between the two surgeries. In this case the specialist could decide to perform two cataract surgeries at the same time. This is not in line with the protocol embedded in the process performance indicator, but does this act make the specialist in question a 'bad' medical specialist?

The measurement of outcome indicators also faces an important complexity, since difficulties emanate from the nature of health care services. The outcomes of care are not just related to the quality of the provided care itself, but also to the severity of the patients' condition, their age and co-morbidity; factors that are beyond the influence of the provider. This implies that in order to assess performance, risk or severity adjustment is required. Both hospitals and insurers note this is happening insufficiently at the moment. However, a method of risk adjustment will bring along high transaction costs, as it "requires sophisticated systems for collecting the necessary data" (Figueras, 2005: 218).

Regional care offices in the home care sector join in the national performance indicator sets, which are included in the performance criteria designed by the care office at the start of the tender procedure. The sector nursing and care applies the quality framework 'Safe Care' (*Kwaliteitskader Verantwoorde Zorg*). This set of performance indicators is part of the sector-wide Dutch Health Care Transparency Program (*Zichtbare Zorg*) and is therefore legally obligatory. The quality framework 'Safe Care' sets so-called frameworks for the presence of guidelines. For example, the provider has to work according to a bedsore guideline. Subsequently, it is up to the home care organization to develop this guideline, attuned to their own organization. In order to determine the increase in volume or price, home care providers can receive points based on the performance indicators. The sum of points for all criteria determines the yearly increase in price or volume. All care offices distinguish five categories of contracting criteria; availability/accessibility, price/efficiency, quality of care, management information/administrative organization, client centered practice. All four types of performance indicators are used (input, process, output, outcome), but there clearly is a strong emphasis on input indicators. For example, a home care organization has to guarantee that a specialized nurse is available 24/7, or that a 'care plan' is present for 100 percent of the clients. Most care offices demand the provider has to conduct an independent client satisfaction test; only some care offices require a certain score on this test (outcome).

Monitoring systems

From the interviews it appears that insurers do not check the validity of the information provided by hospitals. According to the insurance companies there are major differences between hospitals in the extent to which they are open about their performance. Apparently, the insurers provide the hospital with latitude to remain vague or less transparent about it. For hospitals it is often unclear what insurance companies actually do with the data of indicators. Most health insurers do not apply any sanctions when the hospital does not provide information or when the organization obtains a low score on an indicator, unless it concerns negotiations about preferred provider contracts. In terms of monitoring, strict agreements are made about how to register and reimburse the costs of the DBCs (hospital care "products"). Since the performance indicators have to be registered,

monitored and evaluated and the care products have to be defined clearly, the transaction costs of the contracts used in hospital care are high. Performance-based contracting in the competitive B-segment is more costly in terms of search and information costs, negotiation and decision costs and monitoring costs than the costs of the relational contracts that were used in the past. In former purchasing procedures the costs of contract development were low and monitoring systems were absent.

In terms of registration and accountability in home care a distinction can be made between business-oriented registration and care-related registration. The first refers to registering production on behalf of costs reimbursements, while the second refers to registration in the clients' individual care plan on behalf of the provision of safe and adequate care. Business-oriented indicators involve the timely and correct provision of production figures. Control on these data is strict. This means that the home care worker should strictly keep track of the date the care provision started, for how long a professional has delivered x-type of care (to determine how much of the bandwidth was used by the provider), and when care provision ended. For home care workers the business-oriented registration is considered to be an administrative burden. Care-related registration is seen as an important task that guarantees the provision of safe care. The performance criteria are checked in a different manner. When the tender starts, care providers have to fill out a form on which they have to indicate whether they meet a certain criterion. For some of these criteria the provider has to prove if the information is correct (e.g. a clients' satisfaction test has to be included in the appendices), but in other cases the information is merely checked randomly on an occasional basis.

How contracting affects professional autonomy

An indicator of change in autonomy due to contracting is how far health insurance companies and regional care offices have been able to establish control over the structural conditions of work and the workplace (input), the patients'/clients' diagnosis and/or control over the process of care provision, and over the time spend on a treatment or on a particular form of care provision (process), over the volume of care to be provided; total number of treatments (hospital care) or total numbers of hours (home care) (output), over the decision-making power of professionals in the field of social policy development (corporate political) and over the costs of care that is provided (corporate economical). In order to detect consequences for professional autonomy the type of indicators used by the care purchasers will be the hub of analysis. It is important to understand that indicators are ambiguous and linked to one another. For example, the presence of a particular quality framework can be considered a structural indicator; however, this framework itself may contain demands about the use of protocols, which concerns the process autonomy. Firstly, a general view about the use of performance indicators is depicted. Secondly, the alterations in the different dimensions of autonomy are analyzed and compared.

