

# Signed, sealed and delivering

Moving towards a new social contract  
in healthcare

Professor Kim Putters



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Moving towards a new social contract in healthcare

## Professor Kim Putters

### Inaugural lecture

Delivered in abbreviated form on the occasion of accepting the post of Endowed Professor on behalf of the Erasmus Trust Fund. The teaching and research remit is 'Policy and governance of care in a changing welfare state' at Erasmus School of Health Policy & Management, Erasmus University Rotterdam, on Friday 15 September 2017.

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**Rector Magnificus,  
My dear colleagues,  
My family, friends and students,**

# I The changing welfare state

*However important the achievements of the welfare state may be, there is nevertheless a danger that they make people less assertive and less independent. People have lost a large part of their direct involvement in their own welfare and that of others. [...] They have 'learnt' to outsource care of their own health to a healthcare system that seems to become increasingly perfect. On the other hand, the ever-present healthcare systems are gradually and entirely taking responsibility for their own welfare away from people. [...] This is one of the reasons why we are forced to seek other ways for promoting public health: ways that make people less dependent on the care systems. In this respect, the emphasis will be on self-help, voluntary work, keeping matters on a small scale, and decentralisation of government administration.*

This could very well be a passage quoted from a new coalition agreement or an explanation on working with local police teams (as according to Van der Lans and De Boer 2014), but it was actually said by Jo Hendriks, who was State Secretary for Public Health under Prime Minister Joop den Uyl in 1976.

The quote is characteristic of the central issue in my lecture: how combined action between the government, civil society organisations and the public actually works in a changing welfare state. I would describe this as the basis of a 'social contract' as derived from philosophers such as Locke, Rousseau and Rawls. These philosophers refer to citizens who renounce their personal power to an absolute monarch or to the community, in exchange for protection. In this lecture, I will be citing six separate characteristics of today's social contract in healthcare:

- a system of agreements on accessibility, efficiency and quality of the care and support provided;
- which are concluded by means of written and unwritten rules between the central government, professional and civil society organisations, and members of the public;
- which are based on solidarity between people with large incomes and people with small incomes, and between those who enjoy good health and those whose health is not so good;
- it includes willingness to share social risks as well as power and responsibilities;
- it is based on an assumption of relative autonomy to elaborate on this in practice in professional healthcare institutions as well as in healthcare cooperatives;
- and willingness to accept the outcome of this.

In 1976, State Secretary Hendriks already referred to the increasing variety of stakeholders in this combined action, which was due to the involvement of more small-scale and market-oriented organisations and local government bodies and to the fact that more was being expected from the public and their social networks. Although the national government has been constitutionally responsible for healthcare since 1983, it still depends on all these stakeholders with respect to the quality, efficiency and accessibility of the relevant facilities. The above quote makes it clear that no dichotomy exists between 'the government' and 'society', and refers to several administrative models existing side by side: from market negotiations to regulation by government bodies and self-management by civic society organisations and the public (Van der Grinten, 2007; Moore, 1995; Mouwen, 2006).

The social contract mainly focused on protecting the public against social risks for a very long time. Nowadays, we can see that this is shifting towards participation, personal responsibility, and support from local government bodies in this connection (Esping-Anderson et al., 2003). To paraphrase Kees Schuyt (2013), however, it is intended to prevent 'rough and tough' individualism as well as equally 'rough and tough' collectivism or 'peer pressure' in this kind of 'investment state'. In theory, a government with hierarchical control that makes agreements on market forces, self-management and decentralised care-related tasks with central stakeholders fits in less and less with a network society in which the above phenomena are on the increase (ROB-RFV, 2017; Van der Veen, 2011). Moreover, if we expect more personal initiative from the public, the question is what effect this will have on their willingness to share social risks. Nevertheless, 2.1 million people still depend on healthcare or other facilities in the social domain, and the central government still exercises a great deal of control (Bijl et al., 2015; Pommer and Boelhouwer, 2016).

Although the numerous stakeholders and the existence of various different administration models do not invariably lead to quick and efficient combined action, they ought to result in solutions that enjoy wide support. If the differences in access to and quality of healthcare increase further, e.g. due to income, age and ethnicity, this might put pressure on confidence in the inclusive outcomes of the social contract (Vrooman et al., 2014). The above quote from that statement made in 1976 makes it clear that although this is not a new issue, it is a very persistent one. Why is this, and can it be changed? How has the social contract evolved, and is it still effective? Does it still enjoy public support?

These questions form part of the teaching and research remit for the Chair entitled 'Policy and governance of care in a changing welfare state'. I have linked this to my research for the Chair entitled 'Management of healthcare institutions' that I held prior to this, whereby I previously studied the effects of multiple administration in healthcare (Putters, 2009). I am focusing on the changes in the schemes and outcomes of the social contract in healthcare and on their impact on the public as well as on policy and administration. My aim is to make a contribution to the development of theories on *changing welfare states* from the 'schemes and perceptions' angle. To this end, I have combined historical, administrative, sociological and health science viewpoints.

First of all, I examine the social contract in healthcare and the changes that have taken place in schemes and perceptions. I subsequently explore how we can find the social contract in current healthcare practice, the anchor points along which it evolves, and what management philosophy fits in with this in the welfare state in the near future. I have completed it with a research and education agenda.

# 2 Dynamics of the social contract: schemes and perceptions

The social contract in healthcare relies on a centrally-controlled system which used to focus on social protection for the public with a clear role for the private sector and which always remained in contact with the government through a hierarchical structure (generally via umbrella organisations). On the one hand, this is a 'fixed' contract on the way in which rules, regulations and central institutions are set up, but on the other hand, the parties are continually negotiating on matters such as purchase and implementation of healthcare (Kalshoven and Zonderland, 2016). Although this combined action is firmly entrenched in legislation and regulations, its character has nevertheless changed over time due to various historical, policy-related and social developments. I will examine each of these in turn below.

## 2.1 Historical and policy-related developments in the social contract

It is important to give a brief historical retrospective in order to enable interpretation of the government's increasing involvement in public health and healthcare, and to clarify how power sharing with the public and civil society organisations came into being. The relationships between these stakeholders is changing, but this change still remains within the framework that has developed over time.

### **Public health: from individual to collectivity**

First of all, public health issues gradually changed from an individual responsibility to an increasingly collective responsibility. Developments from circa 1850 on show a fluctuation between individual and collective health and responsibilities for public health (Box 1).

### Box 1. How do staff experience contingency research (with an external president)?

---

**From circa 1850 on:** Emergence of *public health* as a field of expertise and as a social domain whose aim was to improve hygiene, combat epidemics and increase human life expectancy.

**Between 1850 and 1900:** Life expectancy increased by 10 years - to an average of 48 - thanks to specific measures concerning clean drinking water, sewers and public housing.

**From 1900 on:** Emergence of inter alia patient-oriented medicine, combating infectious diseases and infant mortality, and preventive care for mothers and their children.

**From 1950 on:** Effective medicine for affluence-related diseases; improved curative care for adults; combating chronic diseases (from circa 1975 on), thereby focusing on *care* for the elderly (and older people generally).

**Between 1900 and 2000:** Life expectancy increased by 30 years - to an average of 78 - thanks to improved living and working conditions, more healthcare facilities and more medical options.

**From 2000 on:** Emergence of positive healthcare and combating 'predictable' diseases. Combating problems and deficiencies. We anticipate that human life expectancy will increase to an average of 100 years during the course of this century.

Source: inter alia Bijl et al. (2015); RV&S (2017a); De Swaan (1988).

We therefore see that government involvement in protecting the public against illness and ill health has increased over time. The Public Health Act (2008) most recently formulates a major responsibility for local and other government bodies with respect to prevention of illness and to 'stable and cooperative public healthcare'. The government not only offers people protection; in addition, it has now started to address people on their personal responsibility and encourage them to lead healthy lives.

## **The welfare state: between protection and participation**

In the academic debate on *welfare state regimes*, the Dutch welfare state can be characterised as a combination of a social-democratic model and a corporatist model (Esping-Andersen, 1990; Van der Veen, 1990, 2011; Vrooman, 2009). The social-democratic model is based on extensive collective facilities for all citizens; this entails substantial costs and therefore high taxation, and it assumes that people will not use the available facilities for longer than is necessary. The corporatist model is more selective, focusing on support for specific groups such as major wage earners and elderly people (Veldheer et al., 2012).

Financing the necessary facilities - by means of taxes, premiums and personal contributions - is geared to this model. For example, people in the Netherlands do not pay education costs in full; they make a personal contribution through school fees or tuition fees. Similarly, Dutch households do not have to pay the full costs for their own home or those for healthcare (Olsthoorn et al., 2017). The 'ability-to-pay' principle and relationship reciprocity form the foundations of the social contract on which this is based, i.e. that people contribute according to their income, and they can benefit whenever the need arises. Those with lower incomes and poor health are compensated by contributions from people with higher incomes and good health (Vrooman 2009, 2016). People know that they will receive care if they themselves end up in a situation where they, too, need care (Kalshoven and Zonderland, 2016).

According to Gilbert (2005), the welfare state is meanwhile being transformed into an investment state which invests in resources that enable people to participate (Hemerijck, 2013). This indicates the transition from a protective welfare state to a participative welfare state in which people are addressed on their personal options and responsibilities and those of their social environment. Support from the collectivity (mainly temporary) is only available if the above proves impossible (Van der Veen, 2011). Use of healthcare facilities is curbed as much as possible, and prevention is encouraged. However, this does not mean that everyone is able to accept this changeover or cope with it.

People's own wishes and options for more self-determination differ greatly for each generation and each population group. Members of privileged groups are better equipped to find work on the employment market, or power in associations and neighbourhoods, or healthcare and support, than less self-sufficient people. Although recent perceptions of comprehensive healthcare (Minkman, 2017) and positive health (Huber, 2016) contribute to a wider range of options for dealing with poor health, our more vulnerable citizens may view the government's call for self-sufficiency as a hidden agenda whose real purpose is to cut back government spending (Dekker et al., 2016b).

The government also tries to control people in all kinds of ways, mainly through supervision and monitoring. This results in catchphrases such as 'working according to capacity', 'customary healthcare' and 'quid pro quo'. On the one hand, the government gives people less support, and they have to do more themselves to find work or obtain healthcare, but on the other hand, the conditions under which they have to do this are subjected to considerable discipline focusing on language, behaviour, clothing and employee skills (De Boer and Kooiker, 2012). In this connection, Vrooman et al. (2012) refer to increasing emphasis on 'responsible citizens'.

The debate on a 'participation society' in this respect, which commenced after the Speech from the Throne in 2013, fits in with this trend (Putters, 2014). According to

the government, people must reduce their dependence on social security and other benefits, contribute to a pleasant living environment in their own neighbourhoods, provide more voluntary care to their fellow citizens, play an active part in their children's schools, and help the police trace criminals through neighbourhood watches or by informing the police if they witness a crime being committed, and so on. There is a specific civic viewpoint behind all this, i.e. not necessarily less government control, but less government commitment. In this respect, the government is implicitly basing its views on 'good citizens' who possess the skills required for acting in accordance with the government's ideas, whereby local authorities increasingly create the preconditions: greater central control and decentralised responsibility.

This transformation of the welfare state's schemes from the classic, traditional protection of citizens to their active participation, as well as heading towards greater responsibility for local authorities and private individuals, is not proceeding very smoothly (Schnabel, 2013). The groups in the middle are benefiting less and less from their solidarity because they are often less eligible for compensation, or because they simply do not have the right networks to help them find their way about (Oltshoorn et al., 2017; WRR, 2017a). Vulnerable groups do not always have sufficient resources at their disposal, which means that the conversion of the right to healthcare into a municipal duty to encourage people to participate, in combination with the complexity of a large number of regulations for healthcare, can cause a considerable degree of uncertainty. And this in turn means that the benefit that people actually obtain under the system is being undermined, although it relies on people's continued willingness and that of civil society organisations to contribute to healthcare for people who cannot do that themselves due to illness or lack of funds.

