Working under Supervision; the Limits of Professional Action in (Health)Care and Welfare

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Introduction

It is only 15 years ago that Smith and Lipsky (1994) argued that in corporatist countries like the Netherlands and Germany non-profit organizations have a monopolistic position in the delivery of social services. These organizations do not suffer from the downgrading influence on the cost of services, the quality of the work and the degree of professionalism that result from contractualization, outsourcing and tendering. In the meantime much has changed; insurance companies have contracts with hospitals and family doctors, local governments with social work organizations, parents with child care centres, municipalities recruit home care via tenders and local labor offices contract commercial companies to guide unemployed towards the labor market.

The introduction of contracts in the social sector could happen because of several political and social developments. At the political level the neo-liberal ideology of less state more society, went hand in hand with a growing distrust in professionals in the social domain. At the same time clients turned into consumers demanding a greater say on services, more transparency and a 'real choice'. This is exactly what the New Public Management Theory has proclaimed (Osborne and Gaebler 1993; Pollitt and Bouckaert, 2000). According to that theory the introduction of market principles promotes competition in the social sector and thus improves the quality of the goods and services and lowers their prices. It meets consumer demand for information, which constitutes the basis for making a well-considered choice. Furthermore, contractualization is an inevitable condition for breaking supply monopolies of service institutions, which can meet the increasing variety of demands of an increasingly divers population (Van Waarden, 2002).

The consequences of the introduction of market principles in the former public sector have not gone unnoticed. The Dutch Scientific Council for the Government WRR (2006) observes that this has resulted in a division between management and implementation, which works to the detriment of the quality of services provided and adds to the bureaucracy. They labeled this as a 'property split' between management and professional work. Hutschemaekers (2005), Freidson (2001), Van den Brink, Jansen and Pessers (2005) and Duyvendak, Knijn and Kremer (2006), indicate the risk of the deprofessionalization, because competition is mainly focused on cost price the more so as it is hard to objectively determine quality standards. In sectors where professionals are not capable of maintaining strong quality criteria, the market mechanism will lead to the replacement of better trained professionals by less qualified ones.

De Bruijn (2001) and Gilbert (2002) finally signal that contracts are only meaningful when they are operationalized in measurable performance indicators. They state that such performance indicators could lead to perverted effects. On the one hand; if precisely defined they limit professional discretion, undermine the relevance of professional knowledge, and make the professional a mere implementer of standard protocols that do not (cannot) do justice to the specific characteristics of the individual client. On the other hand, if they are formulated too generally the financier is not able to inspect whether there is compliance with the implied relation between price, quality, and result of the services provided. The risk then exists that performance indicators are maintained which can easily be complied with or that street level professionals register in such a manner that every activity can be accounted for. In that case registration goes at the expense of service provision without an improvement in the quality of the services.

One direction, several routes

One of the interesting aspects of contractualization is that it leans to a large extent on path dependency. This means that the nature and content of contracts and the methods of registration tend to vary strongly with the sector in which such contracts are being introduced. Governments in the Netherlands and Germany introduced highly centralised accounting systems in the medical domain in the first years of the new millennium. In both countries Diagnosis Related Groups (In Dutch: Diagnose Behandel Combinaties) form a new cost-accounting system for medical treatments based upon diagnosis. Contractualization in social work and home care, in contrast, have taken place at the local level and accordingly shows a great variety in the nature and content of the contracts. In the Netherlands child care is even more decentralised; each child care company has its own kind of contracts that parents have to sign.

In addition sectors differ in the extent of professional involvement with the development of contracts and protocols. For instance, the medical professionals and psycho-therapists, or at least their representatives, have been strongly involved in the development of the Diagnosis Related Groups. In social work accounting systems have been developed by the managers of the social work organisations while in home care these systems are based on national assessment criteria, developed by the Centrum Indicatiestelling Zorg (CIZ) and implemented by local governments without any influence of the care workers. Path dependency as well as the sociological composition of the professional group therefore seems to influence the kind and character of contractualization in social services. Hence we argue that the higher the degree of professionalization, and the more masculine the profession is, the greater is the say of the professionals on the content and nature of the accounting system, the contracts that are introduced and the registration criteria.