Types of indicators used

Generally, we found that in hospital care the performance indicators that are used by insurance companies mainly cover input and process indicators, and to a smaller extent output and outcome indicators. Despite a sense of dissatisfaction with current indicators among specialists, most

indicators have been developed in consultation with the occupational group. The performance indicators are used by insurance companies and other third parties to hold doctors accountable for their performance and to gain control over the work processes; by that professional autonomy is weakened.

It appears that hospitals put their foot down to prevent health insurers from demanding additional (not legally obligatory) sets of indicators. They mostly succeed in this, except from those cases in which insurers tie the extra indicators to preferred provider contracts, which most hospitals believe to be financially beneficial. In these situations the market power is on the insurers' hand. Contrarily, it is also possible that the use of market principles in health care in fact increases the autonomy of professionals. This is possible if hospitals have more market power than insurers, for example when the hospital demonstrates excellent performance or when the hospital has a monopolistic position in the region. In those situations hospitals, including specialists, can exert power and demand more freedom or reject particular demands from health insurers. So, an advantageous market position seems to enhance the corporate political autonomy of professionals.

In home care, it appears that most of the contracting criteria used by the regional care offices are input or structural criteria. The development of performance criteria used by care offices is a unilateral process; home care workers are not consulted when the performance criteria are designed. Contrarily, the occupational group has been consulted for the design of the legally obligatory indicator set "Safe Care". However, this quality framework is just one element of the entire tendering procedure.

Input autonomy

In both hospital care and home care the purchasers of care use input (or structural) indicators. These indicators predominantly demand structural adjustments in the workplace, such as the 24/7 presence of a certified nurse (home care) or the presence of a proper administration and registration system (hospital and home care). So insurance companies and care offices gained more control over the way the work environment is set up.

Process autonomy

The use of input indicators sometimes goes along with changes in the type of activities that have to be performed. For example, if regional care offices require a correct and timely supply of production numbers, it demands that the home care worker should register the production data and it demands that the professional delivers this information within a certain time frame.

Health insurance companies mainly use process indicators in order to assess the performance of specialists. These process indicators are predominantly based on the existing protocols and guidelines currently available in the field of medicine. So, the protocols and guidelines developed by the occupational group are a grip for insurance companies to gain control over the work process of doctors. In medicine, specialists highly value the use of protocols and guidelines in an environment of peer control where doctors can deviate from a protocol if they believe, based on professional expertise and experience, a unique case demands deviation from the protocol. However, the norms, protocols and guidelines embedded in the process indicators

are often used by insurance companies in a rigid manner; leaving specialists little room to deviate from the norm or protocol. By this, insurance companies get control over the work processes of doctors. Also, by using process indicators agreements are made between insurers and hospitals about the operational processes of care. For example that more patients can be treated in the same time span in order to enhance efficiency. Such agreements affect the specialists' autonomy with regard to the throughput of patients.

Since the introduction of performance-based contracting, medical specialists are directly hold accountable for their performance by health insurers, something specialists were not used doing. In some cases individual specialists are called to account for their work performance against a doctor working for the insurance company. In these situations a specialist has to account for decisions made in the clinical work context. For example, the specialist has to explain why he prescribes the most expensive medicine in most cases.

Process indicators are less common in home care. A reason for this could be the lack of pre-existing protocols and guidelines developed by the occupational group, resulting in less grips for care offices to attach indicators to. But, professionals in home care are also affected in *what* they do and *how* they do this in a different manner. The Dutch Health Care Authority (Nza) demands that home care providers only provide 35 percent of the indicated bandwidth⁴. As professionals are allowed to provide only a certain amount of minutes of the bandwidth, their process autonomy is affected because this rule prescribes how long they are allowed to spend with a client. On the one hand this efficiency rule seems to affect professional work seriously. On the other hand, practical experience shows that not all home care organizations consider this rule as an impediment. Whether a professional experiences that this rule infringes with her autonomy also depends on the home care organization itself; some organizations explicitly instruct their workers to remain within the 35 percent, while others do not do this and simply wait how it turns out and take the risk of ending up with the malus of 7 percent of their total revenues.