### **Care and support: between public and private**

During the second half of the 20th century, long-term care was reorganised according to what was known as a 'universalistic' model, and the government ensured that care services were made widely available for people who needed help. The government took over part of the responsibility from the family (Österle and Rothgang, 2010). However, the increase in costs jeopardised the financial tenability of the long-term care system (Zijderfeld, 1999). The Social Support Act (WMO, 2007) replaced the Exceptional Medical Expenses Act (AWBZ), which had been extended over time to include housing and everyday activities. The government started focusing more on care for the most vulnerable people, and implemented cutbacks in less taxing forms of care such as domestic help under the WMO. More stringent criteria for home care assessments and increasing personal contributions have been implemented (Van den Broek, 2016).

In addition, one of the explicit policy objectives of the local authorities - which are now responsible in this respect - is enabling people to continue living in their own homes for longer. These local authorities have to achieve a price-quality ratio using market tools such as tendering in order to ensure that people can live at home for longer (Den Draak et al., 2016). Responsibility for care of the needy has now shifted back to families and other private individuals, where it originally was in the 1950s and 1960s (De Boer and Kooiker, 2012). Municipalities have a duty of care to support this process, and to this end, they deploy tools that focus on the market (e.g. tendering) and the community (informal assistance).

The regulated market has become part of curative care through the 2006 Care Insurance Act. As the insured party, people can choose their own insurance policies, while healthcare insurers purchase care from healthcare providers on the basis of price and quality. This system entitles people to an insurance package whereby insurance payments are managed by social insurance funds and deployment of these funds is carried out by healthcare insurers. These were health insurance funds (ziekenfondsen) until 1 January 2007, after which their duties were transferred to private healthcare insurers. Everyone is free to choose their own healthcare insurer at their own discretion. The idea behind this greater role for the public to choose for themselves is to generate cost-consciousness, to keep rising healthcare costs under control, and to increase quality. Therefore, we can see collective schemes for sharing social risks here as well, but with the addition of greater personal responsibility and a range of market-oriented tools focusing on competition and greater freedom of choice.

The same diversity applies to healthcare implementation and management because government bodies depend on collaboration with private institutions and independent professionals. The number of market-oriented and locally-involved parties has increased due to the advent of regulated market forces and decentralisation of care-related tasks. Healthcare institutions and insurers are private organisations (known as 'hybrid organisations') which are now obliged to adopt a more commercial strategy to achieve public targets (De Graaf, 2017; Putters, 2001). Continuous dialogue between the government and the sector is essential because neither of them has the overriding authority. Or, as Van der Grinten (2007) puts it:

*A massive system of legislation and regulations (relating to quality, accessibility and efficiency, KP) has admittedly been built up during the past years, which could be used to keep a stranglehold on the sector. But at the same time, government policy strongly depends on the efforts of this same sector.*

This point is still valid despite more focus on the market, on personal responsibility and on freedom of choice for citizens.

The policy trends can be described as 'more of everything at the same time', yet still as 'hybrid'. More government regulations on monitoring and cost control, more contracting between healthcare providers and healthcare insurers on the healthcare purchasing market with respect to price and quality, more *shared decision-making* with physicians on the healthcare process (Hilders, 2015) and more consideration and loyalty vis-à-vis the social environment, e.g. through informal care or assistance in cooperative contexts (De Boer, 2017; De Roo, 2016). According to De Boer and Kooiker (2012), this means that people have to be able to do all the things listed below at one and the same time:

*cleverly negotiating with insurance companies, responding to our fellow citizens' needs with a tremendous sense of duty and willingness to sacrifice oneself, independently and assertively choosing a personal budget, refraining from violating the smoking ban.*

*With respect to a healthy lifestyle, the government expects [...] citizens to respond adequately to incentives. Incentives based on prices, prohibitions or limited availability.*

All this requires a certain degree of flexibility. However, people are not always able or willing to fulfil all these expectations simultaneously. This is partly due to public indignation/anxiety concerning cutbacks in care for elderly people. I will go into this again in the paragraphs below.

## 2.2 Developments in the social context of the social contract

A great deal has changed in social relationships with respect to families, friends, companies and social connections during the past years, and this has an impact on the functioning of the schemes in the welfare state and how members of the public perceive this. For example, a greater degree of emancipation and a higher level of education have been converted into a minor role for the government and more choice and control for private individuals. Moreover, increasing secularisation has resulted in the disappearance of fixed structures in which people were part of a wider community.

It has emerged that many people are able to manage their own lives in a more independent manner and to regard this as the norm, including health and healthcare. In addition, the fact that the population is ageing means that there are fewer younger people to finance social security through premiums and tax contributions. The number of persons who are inactive on the employment market shows a substantial increase compared to the number of active persons (Bijl et al., 2015; De Beer, 2016).

All this means that tenability and public support for care and security systems have been at the top of political and social agendas for a long time (Hoff and Putters, 2016). I cite three social discussions here which are relevant to the way in which we deal with this issue.

### a. Down with all misfits!

It seems that many people increasingly consider individual rights as the norm. This is having an impact on the collective norm, on how to cope with risks, disappointment, bad luck or loss. In its *Recept voor maatschappelijk probleem* (A recipe for social problems), the Council for Public Health and Society gave a broad outline of the fact that medicalisation of our lives is primarily due to our own views on life and our expectations on coping with risks (RV&S, 2017a). People's wishes and requirements are made more explicit due to (inter alia) all the available information on the quality of healthcare, although risks or defects appear to be less readily accepted. The tendency to approach health issues on the basis of a medical model involves a risk that the prescribing of medicines and medical treatment will predominate.

The idea that we can shape our society through government policy - "down with all the misfits" - and the fact that we no longer accept deterioration or physical and emotional disabilities, serve to bolster up all this medicalisation. And if we add the vast quantity of technological and medical options and the equally huge amount of information on these options that can be obtained through the (social) media, we do not anticipate that this will become any less in the near future. It might give more control to many, but at the same time, it increases stress levels because disappointments occur. Despite the fact that we are demanding more and more perfection, we still have not invented that one pill to cure dementia or to ensure a peaceful and dignified death. Moreover, some people are less able to absorb all the available information, or they wrongly believe they can.

There are limits to what medical care can do for us, and also to what we can afford as a group (FMS, 2017; RV&S, 2017a). And this involves uncertainty for many people, not only for those without the financial or intellectual ability to access new technology and medicines, but also for healthcare professionals because they are often expected to perform miracles.

## **b. Self-determination as an ideal**

There seems to be a tremendous belief in individual control over the quality of life which is being fuelled by the unbounded opportunities offered by new media, medicines and technology. This is additionally reinforced by innumerable types of self-management, *shared decision-making* and online sharing of knowledge and experience. Although this is helpful to many people, it does not necessarily result in increased patient compliance, appropriate use of healthcare, or patient confidence in their physicians (Janssen, 2016; Vennik, 2016). Some people want to make choices themselves, and they do this more frequently, although the existing care schemes do not always provide them with an opportunity to do so, or people themselves do not always possess the necessary insight or knowledge.

Resources such as income, work, social networks, education, and ability to communicate in Dutch are essential to self-determination. Those who possess plenty of these resources are better able to fill in their everyday lives more easily without assistance from the relevant institutions than those with a great many limitations. In respect of the debate on positive health, Huber (2014) refers to:

*the ability to adapt and to manage one's own life in respect of the social, physical and emotional challenges in life.*

This definition is relational and dynamic and emphasises the role played by people themselves in situations relating to health (Huber et al., 2011). It constitutes an alternative to the World Health Organisation's more static definition (WHO, 1948):

*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*

A discussion on this recently took place in the *Tijdschrift voor gezondheidswetenschappen (Health Sciences Journal)* (Huber, 2016; Poesz et al., 2016). According to some people, positive health unfairly confers an extremely heavy responsibility on individual people themselves. Moreover, if a large number of social issues come under the heading of health, this may have an expansive effect in terms of care-related tasks as well as costs. The question here is what exactly we should and should not understand by the terms health and healthcare.

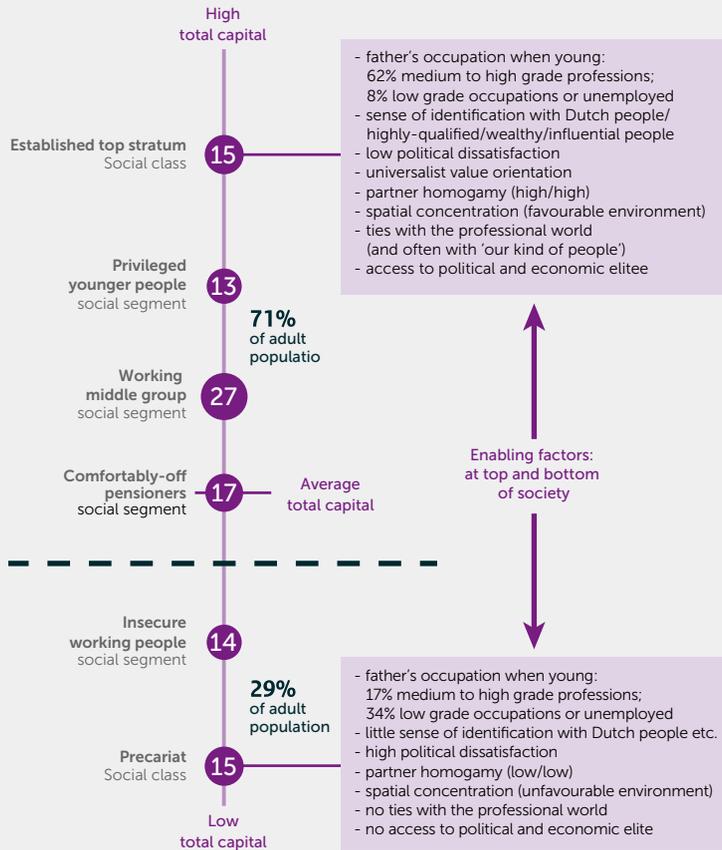
In order to avoid a whimsical debate on the definition of health between health scientists, business administration experts and organisational experts, I shall return to what sociologists say about these environmental factors.

## **c. Unequal distribution of resources**

Due to the fact that health and healthcare is increasingly interwoven with other factors in everyday life, a dynamic description of individual and collective health is becoming more fashionable. In this respect, other resources such as work, income and social networks are becoming more relevant. In sociological terms, we refer to types of capital that people possess to a greater or a lesser degree. This has an impact on their social position and the quality of their lives (Bovens et al., 2014; Vrooman et al., 2014).

Firstly, we have *economic capital*, which refers to people's income and assets and which is often linked to their profession and level of education. Secondly, we have *cultural capital*, which refers to people's ability to speak the relevant language (Dutch, in the present case), whether they possess digital skills, whether they are included or excluded, and whether they are discriminated against. In other words, are you part of the group or not? Thirdly, we have *social capital*, which refers to the social networks that people can fall back on, such as voluntary carers or the influential connections who can help people to get on. And finally, we have *personal capital*, which refers to people's physical and mental health, as well as possessing a pleasant personality and communicative skills. In this approach, therefore, health is defined more narrowly, but it is examined in conjunction with other resources. This is in order to ascertain how people participate and whether they require care and support to help them in this. There are very few people who have total control over this, and the relevant resources are always unequally distributed.

Figure 1. **Worlds apart in the Netherlands (2014): distribution of resources**



Source: SCP (ViN'14).