Professionalism, a logic and a practice

A continuously repeating question, that is not yet solved by empirical studies, is what this kind of regulation via contracts and accounting systems means for professionalism as a distinguished mode of production, and for professional workers. We have introduced here three social services that can be distinguished on basis of their degree of professionalization according to the criteria introduced by Elliot Freidson (2001). Freidson characterizes professionalization ideal-typically by: 1) a specific knowledge domain that is supervised by the professionals themselves, 2) an internal division of labour and quality control, 3) professional control on the access to the profession by certification, registration and protection of the titles, 4) professional control on the training programmes, grading systems and the exams, and 5) a professional ideology, identity and codes in which professional norms ad standards are guaranteed. According to these criteria we can distinguish the professionals in the here fore mentioned social services as full professionals (the medical specialists and family doctors), semi-professionals (social workers) and quasi-professionals (home care workers). In a research project that has yet to be started we will explore whether the degree of professionalism (full, semi or quasi), the nature of the contractualization (central, local or based at tendering), or the gender composition of the professional group (male, mixed or female) influences the character and the outcomes of the regulation for the service providing organizations, for the maintenance of professional discretion, and for the quality of service. Via a comparison of service sectors (healthcare, home care, and welfare work) the study aims at acquiring insight into the factors that explain why and how the introduction of contractualization has taken different shapes. The professionals to be studied are medical specialists, welfare workers, and home care employees.

Exemplified Assumptions

A first assumption of the project is that contractualization promotes standardization of work because of accountability procedures that require registration of activities. This reduces the individual discretion of professional practitioners. This is facilitated by computerization.

Computerized home care workers

A home care organization in the North of the Netherlands has provided all home care workers with a Personal Digital Assistant (PDA) in 2004. The small handcomputer is connected to a GPRS system and contains all information on the clients that home care workers need; the name and the address of the clients, the treatments that the client need, the prescribed time for this treatment and also the prescribed arrival and departure time of the home care worker. At the moment the home care worker arrives at the client's home she has to register her actual arrival time, and when she leaves the departure time has to be registered. According to masterstudent Gerrie Koops, who has interviewed the care manager and several home care workers of the organization the reception of the PDA, the workers and the staff are not per definition negative on the device (Koops 2007). Home care workers have been rather skeptical when the PDA was introduced but after a while they say that they can not do their job without the small computer anymore. It surely has decreased the registration time and moreover, the computer contains all kind of gimmicks that can also be used for personal purposes, such as a cell phone, games and a camera. Some report disadvantages, mainly because the already limited contact with colleagues has been further reduced. Only the interviewed care manager is rather ambivalent towards the organizational changes that form the background of the introduction of the PDA. Koops (2006) notices the care manager saying that the PDA is part of the transformation of care into an

economic product, that has to be provided efficiently and is regulated by market competition. Every year the home care organization has to offer a bid to the municipality that decides which organization will be contracted for the coming year. For this reason the home care organization has to compete on the costs of care work. This has resulted in an enormous job insecurity for the home care workers, and the risk of dismissal of thousands of home care workers since 2007, many of them re-contracted on basis of a so-called alpha-help contract without any job protection and secondary labour conditions (no pensions nor paid holidays and social security). In addition the home care organizations have to reduce costs of training and qualification of the home care workers and to increase their productivity. The care managers explains that the PDA helps to reach the ultimate 'target' of 75% productive and 25% unproductive time including transport, registration, training, holidays and sick leave. She states: 'productivity is the icon that dominates all other aspects of the care work' (Koops 2007: 10).

The home care organization has introduced the PDA in an effort to improve efficiency by stricter control on the time the home care workers spend with their clients, by more control on the logistics of going from one client to another and by promoting time management awareness of the home care workers. One could have assumed that home care workers would have protested against this kind of disciplining control on their tasks and on the time they need to move from one client to the other. The regulation they are subjected to is easily associated with 'Big Brother watches you' or an ICT based Foucauldian panopticum. However, the few home care workers interviewed for this student paper just have accepted that within a relatively short period of about fifteen years, they have lost all professional discretion to perform their job in accordance with their clients' needs. Though they never have been completely free to do whatever they thought to be necessary, only fifteen years ago a rather general assessment of the

clients needs offered clients a home care workers with whom they made the decision on what has to be done on this particular day of the week. Objectively spoken the home care work is now not only standardized, it is also completely transparent, which is a condition for the second assumption:

Taylorized medical 'production' work

Standardization of work is a condition for "Taylorizing" service work, thus contributing to a more detailed division of labor in the service occupations. In German hospitals, like in the Dutch hospitals, the taylorization of medical 'production' work has found entrance in between 2000 and 2004, as Werner Vogd (2006) observed. In many European countries cost management systems on basis of Diagnosis Related Groups have transformed the cost-accounting system on basis of diagnoses. The DRG's have been introduced to improve economic control over the medical sector and forms the basis for 'external controls on the plausibility and rationality of professional services by health insurers, contracts between individual hospitals and insurance companies and other "regulative practices"' (Vogd 2006: 156). In the wake of this process also the division of labor has changed; responsibilities for a single patient are no longer owned by a team of physicians and nurses but by the bureaucratic hospital organization in which each specialist has responsibility for his/her own 'part' of the patient. Vogd signals that medical specialists have less interaction with their patients, hand over written instead of verbal information on patients and rely more on routines than on inter-professional decision making. Tayloriozation of the medical 'production' work appears to be the outcome of this process; the work process has been fragmented, each specialist performs his/her

own part of the job and written communication should guarantee that the parts of the production process remain connected and do not overlap.

In contrast to the home care workers, medical specialist do complain and try to resist the new way of working, while hospital management and insurance companies are very enthusiast about it, they insist on bringing larger parts of the medical care under the system. In the Netherlands some medical specialists have quit the job because of the DRG's, in the German hospitals the specialists regret the deterioration of the quality of care they provide, and the lack of interaction with their patients and their colleagues. More seriously, they fear for making mistakes because they have to make decisions for treatment on basis of written documents only; they do not know their patients anymore (Vogd 2006). But they do know that they do not have a say anymore on the organization of the medical work processes; these are regulated by people from other professions; health care managers, epidemiologists and health economists. In spite of many studies on the effects of DRG's overall evaluations are not yet available. The ones that are available point however in different directions; the NZa (Dutch Care Authority) for instance warns for excessive rising costs of medical care since the marketization of parts of medical treatments because of increasing assessments and rising prices. In addition, insured citizens get less care and cure than they are legally entitled to (Nederlandse Zorgautoriteit 2008). German researchers in contrast, have found that the price per DRG for multi-trauma patients are too lowly budgeted (on average 13.000 Euro) because they are not configured according to the German health care system, resulting in budgetary deficits for hospitals (Grotz et al. 2004). Finally, the relationship between managers and professionals in the service sector is changing, even turning upside down. The third assumption therefore concerns the new class of service managers; how do they regulate the professionals?

Regulated social services

Recently Mirko Noordegraaf (2008) plead on behalf of the managers in social services. If they did not form a buffer in between the regulating government and the professional workers the situation might be even more worse. Noordegraaf argues that managing the social services is an unavoidable and even necessary process given the new efficiency claims governments and citizens put on the social sector, given also the scaling up of social service organizations and the transition from a supply to a demand oriented approach of social service providers. Large scale providers need managers to organize the working process, and politicians as well as citizens that have transformed themselves into consumers demand accounts and transparency. Moreover, some managers do a very good job in downsizing the account claims of third parties (governmental departments, insurance companies, local governments), protect their professional workers against too much regulation and registration, or manage their organizations and professional staff according to the new human resource management strategies.

One could agree with Noordegraaf that managers differ in their approach and that bashing managers is not a fair approach. Also his claim that professionals are not per definition or qualitata qua performing a good job is accurate. However, Noordegraaf's argument is not exactly an answer on the critique of the unbalanced relationship between professionalism and managementism. His argument is a voluntaristic reaction on a structural problem; of course there are good managers and bad professionals, but that is not a central issue in the debate. Central here is what managementism (not managers) implies for the quality of the professional work in social services. The Dutch Scientific Council for the Government (2006) coined 'property split' as a consequence of managementism; the division of knowledge and

responsibilities between two organizational layers that do not communicate because they speak different languages.

Two additional intriguing consequences have been detected by some of my master students who have studied regulation of probation officers (Schram, 2006), social workers in shelters for homeless people (Posthouwer, 2006) and institutions for juvenile delinquents (Willems, 2006). First, less than half of the professional workers in all three organizations have understood the *why* and the *how* of the new registration demands; in probation work and institutes for juvenile delinquents the workers have to work with a registration system that comes directly from the national government's department of law, and is implemented with the argument of national security. At the same time probation officers are only allowed to offer guidance to those delinquents that are selected by the national department and by implication have to refuse support to delinquents that voluntarily ask for guidance. Both kind of workers in the area of criminality do not see that the massive administrative load (workers with juvenile delinquents spend on average 5 to 10% of their working time on registration, probation officers even on average 38 %) is beneficial to quality of the guidance they offer to their clients. They claim that the quality of their own work has decreased. In particular older probation officers are very discontent, feeling that their once satisfying job is undermined. In this kind of work some, nowadays called 'old fashioned', calling has been a main motivation for taking the job. Some probation officers fear therefore that efficiency criteria and the claim for effectiveness will undermine national security more than improving it, a conclusion that is shared by a recent study among about 250 probation workers (Van Velzen & Beets 2008). But of course this can not be proven (yet?).