In both sectors there is a trend towards performance monitoring systems and quality frameworks, including calls for protocol usage. It appears the use of quality frameworks in home care does not highly affect the day-to-day practices of specialists and home care workers in terms working methods. It is often asserted that the use of guidelines and protocols curtails professional autonomy, especially when demands for the use of guidelines and protocols are expressed by third parties such as health insurers. However, from the interviews it appears that professionals in home care do not experience the use of protocols and guidelines as a restriction of their freedom; in fact, they highly value the use of protocols and believe it to be important to stick to the working practices that are found to be most effective whenever possible. Moreover, the existing guidelines often make professional boundaries explicit.

The use of DBCs in hospital care and performance descriptions in home care has standardized decisions about care planning and care activities. Also, procedural instructions have increased in both the hospital and home care sector. In both sectors decision making processes

⁴ The indication bandwidth can range for example between 1,9 and 3 hours. The rule prescribes that a home care provider is allowed to provide only 35 percent of the number of hours that is *averagely* provided by a care provider within the indicated bandwidth (this only counts for the care products of personal care and guidance). If the care provider does not succeed in doing this, an extra price deduction of 3,5 percent will be applied to the maximum tariff. This means that in total the provider is cut by 7 percent on its total revenues.

are closely monitored. So managerial and external (purchaser) supervision on professional work has augmented. This is a sign that control over deployment of professional expertise has increased. Mainly in home care there is also a stronger focus on the application of work-study methods (such as calculating bed-making speeds) as regional offices demand more efficient work processes. But also in hospital care managers (re)consider the operational management of their organization. In both sectors the language of management, budgets, and performance indicators have entered the professional life.

As the largest part of medical specialists in the Netherlands is working on a self-employed basis, their entrepreneurial skills are tested as agreements on volume directly affect their income. Interestingly, specialists have attempted to control instruments used in performance-based contracting, such as the development of DBCs and the Dutch Health Care Transparency Program. These attempts of specialists suggest that contracting can be regarded as a new (enlarged) jurisdiction within the system of professions as contracting is about controlling resources, both financially as well qualitatively in terms of quality frameworks, guidelines and protocols.

Output autonomy

Health insurance companies do currently not have control over the number of treatments that is carried out within the price, quality and volume competitive B-segment (34 percent of all hospital care). There are no production ceilings; the total volume is negotiable. In home care contrarily, regional budget ceilings exist; they are only negotiable within boundaries. In both sectors clear product descriptions exist. However, medical specialists have more control over the 'products' they deliver than home care workers. The specialist is in control over the diagnosis, whereas in home care the diagnosis is performed by the Independent Care Assessment Centre (CIZ). Both sectors have a tradition of quality requirements being set by the law. From this it can be concluded that in hospital care the output of specialists' work has remained largely untouched, whereas in home care the workers have had to give in on control over the total volume of care to be provided.

Corporate economic autonomy

In contrast to the home care sector, where maximum prices exist, the prices of care products (DBCs) are freely negotiable in hospital care. So regional care offices have more control over the costs of care than insurance companies have in hospital care.

Corporate political autonomy

It is hard to define the effects of contracting on the political autonomy of professionals. Clearly, the development performance-based contracting itself is an embodiment of the increased power of purchasing parties in the field of health care provision. In a way corporate political is a peculiar dimension of professional autonomy as it demonstrates the ability of a profession to control broader social policy developments. In fact, the characteristics of the phenomenon of performance-based contracting at present, informs us about the pre-existing decision-making power in the field of social policy development of a certain profession.

Sanctions

Important in the context of autonomy restriction are the sanctions applied by purchasers based on performance data. In hospital care performance measurement is largely untied to serious consequences in terms of contract awarding or volume/price determination, whereas performance data in home care is the strict groundwork for contract awarding or volume/price determination. So even though purchasers in hospital care might seem to have impinged strongly on professional autonomy, the consequences of performance measurement by regional offices seem to be more negative for the autonomy of home care workers as the sanctions of health insurers, contrary to those of care offices, are largely absent. Thus, the effects of an extensive use of performance indicators on professional autonomy are further intensified if it is combined with strict sanctions on weak performance. The strict demands processed in input and output indicators in home care dictate the structural working conditions and production numbers as sanction for non-compliance or weak performance are strict. In hospital care the process indicators *do* curb the process autonomy of specialists as they have to *justify* their performance to insurers, but because of the limited use of sanctions the curtailment of autonomy remains limited.