Figure 1 clearly shows that there is an established group at the top of society, and a group of privileged young people with a relatively large number of resources who are happy, enjoy excellent health and have a positive view of the future. But there is also a group of people comprising almost 30% of the population, who only have a small number of resources at their disposal and among whom illness and poor health are more frequently found. People in this group feel less happy and have less confidence in the future. This group includes many mothers on social security, one-parent families and first-generation migrants. The group in the middle mainly experiences a sense of insecurity because the government expects more of them

- inter alia in the shape of voluntary care - although they themselves become or might become increasingly dependent on such care. They have doubts about how they themselves actually benefit from the available facilities, in spite of their solidarity with the vulnerable members of society. For example, in addition to wealthy elderly people at the top and poor elderly people at the bottom, there are also senior citizens with a comfortable pension who are becoming increasingly lonely and infirm. These people are in a favourable position financially, but they are uncertain about its value and they are increasingly called upon to care for one another. Will they still be able to benefit from the facilities in the future? They feel they have lost all the entitlements they have built up, and many of them only have small networks to rely on.

These social and cultural dividing lines are having an impact on life expectancy, healthcare consumption, views on health and perceived loss of health. The difference in life expectancy between highly-qualified people and those with a lower level of education is about 7 years, while the difference in the number of years of poor health or accumulated ailments can mount up to as much as 18 years (Hu, 2016; Huber, 2014; Plogch et al., 2007). We anticipate that social acceleration due to e.g. more technological options will merely serve to increase this division. The people with a large number of resources will primarily be the ones to succeed in having to combine work, learning, care and healthy living (Van den Broek et al., 2015; De Graaf, 2017; Rosa, 2016). However, this is not true of everyone. Moreover, healthcare and other professionals will not be able to contribute to prevention in all respects, particularly if the care or support required is outside their own field of work.

The purpose of the social contract is to move towards a distribution of resources in society which will result in inclusion while combating polarisation. In this respect, therefore, the focus is also on how people perceive this.

### **2.3 Developments in perceptions and expectations among members of the public in respect of the social contract**

This affects the expectations people have in respect of a social contract, i.e. receiving social protection in exchange for sharing risks and power. In this connection, the Advisory Council on Government Policy (WRR, 2006) already referred to 'communication breakdowns' between the institutional 'facilities-and-schemes' environment and the needs of clients and patients. Most of the decentralisations of the past years primarily focused on what the government expects from the public, but a great deal less on what the public can expect from the government. In this respect, it seems that the government has not always taken e.g. social dynamics in family and other relationships into consideration. The government takes an optimistic view - unsupported by any scientific knowledge - of citizens' social, physical and psychological ability to manage their own lives without assistance, and to give each other help and support. Moreover, the majority of the Dutch population is of the opinion that the central government is responsible for care, which is inter alia expressed in public fury and outrage in response to the government's failure to provide proper care for the elderly.

In this connection, however, some people increasingly assume the role of customers and demand their individual rights and freedom of choice, which is partly encouraged by government policy. Not all citizens feel they have a duty to the community, with attitudes such as 'if I feel cheated, I'm going to demand my rights' or going even further, 'otherwise I'll arrange it myself'. These are familiar attitudes in all aspects of healthcare, including physicians' consulting rooms. But at the same time, many people cannot find their way around in the healthcare sector because they cannot understand the complexity of regulations (Rademakers, 2016). Overburdening the care facilities as well as failure to provide such facilities are undermining public support for the social contract. Municipalities bear a major decentralised responsibility to prevent this, but they themselves cannot automatically rely on public support. Let me explain this further.

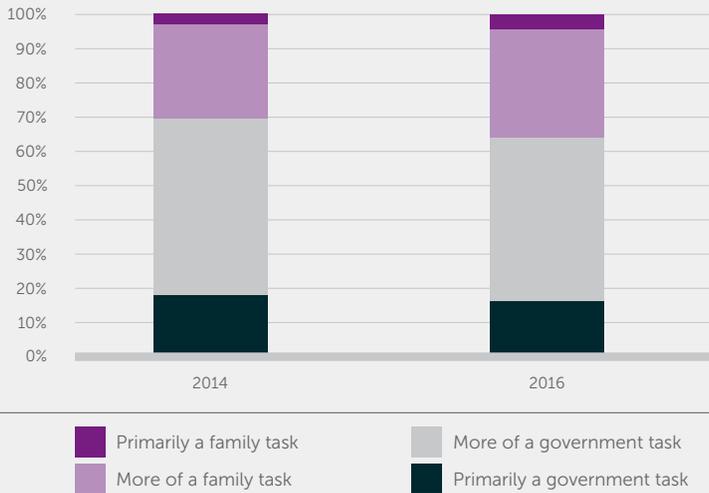
### **Views on health and responsibility**

All my references in this lecture to views on care and attitudes towards it invariably refer to two issues: (1) personal and collective health and (2) the division of responsibility for this.

The Netherlands Institute for Social Research (SCP) regularly asks people how important they find their health. This gets a high score, and the same applies to their families' and friends' health. Care of the elderly, as well as healthcare in a general sense, is also cited as being a government priority, in the sense that a great many people firmly believe that the government should earmark more funds for this. Generally speaking, care is regarded as a (major) problem, but still something to be proud of (Dekker et al., 2016a, b). With respect to legitimacy of policy and control in the healthcare sector, it is important to take account of the fact that although people are often positive about their own experiences with healthcare, they are increasingly dissatisfied with the system, the government's role in all this, and 'the way things are going'.

The SCP's longitudinal research into various sources, such as the Culturele Veranderingen (Cultural Changes, CV) data collection, provides an insight into the percentage of the population who feel that children have a duty to care for their parents. More than 40% have subscribed to this view since 2010. However, if the parents in question have special needs, many people feel that this is the duty of the government (see Figure 2). There is a slight increase in the percentage of people who consider that care of one's parents is the duty of their families. However, in the case of elderly people requiring special care due to a chronic disability or impairment, the percentage of citizens who consider that family and friends should care for these elderly people decreased from 40.6% in 2010 to 22.6% in 2016.

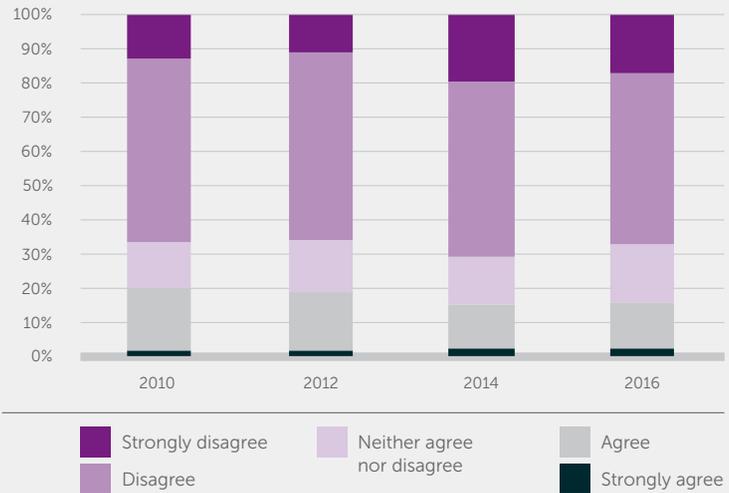
Figure 2. Responses to the following question: 'Do you consider that care of elderly people with special needs is the duty of their families or the duty of the government?', 2014-2016 (in percentages)



Source: SCP (CV '14-'16).

From previous research carried out in 2014, it emerged that a 63% majority of the population felt that people should help their relatives, while about 50% felt that people should do the same for their friends too. However, the percentage of the population who felt that one should help one's neighbours was considerably lower (De Klerk et al., 2015a). Figure 3 gives the same picture for the entire period between 2010 and 2016. 15.8% of the respondents agreed or definitely agreed with the statement: 'Neighbours have a duty to care for each other if any of them require help'. Therefore, we see that a large percentage of the population feels it is their duty to help their own families, but this percentage soon shrinks as the distance increases. This sense of duty is the weakest in cases where considerable sacrifices are required, such as an invasion of privacy or loss of income, and the same applies to cases where there are good alternatives to personal voluntary care (Van den Broek et al., 2015).

Figure 3. Responses to the following statement: **'Neighbours have a duty to care for each other if any of them require help', 2010-2016 (in percentages)**



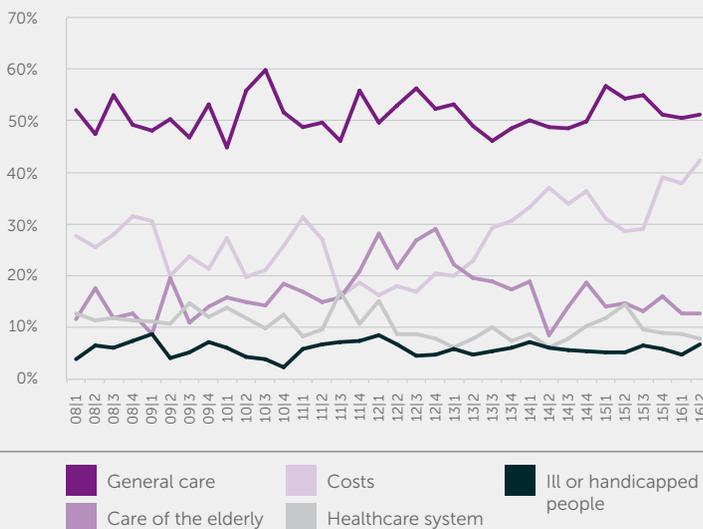
Source: SCP (CV '10-'16).

In particular, fewer respondents regard focusing on prevention of an unhealthy lifestyle as a government responsibility. People's individual situations make a difference in this respect. For example, more men than women are in favour of government intervention relating to people's lifestyles, although the opposite applies in respect of work-related tasks. People with a lower level of education have more positive views on government intervention relating to care, work and debts than highly-qualified people, although the opposite applies in respect of smoking or eating habits. An increasing number of people who are in poor health feel that the government is responsible for their medical treatment (Kloosterman, 2013). People's attitudes are gradually changing in accordance with their position in society (Van der Lelij and Lampert, 2011). And this also influences people's views on the division of responsibility and their confidence in this.

### Decentralisation only enjoys a limited degree of confidence

During the period following decentralisation of the central government’s duties and their transfer to the municipalities, particularly those relating to care and domestic help, we see that Dutch people were extremely concerned about this. In 2016, 48% of respondents considered that the disadvantages outweighed the advantages, while only 14% felt that this would entail greater advantages. In addition, 55% were of the opinion that the main purpose of this decentralisation was to cut back on government spending. However, those who were able to see the advantages to decentralisation (such as personalised care), also feared a decrease in such care. Incidentally, not many people voiced an opinion on this, or they had little experience in this respect, but their views are related to opinions on healthcare and care of the elderly in general and the changes in this (Dekker et al., 2016a, b).

Figure 4. **Five of the most frequently-cited problems in the ‘healthcare and care of the elderly’ category, population aged 18 and over, 2008-2016 (in percentages)<sup>a</sup>**



a With respect to the respondents who spontaneously named a problem in the category ‘healthcare and care of the elderly’, this gives the exact problems these people cited.

Source: COB 2008/1-2016/2.

People generally have greater confidence in the government in proportion to the degree in which the government is close to the people. Respondents were more positive about municipal authorities than other government bodies. Nevertheless, an increasing number of people disagree with the statement that municipalities possess sufficient expertise to enable them to carry out tasks in the care sector. This percentage increased from 24% at the end of 2014 to 30% in 2016. In addition, an increasing number of people disagree with the statement that municipalities are capable of providing personalised care: this percentage increased from 25% in 2014 to 32% in 2016. This can be explained in a number of ways (Dekker et al., 2016b).

First point: people have firmly-entrenched ideas on the central government's responsibilities in respect of care. Second point: the austerity measures that accompanied decentralisation have given rise to a sense of discontent among the public in respect of the government's call for personal responsibility. Third point: the central government still fulfils a dominant role through supervision and monitoring. The regulations arising from this often impede investments in local and personal responsibility. Fourth point: this is also used as an argument against invariably regarding municipalities as the responsible parties. Fifth point: although private initiatives such as healthcare cooperatives and neighbourhood initiatives are not 'by or for' the local authorities, those taking such initiatives do sometimes feel pressurised into assuming this role as an extension of these authorities. People are especially opposed to anything involving a great deal of bureaucracy (Van der Klein et al., 2013).