Secondly, and in particular among the workers in the shelters for the homeless many pervert effects result from the new registration demands (name, 2006) as De Bruijn (2001) already has predicted. The registration system these workers have to use is introduced by the national insurance for exceptional medical expenses (AWBZ) that pays for the guidance of homeless people living in shelters. Maybe due to growing pains of the recently introduced system, many workers said that for surviving the new system they have to use it very ‘creative’. Hence obstruction, creative reporting or just writing to the average are common strategies to deal with the registration system that takes them about 12,5% of their working time (Posthouwer, 2006). One of the complaints is that only direct contact with the homeless people can be registered, not all the related activities such as transport to and from, phone calls on behalf of the client, finding information and staff meetings. Some social workers say that they ask the client to stay at the office till all the support related activities have been done, only in that case the real working time can be registered. Another strategy is to move clients to another part of the shelters that is not yet governed by the AWBZ and where less detailed registration are demanded. As the organization as a whole struggles with the system, it has taken initiatives to extend that les registered part of the organization more than was planned before. In addition one of the aims of the project is to study the expansion of new functions in between the management and the executive. At the moment that expansion is not yet traceable, but there are strong indications that the percentage of directly supportive professionals is rapidly declining in favor of the percentage of intermediate or relegating professionals in many social sectors.

So far these cases of several social services lead to the conclusion that regulation processes in all sectors, the full professional as well as the semi- and quasi professional sectors, decrease the level of professionalism according to Freidson’s criteria. If we only look at the

highest category of professionalism, the medical specialists, we see that they not any longer supervise their specific knowledge; insurance companies, consumers organisations and the national health departments have taken over the control on the length and quality of medical treatments, appropriate medicines and of hospitals. In addition the internal division of labour is now in the hands of managers that are not medical specialists themselves but health care managers or economists. The professional control on the access to the profession by certification, registration and protection of the titles is still in the hands of specialists but the curriculum is becoming contested. The professional ideology, identity and codes in which professional norms and standards are guaranteed have been weakened, at least in the Netherlands where the government in 2006 stopped subsidizing the professional medical organisations that have been responsible for training programmes, the exchange of professional knowledge and the spread of information. The codes are undermined since, in contrast to one of the main characteristics of medical profession, specialists, family doctors and even psychiatrists have to hand over detailed information on their patients to the insurance companies. In reaction professional workers vote with their feet; that about 20% of all psychiatrists and about 30% of the home care workers have left their profession the past few years (Stichting FOAT, 2007; NRC Handelsblad, 2008), and about 30% of the probation workers considers to quit their job (Van Velzen & Beets 2008).

Working under supervision; some preliminary conclusions.

Enormous turnover rates and taylorization of work processes are common phenomena in all three professional sectors. In hospitals and home care alike professionals work according to schedules that are based upon the objective of reaching maximum efficiency, transparency and

accountability. Social services are increasingly organised as taylorized production processes, transforming social and medical professionals into production workers. This brings us to the fourth assumption concerning the limitation of the discretionary space of professional service providers and thus of the relation between service providers and their clients. Professional discretion however should not be considered an aim in itself. Like managers – and politicians – professionals make failures, are not self evidently innovative and also Freidson's ideal-typical professional because he bears the risk of paternalistic or elitist conservatism of a professional group that refuses to change its habits and rituals. So the first question should be whether professional discretion more than managementism contributes to good cure, good care, public safety and the common interest of citizens who depend on professional care. A second question is, if there is a structural and unsolvable contradiction professional discretion and marketized efficiency. Finally, we will have to find answers on these questions by detailed case studies of several specific professions; although general trends are already visible each profession is submitted to very specific forms of regulation.

Some preliminary conclusions can already be drawn; 1) figures about professionals leaving their jobs are enormous; about 30% of full professional psychiatrists and quasi professional home care workers have just quit their jobs in the past few years and the same percentage of probation workers considers to take the same step. 2) medical specialists as well as probation workers fear that the new accounting systems undermine the service they have to provide, resulting in respectively medical failures and more criminality. 3) Possible drawbacks also are: reduction of understanding of the situation of the client, of quality of service and work satisfaction, increase in internal conflicts, distrust or alienation in the relation between management and implementation, and finally an increase of paper work and risk avoidance.

Some claim that a positive aspect could be increased transparency for clients and society. If this is the case we soon will be informed about the consequences of regulated professionalism.

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