Discussion & conclusion

In this section of the paper the research question will be answered and the most significant conclusions are presented.

To the first question, “does contracting enhance the transparency of professional activities”, the answer is not straightforward. If transparency refers to the input and process aspect of professional work, we could answer ‘yes, the use of performance indicators in the contracting process does enhance the visibility of professional work because insights can be gained in *what* work is done, *how much* work is done and *how* the work is done in terms of methods used and procedures that are followed’. But in terms of outcomes it remains questionable if the performance indicators and monitoring systems used enhance the transparency of professional work. Especially in hospital care this issue was apparent as hospitals and specialists express their worries about the framing of performance indicators into classifications of ‘good’ or ‘bad’ performance by health insurers. This is important in the light of the main goal of transparency in the process of contracting: holding providers/professionals accountable for their work. If accountability refers to *discussions* between purchasers and professionals/care providing organizations about the way professionals carry out their work and the effects their work has on patients and clients, process and outcome indicators (including risk adjustment) can be valuable as it makes specialists reflexive towards their own practices. However, if holding professionals accountable based on process and outcome indicators (excluding risk adjustment) is tied to contract awarding or volume or price determination, purchasers venture onto thin ice as the ‘performance paradox’ lurks around the corner. These findings resemble the hypothesis that performance-based contracting will lead to an increase in transparency about the *type* of work that is done and *how* the work is being done. As outcome indicators often do not adjust for patient severity, there is a weak relation between the performance indicators and the performance itself as. The conclusions are consistent with the work of Van Thiel and Leeuw (2002), in which the weak relation between performance and performance measurement is addressed.

Recalling the second research question, “are the consequences of performance-based contracting for professional autonomy different for distinct professionals groups and how can this be explained?” it can be concluded that there is uneven change across sectors in terms of professional autonomy. The overall picture shows that highly professionalized groups such as medical specialists are able to maintain the status-quo and mediate change according to their occupational standards because of high levels of pre-existing corporate political autonomy. Medical specialists, more than home care workers, are responsive to social policy changes. This responsiveness is mainly expressed in the involvement of specialists in the process of contracting; involvement in the development of contracting instruments such as the DBCs or performance indicator sets and the involvement in sessions with health insurers and sometimes participation in negotiations with health insurers.

I also found that medical specialists are sometimes part of the negotiations between health insurer and hospital, whereas the home care worker is fully absent throughout the tendering process. As expected, from this we can conclude that the corporate political autonomy of medical specialists is higher than that of home care workers as specialists have a greater decision-making power in the field of social policy development than home care workers. Specialists are involved in a larger range of method and instrument development in the field of health care reforms than home care workers when the advance of performance-based contracting is concerned. Moreover, medical specialists seem to be able to mediate decisions taken by insurance companies about preferred-provider contracts, volume and price of the provided care.

However, the analysis also shows that involvement in indicator development does not necessarily prevent professionals in medicine from autonomy curtailment. From this it can be concluded that in medicine, professionals partly curtail their work autonomy *themselves*. Of course, taken the strong pre-existing corporate political autonomy of medical specialists into account, it can also be argued that specialists use the cooperation in indicator development as a way to shape reforms in their field. By that the profession of medicine retains influence in a process in which external control on their work is intensified. Contrarily, the development of performance criteria used by care offices is a unilateral process; home care workers are not consulted when the performance criteria are designed. This is most likely to be the result of the weak pre-existing corporate political autonomy of home care workers. In contrast to the situation in hospital care, home care organizations are not in the position to refuse the provision of certain data without this having serious financial consequences (e.g. contract termination).

In hospital care the use of process indicators is most common, even though the usage of outcome indicators is on the rise. The use of process indicators is a form of performance measurement that strongly affects the daily work autonomy of professionals. However, if the outcomes of these indicators are not tied to (financial) sanctions, the effect seems to be weakened. Such financial sanctions are presently largely absent in hospital care. Does this mean the process autonomy of specialists has not been weakened? No. Specialists are held accountable for their work as their performance is strongly monitored by health insurers. Weak performance (in the eyes of insurance companies) has to be justified and by that insurance companies gain control over the work of doctors.