Although the relevant figures show that people acknowledge the complex nature of shared responsibility, this does not guarantee public support for new types of risk sharing. People perceive this as a hidden agenda. A certain degree of dissatisfaction is admittedly inherent to strong mutual dependence (which emphasises the importance of acknowledging each other's position in the social contract), but the recent reforms do not always run parallel to citizens' underlying views in this respect, nor to their expectations which have accumulated over a long period of time.

## **2.4 Path dependence and dynamism: guarantees given in the past do not provide security for the future**

The social contract is continually in motion but it also has continuity (Meurs, 1997). For many people, collectivisation of care and security has resulted in emancipation and an improved social position, and it has also resulted in greater individualisation. The government is now making use of privatisation and decentralisation to emphasise people's personal responsibility for their own social security, which is mainly prompted by the increasing collective burden. This means that new agreements will have to be concluded with municipalities, market parties, civil society organisations and the public on e.g. linking of care to living and working. Although the hybrid system prevents changes which are too intermittent from occurring, it may nevertheless constitute an impediment to the dissatisfaction and to being able to benefit early on from the social changes as we have already discussed in the foregoing (Hemerijck 2013).

The emphasis on personal responsibility and the fact that people still expect a great deal from the government as referred to above, as well as the more limited

acceptance of risks and defects and the unequal distribution of resources among members of the public, have an impact on the institutional arrangements in practice. A lack of clarity among citizens in respect of their own roles and access to care and support may well result in greater public dissatisfaction if the differences in health and social circumstances increase any further. This will definitely be the case if citizens benefit less from their solidarity in the centrally-managed system (Olsthoorn et al., 2017).

If people begin to feel that the call for personal responsibility is rather a government order for austerity measures, this will clash with the duty of care that many people attribute to the government. Moreover, although the central government has reduced its commitment, it has not done so with respect to government interference. This can mainly be seen in supervision and monitoring, as well as the tightening up of home care assessments, which people regard as bureaucratic. If it is unclear what exactly people can expect from the government or if the government fails to fulfil people's expectations while exercising considerable control through regulation, this will gradually undermine public support for policy, administration and the outcomes of the social contract (De Graaf, 2007).

# 3 The social contract in healthcare in practice

Does the social contract still exist in practice in the care sector, and how does this manifest itself? Research carried out with my PhD students has shown that in practice, links are continually being established between private and public interests and with views and orientations of patients, clients and healthcare professionals. This results in a conceptual framework for additional research, with three separate places for the social contract in healthcare practice (inter alia Janssen, 2016; Oldenhof, 2015; Van der Pennen, 2016; Postma, 2015; Vennik, 2016).

1. The **structures** that regulate the ownership ratios and financing of care in organisations and institutions in the social domain (more or less, public and/or private). This generally concerns the scale of organisations, collaboration in networks and using a variety of tools such as tendering, contracting and regulation. It manages relations with the multiple environment.
2. The **processes** and interactions that stakeholders in the care sector enter into with one another in networks, i.e. the way in which they experiment and learn as well as how they create a process architecture which brings all the various interests together and coordinates them. This frequently concerns negotiations and compromises on 'good-quality' care.
3. The **people**, their views and orientations. Professionals, administrators and ordinary citizens have views and expectations on care and also on risk sharing in the social domain. These have an impact on the role of patients and clients when designing their care and support, such as exercising all kinds of participation and control.

Let us examine these one by one.

## 3.1 The social contract in structures

The first location is the structures. During the past years, we have seen agreements concluded at national level between the government and the sector, relating to budgets and responsibilities for the quality of care. In addition, new organisations are being set up in the social domain, some of which are in the nature of networks while others are care groups or work as a franchise. Some of them refer to *network & neighbourhood governance* (Lowndes and Sullivan, 2008; Postma et al., 2015). In this connection, tendering and contracting of care are not new tools, but they are becoming increasingly significant when weighing up the numerous public, private and professional interests in informal home visits, neighbourhood teams, district care and cooperative relationships.

The level of confidence that people have in these tools and structures depends inter alia on the division of tasks and the outcomes. The dissertation research carried out by Jeroen Postma (2015) on hospital care, district care and long-term care shows that the scale of organisations matters in such cases. People are more inclined to associate large-scale organisations with bureaucracy, megalomaniac officials and an impersonal approach, and small-scale organisations with warmth and humanity,

flexibility and a personal attitude. Nevertheless, large-scale and small-scale organisations - or small-scale care at large-scale organisations - still generally subscribe to the same quality and efficiency arguments for the choice of their type of organisation. In addition, there is a considerable degree of cross-border collaboration among organisations, and personalised care is provided at large-scale organisations as well. Besides the structure, the focus is also on sharing a vision on care and the envisaged result.

A wide variety of organisations and networks in the social domain are involved in this (De Boer, 2017; De Klerk et al., 2015a). For people with a disability, the family care network is important, even though their circle of family and friends is often small (Woittiez et al., 2014). This not only concerns people with disabilities, either congenital or otherwise, but also elderly people suffering from loneliness. Children do not generally reside near their parents, which means that elderly people often care for each other. If family members assume responsibility for care, this is known as a family network. Those who do not have family or friends to care for them often have to rely on networks of friends. Since this is not self-evident and not always effective either, it is important to maintain contact with professional carers.

Neighbourhood networks are also in existence. In their research into district and neighbourhood care work, Oldenhof et al. (2014) demonstrate that informal and voluntary carers in these networks are in continual dialogue with those requiring care in order to try and reach agreement on what exactly is regarded as proper care, and what exchanges between efficiency and quality or privacy are acceptable. Technology can sometimes be of assistance in such cases, such as a neighbourhood app that people can use to request help, but they still have to rely on professional organisations at regular intervals.

In addition, there are care and work networks. A large number of informal and voluntary carers provide care to people outside their work. However, this is not always easy in respect of time, money and distance, and employers do not always provide sufficient scope for these activities. This means it is very important to conclude agreements with the (generally regional) business sector on matters such as leave and part-time work. The options offered by work-cum-care schemes are important for providing proper care and for ensuring permanent support for this type of participation and risk-sharing.

And finally, we have the church and sports clubs networks. Social cohesion not only involves care; it also involves spiritual and domestic help or sport (De Hart, 2011; Zonderop, 2017). In this connection, investing in meeting-places in neighbourhoods and city districts is important, as is dialogue with district teams or district nurses. This can help people break out of their isolation, encourage others to do voluntary work, and assist in identifying problems. Those with the fewest available options are those who are most frequently convinced that they cannot ask for help. This does not necessarily mean that nobody wants to help these people; it might also be an indication that they lack the courage to ask for such help (Linders, 2010; Vermeij and Kullberg, 2015). The existence of this type of network provides these people with an opportunity to join in.

In this way, formal and informal networks and organisations have emerged as major locations of the social contract in practice. This can be seen in neighbourhood teams, informal home visits, care plans, decisions and assessments, where agreements

between professionals, citizens and their environment are formalised. De Boer and Van der Lans (2013) propose that the social neighbourhood teams can easily be incorporated into existing institutional practices. On the one hand, this could mean that the image of self-sufficient citizens is predominant, or that the government traditionally exercises considerable control on the other hand. Another possibility is that people will try and claim their former rights to care from the district teams. I found an example of how this works and its potential results at Humanitas. One of their employees was at the home of an elderly man requiring domestic help, and the visiting municipal official was encouraging him to ask his family for help. This finally resulted in the elderly gentleman resuming contact with his son, whom he had not seen for many years and who turned out to be willing to help his father. This seemed an ideal solution at first, but an old family quarrel flared up again after two weeks, so the situation was actually worse than it had been before (Vriends, 2015). Although this could be viewed as an unfortunate decision on the part of the municipal official in question, which could be rectified by simply providing the elderly gentleman with domestic help, it is also a manifestation of an ill-considered comparative assessment between personal responsibility, professional support and family care, with extremely negative results.

So the question is whether people are actually better off with more help from their families, whether they are able to find their way around in the care system, and whether they have influential connections who can provide them with the necessary assistance. Making use of structures such as care networks and making informal home visits forges links between public and private, individual and collective, whereby a rational call for personal responsibility easily comes into conflict with views on equal rights to care or personalised care. If no attention is devoted to this point, there is a risk that the outcome will not correspond to citizens' expectations (Steenkamer et al., 2017). The above example at Humanitas makes this clear. And that brings us to the second type of social contract practice.

### **3.2 The social contract in processes**

The interaction between the relevant stakeholders and the way in which they set up processes for provision of help and care in the social domain are also a location for the social contract in care (Oldenhof et al., 2014). Let us examine a few examples, such as care for people suffering from dementia. A great deal of attention is being devoted to discovering a medicine to cure dementia, but in the meantime, the social questions on contact and behaviour in care processes are mainly the ones that remain unanswered. The ideal of self-determination frequently predominates. Anne-Mei The (2015), on the other hand, focuses on a model combining the social and psychological effects of dementia, including those for the people in contact with the sufferer. One example of a care institution which does take advantage of this is Viattence in Epe, where I was visiting.

The people sleep above the living room instead of on the ground floor because they have been doing this all their lives. This means they lead far more regular and restful lives. The professionals feared at first that they would have to do far too much 'traipsing about' with the residents, but as it turns out, everyone is happy with this arrangement. There is a living room, dining area and a rest room on the ground floor. If the residents get tired during the daytime, they do not go and lie down in their

bedrooms; they simply have a nap on one of the beds in the rest room. So when they wake up again, they are immediately part of everyday life. The toilet has an old-fashioned cistern with a chain attached, which the residents pull to flush the toilet just as they used to in the past. But the cistern doesn't actually function: pulling the chain activates sensors which flush the toilet. The residents are surrounded by old-fashioned radios, the colours of their childhood, photos of Queen Wilhelmina (they do not know who King Willem-Alexander is) and bakelite switches and plugs, just like in the old days. Everything is designed to appeal to their sensory and olfactory systems.

While there, I met a lady who was unable to read anything except sheet music. And now she can play the piano every day as she is given sheet music to read. If she wants to sit out in the sun, the assistants put sun cream on her skin. This is a bit difficult due to hygiene regulations, but everyone has a lovely tan and is happy. Separate agreements on this are made with the inspectorate, because it is actually against the rules. And all this results in a more natural kind of informal care, as the residents' children and partners feel they are visiting them at their own homes, not in a care home. They help tidy up the rooms and do odd jobs for them.

But these people with dementia are still very confused. I met a ballet dancer who said she was going to join in a circus act, and an aged gentleman who told me he was going to the butcher's with his parents. However, the quality of their lives is perceptibly higher than at other care homes. All this fits in with the regular budget, only the money is spent differently, the care process is set up differently, and appropriate agreements have to be made on assessing private, public and professional interests. The care home adopts a position based on its own views of the care process vis-à-vis the central control framework of government and supervisors, as well as residents and their families.

I found another example at De Lange Wei care home in Hardinxveld-Giessendam, where my own grandparents used to live. One Saturday, this care home organised contacts between staff and people living in the immediate vicinity, the idea being to get to know each other and to come into contact with potential voluntary staff. There is a strong social cohesion in my village, and this activity resulted in more than 400 volunteers who offered to help residents with leisure activities, visits to the hairdresser, reading aloud to them or driving them to the hospital. And the majority of these volunteers are still actively involved even now, a couple of years later (Zorg en Welzijn 2015). The care home has fought hard against takeover endeavours on the part of large-scale care providers: the results of market forces. It wants to remain on a small scale and focus on relationships in the neighbourhood. And this has been a success thanks to the strong links and contacts with the neighbourhood and with the residents' families. By doing this, the care home has adopted a position vis-à-vis *civil society* (the neighbourhood) as well as the market (other care providers).

Enabling elderly people to remain in their homes for longer is another example. For the elderly, this often focuses on retaining their skills and their links with a social network, as opposed to young people with a disability who are still able to learn skills through e.g. home automation or other technology which means that they too can live at home for longer. For people with psychological disorders, this often focuses on learning how to cope with their illness and being able to rely on professional help or daily activities (De Klerk et al., 2015b). Moreover, being discharged from hospital

and recuperating at home is quite a different story to young disabled people leaving their parents' homes to live on their own. It requires specific collaboration between families, voluntary workers and professionals, as well as continual communication with a large number of stakeholders and their interests. Unless the care process is linked to suitable housing, living environment, work, school, debt rescheduling and learning new skills, being able to live at home for longer is an undefined concept whereby it is unclear what exactly is required to achieve it (Den Draak et al., 2016).

Maarten Janssen (2016) describes these quests for improved care and support 'experimenting and innovation'. This does not mean merely concentrating on the exact ownership ratios or financing structures; it means continual discussions with the parties involved in order to examine the meaning of 'proper care'. At process level, the social contract appears to be a question of radar homing in the direction of the 'right' solutions for patients or clients and their families. To this end, connections are made between public, private and professional parties. During this process, proper care requires substantiated choices and compromises, which means that all the relevant interests must be well considered or represented, that control must be properly regulated, and that networks between professionals, informal carers and voluntary carers must be developed and maintained.

All this is part of what I have described as the core of the social contract. The borders between the domains must be crossed, and behaviour learnt in a professional or bureaucratic sense will sometimes have to be disregarded in order to arrive at a well-substantiated result. In this respect, we need a vision on e.g. people suffering from dementia or young informal carers. In the care process, therefore, it also depends on convictions held by e.g. professionals, informal carers and administrators. This is the final location where the social contract can be found.

### **3.3 The social contract in people**

The third practice is that of human beings' own orientations and perspectives: those of administrators as liaison officers between views and interests, those of patients and clients as *co-producers* and *co-designers*, those of city districts that share tasks as a community, and those of professionals who cooperate with citizens as partners. These are *boundary spanners* that link public and private interests and endeavour to contribute to proper care (Bekker et al., 2010; Van den Brink et al., 2012). We will be examining a number of examples of this below.

For instance, location managers and district nurses working in city districts and neighbourhoods are trying to maintain a balance between accessibility of small-scale living accommodation and round-the-clock care (Oldenhof, 2015). In terms of deployment and supervision of these small-scale locations, the available funds do not always enable round-the-clock care to be provided. At the same time, however, the clients themselves would very much like to receive round-the-clock care. Moreover, efficient scheduling of staff often conflicts with freedom of choice for clients. If the available resources have to be deployed efficiently and costs have to be controlled, it is not always possible to accede to the wishes of clients and their families. We also cherish a wish to integrate clients receiving long-term care into society, thereby

creating public support in the district or the neighbourhood where the living accommodation is located. This requires practical compromises when designing living accommodation and fleshing out daily activities. Carers and location managers must not only have a vision of proper care; they must also be capable of conducting a dialogue on this with clients, their families and the rest of the neighbourhood. And a vision and skills are required for this.

We can see this in youth care professionals too. In youth care, there are various standards for proper care which are all vying for priority. These needy young people's problems are often complex and relate to health, social networks, skills, the family situation, performance at school, and generally crime as well. What we frequently see is a tendency towards central control for one particular family through one particular plan by one particular administrator. However, if the central plan prescribes that combating potential fraud on the part of the parents receiving benefit must be given priority over care-related arguments in favour of deploying staff, the carers will find themselves in a dilemma. Should they report the parents to the authorities? If they do this, it could damage their relationship with the young people they are trying to help. Some people will say that they must report the parents in question because this concerns public funds. But people providing care to youngsters who are the victim will rather opt for effective care for these youngsters. Clients, families and professionals do not always share all the available information due to fear of 'hidden agendas', e.g. that cost saving or legal arguments will carry more weight than care and support in respect of the care provided (Rutz, 2017). Besides a plan, professional action should also entail consideration of the best solution in each individual case. Dialogue and reflection in a safe environment are what is needed.

In the same way as youth care, when helping what are known as "care avoiders" we see that various organisations in sectors such as care, debt rescheduling, social security and mental healthcare are often involved. Each of these organisations frequently takes on part of the care, and they sometimes have to cross each other's borders in the interests of their clients. However, there is a considerable fear of getting into trouble with the supervisory bodies, which means it is up to coordinators, voluntary workers or "buddies" to help people cope with all the red tape and the jungle of professionals. They often exercise the power to overrule based entirely on the interests of the person requiring care.

The definition of proper care is partly determined by the views and conduct of those concerned. Oldenhof (2015) describes the relevant process as "borderline work". Youth care workers, civil servants, patients and voluntary workers conclude mutual agreements on quality, efficiency, safety and privacy, or they enforce these. These *boundary spanners* investigate what proper care entails in specific situations. In this respect, people's own views control the compromises effected through dialogue with stakeholders and through agreements with supervisory bodies. They are seeking 'moral scope' and what the parties concerned consider to be 'the right course of action' (Van der Pennen, 2016). In this connection, market logic (competition; negotiations on price and quality), the public domain (equal treatment; reliability) and civil society (loyalty; a caring attitude) are vying for priority and for 'the right course of action' (Brandsen and Karre, 2010; Putters, 2009). These are the people who have to break through the existing codes, regulations and convictions in

order to arrive at a compromise. This affects the social contract in people's minds: the perceived discretionary scope and the guts to use it.

To sum up, the locations as I have described in the foregoing are not merely 'places' and 'situations' where people strive to achieve proper care: they also make the foundations visible. The weighing up of public, private and professional interests is continually being fleshed out by negotiating, regulating and inspiring confidence in each other. This ensures that control and risks are shared and support sought. The social contract relies on the strength of these foundations. These examples make it clear that it does not automatically and invariably result in a legitimate outcome. It is relevant to learn lessons for the social contract today in respect of future care.

## 4 Moving towards a new social contract

'The social contract' is not merely a noun plus an adjective: it is in actual fact a verb. There is far less combined action on the part of fixed organisations in classic centrally-controlled processes of compromise-seeking than there was in the past. The boundaries between care and other parts of the social domain are continually being explored, as are the boundaries between the various stakeholders' responsibilities. Schuyt (2013) proposes that the historic path of the welfare state continually inspires the following period of time

*to redefine concepts such as freedom and equality, solidarity and social justice.*

We are seeking ways in which we can share social risks, power and responsibility in a *local welfare state*. In this respect, it also focuses on 'defining' the division of power and roles.

### **Working on a social contract**

There is a risk that the quest for a new definition of the social contract will turn out to be static despite the fact that there is a great deal of social dynamism. And this might be a disadvantage. Examples gained from practice show us that we continually have to respond to changing views in our society, as well as to changes in the networks in the social domain. To use the same metaphor, this continually means 'contracting'. This is carried out with courage, care and involvement by people in care institutions, neighbourhoods and networks. The social contract is developing in the direction of changeable forms with changeable coalitions. It is a contract in the plural form (Putters, 2016a, 2016b, 2017). The question is: who should profit and who controls? Rousseau regarded the social contract as inclusive and therefore intended for all citizens under equal circumstances. Although there is a great deal of continuity in public-private connections, there is still uncertainty in respect of this point. It seems as though we have to get a grip on the situation through learning, reflection and experimentation in a new combination comprising the government, the public and civil society organisations, rather than through detailed regulation. We need

anchor points to help us arrive at types of risk-sharing that enjoy public support, at variable moments and locations. I will specify below what efforts and skills are required for each anchor point in respect of the existing social contract.

#### **4.1 Vision of the local welfare state: roles and preconditions**

First point: one major difference with the existing social contract is the stronger focus on individual health and on transferring responsibility and decision-making authority to citizens, local authorities and market parties. This not only reinforces personalisation of service provision but also the 'claiming' of rights. It is characteristic of the changing relations between the government, the public and organisations, but it is also strongly based on arguments in favour of keeping increased care spending under control. And this means that many people perceive it as implementation of government policy. In this connection, they are sometimes addressed on the care they provide to others, sometimes as contract partners who are entitled to care and the obligations associated with it (e.g. patient compliance), and sometimes as patients who have to set up a care programme in collaboration with healthcare professionals.

Reassessment of the social vision does not mean that an unequivocal definition of the role of 'the public' and 'what we expect' from them can exist, either in respect of 'the government' or 'the sector'. In view of the dynamism with continually-changing stakeholders, we need guidelines to help us fulfil different roles at the same time. Or in other words: preconditions relating to provision of information, participation and influence, and the ability of local authorities, institutions and professionals to sympathise with the situation in which patients and their families find themselves. And this also means that practical and moral limits must be set in respect of what we can expect of people and what obligations the government can impose on them such as e.g. informal care-related tasks. Local authorities will have to conduct this debate on what the government and the public can expect from one another more regularly and more explicitly.

We need a social vision that provides guidance in respect of what the government and the public can expect of each other. This vision will have to be more locally oriented and go further than merely examining illness and poor health. In this respect, acceptance of local variety is essential, even though the central government's insight will still be required in connection with public support for measures in the welfare state and in the legitimacy of their impact in relation to fundamental social rights. For this reason, we need a great deal of information on healthcare practices and their outcomes, e.g. in terms of access to proper care. This insight must constitute the basis for improving practices, i.e. for learning supervision on the part of local and central supervisory bodies. In this connection, imposing uniform requirements might also result in more unequal outcomes, namely in a local sense.

#### **4.2 Defining (new) social risks and organising risk sharing**

Second point: we need to reassess the definitions of social risks and solidarity. Defective identification and cohesion among citizens serves to undermine mutual solidarity as a major foundation of the welfare state, and this in turn leads to separate

worlds. For a long time, the focus was mainly on the *haves* and *have-nots*, and compensation provided through care, work and income to enable the less fortunate members of society to participate. The social risks followed these classic dividing lines, and people were willing to share these risks with each other (Bovens et al., 2014; Vrooman et al., 2014). The dividing lines in respect of age, level of education and ethnicity seem to be intensifying even further. Nowadays, we refer to the *cans* and *cannots*, or in other words, the question of whether people genuinely benefit from care provision or care allowances, whether they can find their way around in the maze of regulations, and whether the right groups are taking advantage of the available facilities (De Beer, 2016; Van den Broek et al., 2016).

Young people who are paying for elderly people's care or their pensions must be able to rely on these facilities being available to them in the future too. The same applies to independent entrepreneurs, who do not build up much security in respect of social risks. However, people's willingness to participate in collective risk-sharing schemes, or in other words, to subscribe to the common interest and to make contributions for other people's benefit, will be undermined unless these people benefit as well (WRR, 2017a). The schemes in the welfare state do not yet seem to respond satisfactorily to this question, despite the fact that they still enjoy public support in our individualised society (Van der Veen et al., 2012).

The question which needs to be researched further is how we can define and share social risks in new ways, locally and centrally. And a great deal of local collaboration is required in this respect, with different and changing partners in the care sector as well as outside it (e.g. in sectors such as education, housing and employment). For example, healthcare cooperatives help give support to the needy, but people who are unable to find the network or to access it run the risk of exclusion. Are you part of the social contract, even if you do not make your needs and wishes known or if you are unable to find the way? We need new institutional and moral frameworks which act as links (Kremer, 2016) and which provide people with more opportunities to seek support, participate more in society and improve their social position.

### **4.3 Comprehensive health concept**

Third point: from a social and civic perspective, we need to broaden the concept of health. People's health is influenced by many environmental factors. As we discussed in the foregoing, this relates more than ever before to combined access to social, cultural and economic capital. The differences between those with a large number of resources and those with an equally large number of deficiencies are steadily increasing. This refers to the ability to think as well as the ability to act (WRR, 2017b), because in addition to intelligence and knowledge, it is important to be able to set objectives, recruit resources and cope with setbacks.