Interestingly, the presence of clear and well-developed guidelines and protocols in medicine enabled health insurance companies to develop strictly defined process and outcome indicators, which eventually frame and structure specialists' activities; those indicators that highly affect the day-to-day work autonomy of specialists. We call this the *professionalism paradox*: a high level of professionalism, including high levels of professional autonomy, at the pre-policy reform stage seems to offer grips for external parties to curb that autonomy. Well-developed protocols and guidelines partly indicate a high level of professionalization as the norms and codes of conduct of the occupational group and professional boundaries are established. The lack of guidelines and protocols in home care has resulted in a strong focus on input indicators; these types of indicators seem to affect the process autonomy of home care workers only marginally. This shows that it is harder for care offices to get a grip on the work processes of home care workers. This does not mean that the autonomy of home care workers has not been restricted. In home care, the autonomy of care workers has mainly been restricted by top-down implemented policy reforms such norms about time spend at a client or the introduction of independent assessments (diagnosis).

Generally, it can be concluded that advanced stages of institutionalization of a profession at a pre-reform stage enables the occupational group to exert power in the stage of policy formation, but at the same time it offers greater opportunities for external parties to control work performance as working methods and procedures are all strictly formalized in protocols and guidelines. This means the hypothesis, that performance-based contracting will lead to a greater reduction of professional autonomy among home care workers than among medical specialist, because they have a lower ability to control and mediate social policy changes, has to be partly falsified. The situation in health care is much more complex than some observers claim. Unlike authors such as Diefenbach (2009), Tonkens (2008) and Broadbent and Laughlin (2002) NPM-policies like contracting do not simply erode professional autonomies. The current paper demonstrated that complex mechanisms are active that complicate the relation between NPM- and market-based policies and professional work.

Ackroyd et al. (2007) conclude that the introduction of New Public Management principles "reveals a picture of change *and* continuity. (...) The available evidence suggests that in many areas older patterns of custodial administration continue to be important in shaping service provision" (p. 21). The present study added to this that a high level of corporate political autonomy at the pre-reform stage does not necessarily imply little infraction on other autonomy dimensions due to a certain policy reform, as the case of Dutch medical specialists showed. Because of the traditionally strongly institutionalized position of specialists, high level professionals are more responsive to changes as they have a considerable capacity to control or affect changes. However, well-developed protocols and guidelines clearly define the boundaries of work process and this provides third parties with a solid basis for performance indicator development.

Another promising line of research would be to carry out large-scale quantitative research on the topic of consequences of performance-based contracting for the autonomy of distinct professional groups. This type of research could increase knowledge about the *directions* of the relations between autonomy, instruments of contracting and type of professionalism.

Literature list

- Abbott, A. (1988). *The system of professions. An essay on the division of expert labor.* The university of Chicago press, Chicago, London.
- Ackroyd, S., I. Kirkpatrick and R.M. Walker. (2007). *Public management reform in the UK and its consequences for professional organization: a comparative analysis.* Public Administration, 85: 9-26.
- Batey, M.V. and F.M. Lewis. (1982). *Clarifying autonomy and accountability in nursing service.* Journal of Nursing Administration, 12: 13-18.
- Bovens, M. and P. 't Hart. (2005). *Publieke Verantwoording: zegen en vloek.* In W. Bakker and K. Yesilkagit (eds.) *Publieke Verantwoording.* Amsterdam: Boom, p. 245-264.
- Brink, G. van den, Th. Jansen and D. Pessers (eds.) (2005). *Beroepszeer.* Amsterdam: Boom.
- Broadbent, J. and R. Laughlin. (2002). *Public Service Professionals and the New Public management: Control of the Professions in the Public Services,* in K. McLaughlin, S. P. Osborne and E. Ferlie (eds.), *New Public Management: Current Trends and Future Prospects.* London: Routledge.
- Bruin, H. de (2001). *Prestatiemeting in de publieke sector. Tussen professie en verantwoording.* Utrecht: Lemma.
- Bureau, V., D. Wilsford, G. France. (2009). *Reforming medical governance in Europe. What is it about institutions?* Health Economics, Policy and Law, 4: 265-281.
- Clarke, J., & J. Newman. (1997). *The managerial state.* London; Thousand Oaks; New Delhi: SAGE Publication Ltd.
- Coburn, D. (1999). *Professional autonomy and the problematic nature of self-regulation: medicine, nursing and the state.* In: *Medicine, Nursing and the State,* edited by David Coburn, Susan Rappolt, Ivy Bourgeault, and Jan Angus. Aurora, Ont.: Garamond: 25-54.
- Dawson, S. (1996). *Analyzing organisations.* Macmillan, London.
- Denhardt, R.B. and J.V. Denhardt. (2000). *New Public Services: serving rather than steering.* Public Administration Review, 60: 549-559.
- Diefenbach, T. (2009). *New public management in public sector organizations: the dark sides of managerialistic 'enlightenment'.* Public Administration, 87: 892-909.
- Dunleavy, P., & Hood, C. (1994). *From old public administration to new public management.* Public money and management, 14: 9-16.
- Duyvendak, T. Knijn and M. Kremer (eds.) *Policy, People and the New Professional.* Amsterdam: Amsterdam University Press
- Etzioni, A. (1969). *The Semi-Professions and their Organization: Teachers, Nurses and Social Workers.* New York: Free Press.
- Exworthy, M. and S. Halford. (1999). *Professionals and the New Managerialism in the Public Sector.* Buckingham: Open University Press.
- Figueras, J., R. Robinson and E. Jakubowski. (2005). *Purchasing to improve health systems performance.* European Observatory on Health Systems and Policies Series. New York: Open University Press.
- Freidson, E. (2001). *Professionalism: The third logic.* Cambridge: Cambridge University Press.