This broad-based approach to health gives rise to the question of what exactly forms part of the unique core of medical and other care nowadays. The difference with the existing social contract is that this no longer exclusively concerns medical matters. Connections with other domains in the welfare state are essential (the 'comprehensive view'). However, the medical sector cannot be held responsible for everything. Demarcation of the unique core of the medical profession is important

in order to be a partner for other parties. This requires reflection on one's own role and on collaboration with citizens and in the public domain. And this in turn requires investment in healthcare training (see also paragraph 5.3).

#### **4.4 More public participation as well as reassessing authorised agents**

Fourth point: many people strongly feel that decisions are made without consulting them, despite the fact that they are more highly qualified, have more information and technology at their disposal, and are often able to arrange their own lives. More decisive power can be located close to the people themselves (Schuyt, 2013). This presupposes greater participation instead of more administration. It presupposes setting objectives together instead of imposing such objectives on others.

But at the same time, people expect institutions to exercise control. There are some medical decisions whose outcome is never entirely foreseeable for the relevant patients. There will always be certain groups whose members are unable or unwilling to join in decision-making. Not everyone has the ability and opportunities to participate in these variable agreements and coalitions. If inclusion is a criterion for the social contract, we will still need "authorised agents", including case managers, "buddies" and health insurers. This requires administrative and social confidence when setting up participation for the interested parties and when providing guidance based on a vision of care and the role to be fulfilled by the public.

#### **4.5 Experimentalist governance with sustainable checks and balances**

There are considerable differences in power between individual citizens on the one hand, and care institutions and professionals on the other hand. In addition, many support pathways were set up on the basis of past decisions which are still making themselves felt even today. One example of this is the confidence that might or might not exist between people in respect of adhering to agreements (Van de Bovenkamp et al., 2016; Wengle, 2015). For this reason, power is generally accompanied by countervailing power (Tjeenk Willink, 2002), e.g. through participation on the part of professionals and the public in local practices and also on the part of authorised agents. There is a certain degree of hierarchy present in the existing social contract, or frameworks for decision-making and allocation of resources and facilities that are centrally controlled. There is greater variety and horizontal accountability in a network society.

In this connection, the central government cannot fulfil its constitutional care-related responsibilities by merely imposing obligations on information and monitoring in relation to centrally-established objectives. This will result in technocratisation and bureaucracy. We need basic principles for proper care which are outlined in policy objectives and discussed and shared with Parliament, as well as with institutions such as the Social and Economic Council of the Netherlands (SER) and the National Health Care Institute, and local partners when implementing this. There is still a centrally-managed framework in existence, although this will function differently in

the future due to decentralisation and privatisation. Responsibility for care and giving an account of this will be organised (or will have to be organised) at an increasingly local level. A parliamentary debate on the number of times residents of care institutions are officially allowed to go to the toilet is not going to resolve all the problems!

In care practice, a great many methods are being developed which also involve patients and citizens, such as *experience-based co-design* (Vennik, 2016), *shared decision-making* (Hilders, 2015) and types of patient participation (Van de Bovenkamp, 2010; Dwarswaard, 2011). These are based on what is known as recursive learning, or in other words, safe sharing of learning experience and implementing improvements in cases where no proper care is given (RV&S, 2016). This does not mean we have to abandon everything; it means we have to take practical experience seriously and join forces to learn about proper care. It might also result in new substantiation of *civil society*.

Preconditions are required for this. For example, all parties must possess the capacity and skills for conducting dialogue on the objectives and ensuring that their own efforts are verifiable. They must be willing to learn from one another and to focus on improving the situation when carrying out tests. This type of system will have to be scrutinised at regular intervals to check that it does indeed result in an inclusive social contract. It must be verifiable at local and national level instead of uncontrolled and without any obligations. Decentralisation does not automatically result in less; it results in a different combined action with the central government (Van de Bovenkamp et al., 2016; Van den Broek et al., 2016).

#### **4.6 Continuous knowledge sharing and dialogue**

The social contract is partly built on the idea of centrally controlled policy making and knowledge development. That is why we have the Netherlands Bureau for Economic Policy Analysis (CPB), in addition to the Netherlands Institute for Social Research and the Netherlands Environmental Assessment Agency. And this tells us something about the role assigned to science in the social contract. I am too familiar with the work carried out at planning offices to be able or willing to deny that they substantiate plans, or to be unaware that monitors and effect evaluations can be performative (Van Egmond, 2010). Policy often conforms with this. Sixth point: therefore, research is not entirely innocent either; it has to take the way in which scientific knowledge is interpreted and used very seriously. This requires continual dialogue with policy and practice (Bijker, 2017).

If citizens, civil society organisations and government authorities are given different roles and new questions on knowledge arise, the necessity for a certain adaptive ability will also apply to science. Where do good and bad practices develop and what is the norm? What do citizens feel about this? Can scientific knowledge be shared at an earlier stage and in a better way? If governance of the social contract has become much more a question of seeking objectives, experimenting and learning, the scientific approach and methodology will have to generate a different type of knowledge and enter into interaction with these rapidly-changing practices. At the same time, we should realise that the delaying effect of scientific research is a blessing rather than a problem. This is because learning requires time and attention.

# 5 A new governance theory on combined action

Although there is continuity of basic principles in the functioning of the social contract, the outcome is less certain than it was in the past. The path dependence of the existing institutional schemes ensures stability in the way in which care is implemented, funded and managed, but it is also important to reassess mutual expectations between government authorities, citizens and organisations, to define social risks on the basis of a broader concept of health, explore new types of risk sharing and solidarity, and share participation and knowledge in care schemes in a different way. Governance of care in the social domain is inevitably full of delaying factors.

The *local welfare state* is characterised by new relations between local and national authorities and the fragmented sector of civil society organisations and networks. They are increasingly responsible for jointly determining what is actually good and accessible care in practice and for whom it is intended. This results in a system of social contracts that are locally oriented and have differences in facilities and participation. The criterion is that it has an inclusive outcome and does not polarise, and that there is an outcome that citizens can identify with, in which they perceive they have a say and in which they are willing to participate. In particular, the social contract is a process that creates a great deal of work for all parties concerned in this respect. We need a governance theory that takes these changed circumstances into consideration. I will be elaborating this governance theory below.

## 5.1 Perspective: from rationalisation to justification

A social contract is based on the acknowledgement of equal positions for local and central authorities, citizens and civic society organisations that share decisive authority with one another. Localisation and the greater roles fulfilled by citizens and patients have resulted in the fact that power sharing requires new forms of countervailing power. Referring to 'the government' and 'society' results in far-reaching administration rationalisation and communication breakdowns with all kinds of care practices. If we decentralise today and re-centralise tomorrow, this will result in confusion or undesirable concentrations of power rather than in more checks and balances. After all, the administrative models exist side by side in current practice as well. It is more important to fathom under what conditions the parties concerned consider the process and the outcomes to be fair and just.

It is often the case that several values and arguments compete for priority, as we saw e.g. in the case of the care institution for elderly people suffering from dementia in Epe. The compromises reached at this institution are entirely justified in practice

(Oldenhof et al., 2014). Automatic reflexes from central supervisory bodies can damage this justifiable confidence because they view care from a specific viewpoint such as hygiene regulations or efficiency. We need a governance theory that focuses on a 'variety of goodness': in other words, what actually constitutes proper care and proper management depends on the values referred to by administrators, professionals and citizens, i.e. the way in which they combine these and arrive at compromises between quality and safety or efficiency (Stone, 1997; Van Hout et al., 2007). On the one hand, this means that the central government and supervisory bodies have to relinquish power, although on the other hand, it certainly does not mean they should withdraw completely. I will return to this division of roles below.

Stakeholders sometimes focus on *pragmatic legitimacy*, if groups are assisted in the short term with care or support based on personal interests. The outcome can also be in favour of persons who are able to assert themselves during informal home visits or in a district team. As opposed to pragmatic legitimacy, which can be acquired through actual information on the care provided, patient satisfaction surveys and benchmarks, *moral legitimacy* is based on acceptable and non-acceptable conduct (Rawls, 1971). In such cases, the focus is on the question of whether people actually do benefit from certain facilities, as is the case for the *cans and cannots*. We use the term *cognitive legitimacy* in cases where it seems sensible or logical to take a certain course of action, e.g. demarcating one's own field of expertise in professional codes, without being absolutely sure that citizens actually benefit from this (according to Cashore, 2002).

These arguments are often used in combination in practice. Boltansky and Thevenot (2006) refer to *justifications* maintained by stakeholders in order to justify their conduct and account for it on the basis of the market position, in the community or on the basis of a profession, a business or the family.

When carrying out research for this Chair, Box 2 can help us discover what is regarded as fair, just and inclusive in care practices, which parties hold these opinions, and what compromises are concluded. This will help us discover whether the outcomes of the social contract are substantiated and accounted for through sufficient checks and balances.

## Box 2. Justification of administrative conduct in implementation practices

generalities	values	state of worthiness	mode of evaluation
market	competition, choice	desirable, valuable, winner	price
industrial	efficiency, planning	effective, functional, dependable	functionality
civic	equality, welfare	representative, free official, statutory	votes, civic rights
domestic	tradition, hierarchy	benevolent, well-bred, wise, sensible	responsibilities
inspired	inspiration, creativity	bizarre, different, original, spontaneous	singularity, uniqueness
fame	public opinion	celebrity, prestige	PR, public recognition

Source: Boltansky and Thevenot (2006).

## 5.2 Objective: an inclusive society

Unless the central and local authorities reassess their definitions of inclusion and solidarity, partly based on citizens' perceptions, it will be difficult to maintain public support for the social contract. People's dissatisfaction increases if they experience injustice, incomprehensible regulations and unequal treatment (Putters, 2014 and 2016b). The authorities cannot merely refer to supervision regulations, freedom of choice or cost saving, which are often based on an idea of the average citizen fulfilling a great many roles simultaneously and doing whatever the government wants him to. References to good average scores in international rankings do not help either in the debate on substandard care, since this means very little to people who are continually deprived of the care they need. Learning from good and bad performance is more important. There should be less official jargon, thinking in terms of systems and using terms such as 'transition' and 'transformation', and more focus on the cares and problems arising in practice (Dekker et al., 2016a).

Terms such as 'personal control', 'self-sufficiency', 'personal responsibility' and 'positive health' are scattered around like confetti, but they have a different meaning within a community than they do on the market (Vermeij and Gieling, 2015; Vrooman et al. 2012). Accepting new concepts in policy with open arms too soon is risky unless the authorities have discovered what they actually signify in practice. Not everyone is able or willing to bear responsibility for all aspects of their own health. Sometimes it concerns people's lifestyles and health, sometimes the role of informal or voluntary carer, sometimes self-management and health skills (also with the aid of eHealth), and sometimes public or patient participation in the development of guidelines. Citizens and patients possess varying degrees of the skills and other resources they require - such as networks - to enable them to fulfil several roles simultaneously. Assumptions of self-determination and empowerment are not always realistic or desirable (Bal, 2008; De Klerk et al., 2015a).

The persistent difference in health between highly-qualified and less highly-qualified persons is striking in the group of vulnerable people. The differences between highly qualified and less highly-qualified elderly people will become increasingly apparent during the next few years in respect of quality of their lives as well as their consumption of care. These dividing lines can be intensified by increased reliance on the people who provide informal or voluntary care, who number 4.5 million in total (thereby taking overlap into consideration). This will definitely be the case if they lose their partner, or if they have no children living nearby who can help them (De Klerk et al., 2015a; Woittiez et al., 2014). Moreover, a greater degree of illness and a lower quality of life are frequent among elderly migrants (and their children). This is often accompanied by a lower level of education and fewer networks (Dagevos et al., 2013). Although it seems as if reliance on a social contract is desperately needed in such cases, this is not self-evident.

The following quote is an appeal in favour of personal responsibility and solidarity based on 'needs' (Schuyt 2013, taken from Noonan, 2006).

*Although there are sufficient resources available to provide for those in real need, it is not necessary for the government to provide the citizens with everything they want.*

Rawls (1974) already emphasised that 'needs' could give cause for political consensus and intervention, particularly if polarisation increases due to e.g. increased differences in health or perceived health. If insufficient attention is devoted to this, it will also have an impact on public support for government policy. If the accumulated shortage of resources increases, if people can no longer find their way, or if groups no longer benefit from their solidarity with others, this will increase inequality and give rise to greater polarisation and dissatisfaction. The purpose of a social contract is to prevent this happening (Miller, 1999).

### **5.3 Allocation of responsibilities: focusing more on the actual issues**

Thinking in terms of citizens and their need for care or ability to participate is essential for substantiated outcomes in the social contract, and sharing and allocating responsibilities forms an inextricable part of this (Gilbert, 2005; Van der Grinten, 2007; Tjeenk Willink, 2002). The social contract binds citizens to one another and to the government and civil society organisations in respect of social risks relating to illness and an insecure existence, and it also gives the contract partners a position in contributing to solutions. Whose duty is it to act, and in what way? I will examine these issues and demonstrate what 'work' is required of them and what knowledge they need to perform this work.

#### **Citizens: issues of healthcare quality and quality of life**

Not all deficiencies can be resolved by care and by other people. Connections with other life domains can be made in which commitment can sometimes be given. Although not everyone has the skills to be able to deal with this complexity, people can use their social, cultural and economic capital in addition to their "personal capital" (i.e. people's physical and mental health) to reinforce their social position. If people suffer from loneliness and social isolation, medication is not generally the best way to achieve more quality of life. In such cases, well-being, happiness, visiting one's children, going to the hairdresser or the barber, going for walks and receiving attention are often more important. People can take this into consideration themselves in plenty of time.

Nevertheless, care professionals must also be sensitive to this and be able to enter into dialogue with people on the quality of care and life. Otherwise, the question of which citizens can rely on professional help and which cannot will soon arise, as well as which citizens are therefore a partner in the social contract. If there is a group of people at the top who are able to achieve better quality with the resources at their disposal, this will erode public support. According to Van Lieshout (2017), this is more likely to happen if there are differences in the perceived quality of facilities than if the costs and personal contributions are raised. It undermines the inclusive nature of the social contract.

The preconditions for being a partner in the social contract in the event of certain social risks, such as illness or loneliness, must be clear. Examples include clarity on the right to information and participation (Marramao, 2012). In order to consider the significance of an accumulation or deficit of resources in respect of the role fulfilled by citizens themselves, we need sociological and health science knowledge. People's knowledge gained from experience in their various roles is important in order to discover how the quality of life and the quality of care relate to one another in the social contract, and what this might mean for implementing personal responsibility and participation.

#### **Care professionals: professionalisation and deprofessionalisation issues**

The ability to learn among professionals and in the care sector is put to the test by the wide range of care schemes and the emergence of new types of professionals and all kinds of intermediaries. This emphasises the need to safeguard the unique core of care professionals and medical science, and to carry out tasks in a different way to the one medical students may have learnt during their degree programme. It is not easy to leave action to other professionals or to the patients themselves, since they

sometimes need to take a refresher course and professionalise themselves. This might be perceived as deprofessionalisation. At the same time, it might also result in new specialisations in e.g. complex care of the elderly.

This has a considerable impact on all kinds of educational programmes ranging from university level to senior secondary vocational education, as well as on providing guidance to informal carers and voluntary carers and for patients themselves, e.g. when learning to depart from protocol in a responsible manner, concluding proper agreements with informal carers, sharing information and providing support to clients and patients. To achieve this, we need a strong training and knowledge infrastructure at national level and scope for active reflection and knowledge sharing at local level. This fits in with the role of professionals in an *enabling state* (Esping-Andersen et al., 2003; Hemerijck, 2013). In this connection, we need knowledge on the development of occupational groups and on experience in informal care and new manifestations of *civil society* (e.g. care cooperatives).

### **Local and national government and politics: solidarity and inclusion issues**

The schemes in the welfare state strongly depend on being able to deal with old dividing lines between work and capital via an insurance system. However, cohesion in our network society not only runs via the classic socio-economic dividing lines. Cultural identity, age, networks and the available skills are increasingly important for guaranteeing people's fundamental right to care. Not everyone benefits from merely receiving a care allowance or a certain number of hours' domestic help every month. Focusing on mobilisation of social networks as a solution for support might help, but it might also result in a blind spot for those very people who do not have these networks and who are the most vulnerable members of society (Kromhout et al., 2014; Pommer and Boelhouwer, 2016).

We need types of risk sharing which can help bridge the gap between the *cans and the cannots*. Since this cannot only be effected at local level, it seems we need a new combined action between national and local authorities. This collaboration has not yet been fixed after the decentralisation of care-related tasks. Despite catchphrases such as 'personal power', 'self-reliance' and 'personal responsibility', practices are invariably based on different assumptions on citizens' roles, without clarifying the roles fulfilled by the government. Greater freedom of choice and self-determination do not automatically result in greater solidarity (Van den Broek et al., 2016). Although many people are able to find their way about in our highly-qualified society, how inclusive is the social contract for people who are unable or unwilling to do this? And this is a big question at local and national level, including the role of the government and politicians.

Potential considerations for government intervention are of a classic nature. On the one hand, these are based on technical features, e.g. this refers to a purely collective product or service or to monopolistic production, while on the other hand, the reason is market failure and perpetual asymmetry of information (Olsthoorn et al., 2017).

This is frequently the case to a greater or a lesser extent in the care sector. However, if matters are more centrally regulated, this will mean that municipalities will become more and more of a regulatory helpdesk for the central government, despite the fact that our local network society requires horizontal countervailing power from citizens, civil society organisations and the business sector.

One potential scenario might be to allow the municipal authorities to generate income themselves through e.g. taxation, and to have this verified by the municipal council by making binding choices in consultation with organisations and residents, as well as setting local policy objectives, monitoring their impact, and submitting reports on all this in a democratic manner. Decentralisation without any transfer of such powers will mean that municipalities will merely become implementers of central policy. Nor will it succeed without a national framework for monitoring, training and knowledge development. Smaller municipalities in particular seem to be insufficiently able or willing to earmark sufficient resources for this.

The House of Representatives and municipal councils set frameworks, although *civil society* and the business sector are also party to this. In this connection, we continually see 'awkward' differences arising between municipalities, e.g. if an informal visit from a municipal official goes wrong, or no help is given to the needy person in question. In addition, discussions are being held on people who do not complete a course of treatment or who apply for too much care. Moreover, private initiatives such as care cooperatives are not equally accessible for all citizens. In order to guarantee fundamental social rights, it is relevant - at national as well as at local level - to be aware of the degree of willingness among citizens to participate in collective schemes. We need sociological knowledge in order to monitor and improve specific local practices, but also to monitor the degree of inclusivity of the social contract at national level and to reassess it where necessary. After all, if solidarity benefits groups of people perceived by others to be less entitled to such benefit, or not entitled to it at all, this may undermine the moral frameworks for care in the welfare state (Van Lieshout, 2017).

### **Civil society organisations and administration: participation and governance issues**

We will always need a vanguard ('elite') comprising care professionals, authorised agents and administrators whose job it is to e.g. organise risk sharing and thereby give a voice to those partners in the social contract who are unable to do so themselves. They will continually have to prove their own worth because 'tension always exists between those who exercise power and those who participate in a society' (Grappnerhaus, 2017). A great many efforts are made to achieve *shared decision-making*, patient and citizen participation and involvement, but people expect official institutions to exercise governance as well. Moreover, if the outcome is unsatisfactory or if members of the public are not involved in major decisions, these citizens will oppose them.

Re-allocating responsibilities in the care sector requires more than merely announcing self-management or new working methods, e.g. in district teams. Technology can help to give shape to the changes, but even this is not self-evident. There are a great many examples of this. For instance, it emerged from the online care community *MijnZorgNet* that the online guide and the exchanging of knowledge and experiences

with fellow sufferers are particularly helpful and supportive for patients in assuming personal responsibility. With respect to other recommendations and functions, the physician still remained chiefly responsible, and patients did not make use of the online community (Vennik, 2016).

Therefore, the call for involvement and co-production or co-creation (Voorberg, 2017) does not automatically mean that institutions lose their authority, but it does mean that dialogue becomes more important (Putters, 2015).

## **5.4 The necessary infrastructure: more knowledge sharing and deliberation**

We still lack a great deal of knowledge at national and local level on how the social contract works in a *local welfare state*. The knowledge infrastructure is only set up to a limited extent at present. To be able to monitor what working with district teams really means in respect of people's self-sufficiency, we need good baseline measurements, long-term research from several different lines of approach, and the unique stories behind the figures. These can be obtained by making an in-depth analysis of citizens' perceptions, including e.g. what exactly participation in social networks means in practice.

The most vulnerable members of society are the ones with the smallest networks. We do not know very much about these people, but they are still partners in the social contract all the same. This also applies to those who are increasingly expected to be able and willing to combine work and care. And it applies to local policy officials, who are expected to possess sufficient expertise to be able to reach care policy target groups efficiently (Pommer and Boelhouwer, 2016).

These assumptions and the stories about desirable and undesirable differences in implementation practice will have to be confronted with each other in order to achieve improvements. In this connection, the WRR (2017b) advocates greater insight into citizens' capacity for thought and action:

*[A] more realistic approach to citizens and policy [...] may contribute to a new interpretation of the social contract between the government and the people which will then be necessary. This is because a government which does not take the limitations attaching to citizens' capacity for thought and action into account is regarded as unreliable.*

This latter point impedes the functioning of the social contract. Use of knowledge experience, experimental learning and *citizen science* could help prevent this (Den Broeder, 2017). Tools such as *community reporting* and *people voice media* can be deployed to reach people who do not consider going to a helpdesk or research panel to be self-evident. In such cases, scientific knowledge develops in interaction with policy and practice by combining stories from the public with insights from various disciplines and confronting them with each other. According to Wiebe Bijker (2017) in his valedictory lecture, this dialogue and these reflections will result in increased knowledge if the different parties actually listen to one another.

New interfaces between research, policy and practice might be able to mitigate the considerable expectations on *evidence-based* policy to a certain extent by making it

clear that society is governed by more than policy alone (Putters, 2017; RV&S, 2017b). Only a limited causal effect can sometimes be attributed to government intervention, e.g. because people's health depends on a large number of environmental factors. However, this does not render government policy or scientific knowledge development superfluous. We do need greater dissent and more platforms for deliberation (RV&S, 2016, 2017b). Centrally-imposed benchmarks and monitors generally do not take local differences into consideration, although they usually form the basis of sanctions if performance is not sufficiently uniform. Dialogue and listening to one another is something else again.

Knowledge development requires time and support, particularly in respect of target groups whose members are vulnerable and limited in number in a local sense. However, such investment in the institutions of our social contract is necessary in order to maintain confidence and public support (Bijker, 2017; Van de Bovenkamp et al., 2016). In a *local welfare state*, this requires willingness to guarantee knowledge development on the part of the central government and national parties in the sector, and it requires local authorities and parties in the sector to guarantee knowledge circulation and reflection by creating sufficient scope for counter-narratives and dialogue. This can result in countervailing power in cases where power is exercised, which in turn might be a source of support when setting up future monitoring and evaluations in the social domain.