- Knijn, T. and S. Verhagen. (2007). *Contested professionalism: payments for care and the quality of home care*. *Administration & Society*, 39: 451-475.
- Kruijthof, K. (2005). *Doctors' Orders. Specialists' Day to Day Work and their jurisdictional Claims in Dutch Hospitals*. Nieuwegein: Badoux.
- Lane, J. (2001). *From long-term contracting to short-term contracting*. *Public Administration*, 79: 29-47.
- Lindert, H. van, Delnoij, D., Groenewegen, P.P., Hofland, S. (1999). Op weg naar een geïntegreerd medisch specialistisch bedrijf. Managementparticipatie van medisch-specialisten in Nederland. In: *Acta Hospitalia*, 2:39-55.
- Newman, J. (2001). *Modernizing Governance: New Labour, Policy and Society*. London: Sage.
- Noordegraaf, M. and T. Abma. (2003). 'Management by measurement?' *Public Administration*, 81: 83-871.
- Noordegraaf, M. (2006). *Professional management of professionals*. In J. Duyvendak, T. Knijn and M. Kremer (eds.) *Policy, People and the New Professional*. Amsterdam: Amsterdam University Press, pp. 181-193.
- Noordegraaf, M. (2007). *From "pure" to "hybrid" professionalism: present-day professionalism in ambiguous public domains*. *Administration & Society*, 39: 761-785.
- OMS. (2007b). *Medisch specialist in perspectief. Een visie op de toekomst van de medisch-specialistische zorg*. Utrecht: Order of Medical Specialists (OMS).
- Perkin, H. (1989). *The Rise of Professional Society: England since 1880*. London: Routledge.
- Pollitt, C. (1993). *Managerialism and the Public Services*. Oxford: Blackwell.
- Pollitt, C. and G. Bouckaert. (2000). *Public management reform*. Oxford: Oxford University Press.
- RIVM. (2008). *Dutch Health Care Performance Report 2008*. Bilthoven: National Institute for Public Health and the Environment (RIVM).
- Schulz, R. and S. Harrison. (1986). *Physician autonomy in the Federal Republic of Germany, Great Britain and the United States*. *International Journal of Health Planning and Management*, 1: 335-355.
- Thiel, S. van and F.L. Leeuw. (2002). *The performance paradox in the public sector*. *Public Performance & Management Review*, 25: 267-281.
- Tilbury, C. (2004). *The Influence of Performance Measurement on Child Welfare Policy and Practice*. *British Journal of Social Work*, 34: 225-241
- Tonkens, E. (2008). *Mondige burgers, getemde professionals*. Amsterdam: Van Gennep.
- Wee, S. van der (2000). Differentiatie en adaptatie. Het draagvlak voor integratie in de organisatie onder medisch specialisten in algemene en academische ziekenhuizen in Nederland. Proefschrift, Nijmegen.
- WHO. (2000) *The world health report 2000. Health systems: improving performance*. Geneva: World Health Organization.
- WRR. (2004). *Bewijzen van goede dienstverlening*. Amsterdam: Amsterdam University Press.