## 6 Signed, sealed and delivering

*The welfare state is in danger, but part of that danger is our own fault: what was presented as a guarantee for collective social welfare and as fundamental social rights for individual citizens is in fact merely a too-optimistic view of a temporary redistribution of social wealth acquired over a very short time. The welfare state would have been endangered anyway, even if the economic crisis had not occurred, only this would have happened slightly later on. Control of the care system and redistribution of social wealth will remain tasks for the welfare state in the future as well, although the guarantee of collective social welfare will tend towards a more limited tenor and the achievement of fundamental social rights will tend towards a lower level.*

This quotation is from Paul Schnabel in 1983. Like the quotation from Jo Hendriks at the beginning of this lecture, it confirms that the social contract is primarily a verb continually requiring input from each of its contract partners: from a more static and more centralistically-defined social contract to a more dynamic quest defined by networks; from more solid to more fluid relationships; from reciprocity based on rights and positions to reciprocity based on connections between ever-changing partners, and enlargement of care to include other facilities in the social domain; from thinking in government, market and society logics and rationalities to thinking on the basis of justifiable confidence; from a protective welfare state with the right to compensation for social risks to an investment state focusing on reinforcing its resources; from knowledge development for policy and practice to dialogue with policy and in care practice; from a Chair on care administration to a Chair on care in a changing welfare state. Van der Veen and Yerkes (2012) emphasise the inevitability of this:

*Therefore, a new welfare settlement appears to be gradually developing; one based on continued support for sharing social risks, which also extends to new social risks; one based on a notion of social solidarity that emphasises (obligatory) reciprocity and which is stimulated by bargaining and exchange practices and the accompanying culture of the reconciliation of conflicting interests associated with a corporatist welfare state. This new welfare settlement is characterised by a focus on social security issues focused on participation rather than income protection, through the increase of individual responsibility and the development of new policies of reciprocity.*

The question is whether we, who live in an increasingly fragmented network society with so many negotiations, can still justifiably refer to 'the social contract' in 'the care sector' or 'the welfare state'. It seems to bear a greater resemblance to a system of social contracts. In respect of policy, we need connections between national and local authorities on the one hand and social parties and citizens on the other

hand in order to give this a legitimate interpretation, or in other words, to ensure that this dynamism does not result in exclusion of and polarisation between groups in our society. I would like to add that we need greater contact with citizens' own perceptions in this respect, e.g. through greater involvement and more dialogue and a firmly-enshrined knowledge infrastructure. The functioning and outcomes of the system of social contracts will have to be monitored through scientific research.

*Signed, sealed and delivering*, the title of this lecture, means in retrospect that solidarity and freedom of choice in our welfare state are centrally controlled and regulated, with relative autonomy for citizens and parties in the sector. However, if large groups - central or otherwise - no longer obtain any benefit from their solidarity, or if they are no longer able to comprehend the system, this will erode public support for it. Calling for more and more freedom of choice or personal responsibility cannot provide all the answers to this either. It might even do injustice to opinions held by members of the public on shared responsibilities for care between the government and the citizens themselves, as well as to the actual divisions between people who are able to make choices and people who depend on others.

Encouraging people to participate instead of protecting them requires a broader approach to health and care in the social domain, as well as continually linking care with local traditions and available networks in which people have a say. This is a question of investing in individual resources and in close-knit communities as well as national and local government policy. Local policy-making will have to focus more on learning and improving outcomes, or in other words, the results in terms of proper care and support. This requires nationwide support in the shape of training courses, knowledge sharing and guaranteeing fundamental social rights.

In this respect, *Signed, sealed and delivering* is also intended to be active and prospective, in the sense of being committed to finding new types of risk sharing, involvement and dialogue in an era where the division between the *haves and have-nots* and the future *cans and cannots* is widening. The combination of socio-economic differences and less adequate social cohesion may reinforce people's feeling that they are not part of society and that they do not benefit from the social contract. This serves to undermine the welfare state as a whole, particularly public confidence in care policy and administration.

# 7 Research and education agenda

The social contract in the care sector results in a research and education agenda, while at the same time realising that this also affects a broader social agenda.

## Academic challenges

We will have to study backgrounds and developments for policy in the care and service sectors in order to gain a better understanding of them (*science of policy*), and we will also have to seek guidelines for change and improvement (*science for policy*). The sociology of policy helps us gain an insight into how people and organisations behave. Public administration helps us in respect of governance issues (Buse et al., 2006; Van de Donk, 1997; Putters and Van der Grinten, 2001) and it also helps us clarify types of behaviour and opinions at institutions and relating to policy. Research into locations where the social contract can be found in care practice can be classified as follows:

- research into **arrangements of** the social contract; how public, private and professional interests merge and how risks are shared in structures and processes;
- research into **citizens'** perceptions, in relation to their own views on health and solidarity as well as to the division of roles and power (participation and dialogue) and outcomes in care and support.

The purpose of this Chair is to contribute towards filling up a number of gaps in our knowledge on care policy and governance in a changing welfare state.

1. We are seeking the added value of public and private connections in the arrangements of the *local welfare state*. If we operationalise those parts of the social contract (e.g. broad concept of health, involvement, experimentalist governance and knowledge sharing), we can analyse how public, private and professional interests are shared, as well as stakeholders' views and attitudes in this respect. Tim Kind's research into the changing relations between professionals and citizens in the *local welfare state* gives us plenty of opportunities for this. What specific significance does the movement of a welfare state in the direction of an investment state have in terms of outcome for accessible, effective and satisfactory care and support? Will this give rise to new interpretations of what used to be known as *civil society* (maatschappelijk middenveld in Dutch)? Working on this EUR-funded REI project (*Research Excellence Initiatives*) in collaboration with our colleagues at the FSW during the next few years is a most inspiring opportunity for me.
2. We are studying the social contract as a 'procedure': an activity that unites stakeholders and their interests, whereby legitimacy is continually sought. Standards for proper administration are then included in the interaction between policy, administration and environment (Lawrence and Lorsch, 1967; Meurs, 1997). Multiple administration is not compatible with the imposition of standards and objectives by a higher authority; it accords more with a goal-seeking and standard-setting attitude. Research carried out by Sophie Bijloos and our

colleagues at the Erasmus Centre for Health Care Management into the role fulfilled by care administrators in this respect, as a link between policy, care and society, will augment our insight into this quest. The same also applies to research conducted by Betty Steenkamer into the legitimacy of population management in care, in which the researchers examined what constitutes proper care and what networks would be useful in this connection. Our collaboration with the National Institute for Public Health and the Environment (RIVM) and Tilburg University will increase our insight into the outcomes of the social contract.

3. In view of the more local nature of the social contract, research into the local welfare state in towns and cities is an interesting site for comparative empirical research. Examples include towns and cities in other countries where the ageing of the population has progressed further than here in the Netherlands, and where support for citizens has been regulated differently, e.g. in Germany and Belgium. I would very much like to encourage new research in this field during the next few years.
4. The experimentalist and searching features of the social contract require knowledge that contributes to insight, effect and development in respect of the governance appertaining to it (Sabel and Zeitlin, 2012). For example, this could be through academic workplaces where science, policy and practice converge. Examples include the academic workplaces at the Tranzo institute in Tilburg, or the *Academische Werkplaats Toezicht* (Academic Workplace for Supervision) at Erasmus University's Health Care Governance department. Research into e.g. district teams or informal home visits can be studied *in depth* at these workplaces, whereby science can contribute to improvements in practice (known as *crafting communities*). The development of patient and client participation and the appurtenant resources such as information and support can be further investigated there.

## Methodological challenges

A qualitative researcher who has the honour to be head of the Netherlands Institute for Social Research (SCP) also has a moral duty to include a methodological reflection in this lecture. Can we combine research traditions? I can honestly say that I sometimes find myself in the middle of extremes. The Health Care Governance section is strongly ethnographically oriented. The SCP carries out a great deal of quantitative research, but it is also conducting an increasing amount of qualitative research in order to interpret the stories behind the figures. This serves to reinforce one another, and this research agenda challenges us to do this.

I am in favour of a variety of qualitative and quantitative research methods for conducting research into the scope and functioning of a social contract in a changing welfare state. Citizens' and organisations' behaviour at institutions can be studied in *in-depth* case studies, but also using observation research as a tool in which researchers visit these institutions, observe the situation there and note down how the social contract functions and is accounted for in practice. In comparative case studies, comparisons can be made between projects on district and neighbourhood-oriented work, informal home visits or various legal forms. Longitudinal movements can be monitored and analysed through trend analyses and survey research, e.g. in relation to informal carers' welfare and their burden, citizens' views on personal responsibility, and developments in participation in social networks

or voluntary work. These are trends to be substantiated which are relevant in respect of setting up new schemes in the welfare state. It provides an opportunity for making larger-scale quantitative statements on ways in which the social contract functions and the influence of policy changes on this.

The SCP's Cultural Changes data collection - and new data collections too - can help us obtain a picture of the components of the social contract I have outlined. We also need to reflect upon existing monitors and evaluations. After all, if the compiling of knowledge remains based on the old classifications although the actual situation is changing in practice, this can still make itself felt in policy (Van Egmond, 2010). All researchers should impose this self-reflection upon themselves.

### **Challenges in education**

As is the case in so many social sectors, fragmented thinking and acting can be seen in healthcare research as well. Institutes such as our own Erasmus School of Health Policy & Management are obliged to examine more than the physical and mental condition of people and organisations, financing and administration of care. We have to prevent ourselves becoming part of that same fragmentation we refer to in our research, despite the fact that views on health, healthcare and experiences in this field are changing at tremendous speed. At our institute we have a solemn duty to keep abreast of these and continue investigating them. The emphasis will have to be more on care in combination with other facilities, and on discovering what health means to members of the public. We must do this in collaboration with our students as well as with the city and region of Rotterdam. We, too, should welcome the social model for care and support with open arms in our work at the university, in addition to the pedagogical model which will enable us to make better use of innovations relating to knowledge sharing and didactic skills.

University professors are not only preceptors; they always have to have a bit of the schoolmaster about them as well, if only because I personally feel this is the most wonderful profession in the world. After all, we are the ones who train people who will be responsible for social contracts in the future.

# 8 A word of thanks

**Rector Magnificus, ladies and gentlemen,**

This particular university professor has a great deal to be thankful for as far as the Dutch welfare state is concerned! I grew up in the countryside, in a loving family of outdoor people - captains of oil tankers - where the word 'studying' was not part of the family's vocabulary. The love and support I received from my parents and my brother have always been my personal compass. The Dutch education system with its wonderful teachers, like Mr Versluis, headmaster at OBS de Peulenwiek Primary School in Hardinxveld-Giessendam, and Mr Braat who taught Social Studies at the Willem de Zwijger Scholengemeenschap Comprehensive School in Papendrecht, encouraged me to develop a critical attitude to society and a sense of commitment to others. My thesis supervisors Tom van der Grinten and Walter Kickert gave me the incentive to do this in an academic environment. This was partly possible thanks to part-time jobs in the catering sector and as student assistant, but in particular, it was thanks to a form of government assistance which used to be known as 'student grants'. I learnt social skills from my friends in the scouts. So you see I was very lucky to have all these opportunities and to make use of them: right up to my second lecture today. I'm simply happy in our welfare state. And my criterion for the future is that everyone is offered equal opportunities or similar ones, and is able to use them too.

I would like to thank the Executive Board of Erasmus University Rotterdam, the Administrative Board at Erasmus MC, and the Boards of Erasmus School of Health Policy & Management and Erasmus Trust Fund for establishing this endowed Chair and for their confidence in me. I've already started this venture, but I'm so much looking forward to the rest!

My dear colleagues at EUR - particularly those at Public Administration (FSW) and the Health Care Governance section (ESHPM): you have been my academic home base for almost twenty years now. Except for five wonderful years in Tilburg. I would like to thank all of you for your good-fellowship and inspiration. And a special thank you to Walter Kickert and Tom van der Grinten for the opportunities they gave me and for what they saw in me. To Pauline Meurs, for being so close to me every step of the way in scholarship, politics and administration: from my doctoral committee to the NVZD Chair, from the Supervisory Board at Rijnstate Hospital to the Netherlands Organisation for Health Research and Development, from the Senate to the independent knowledge institutes of the Ministry of Health, Welfare and Sport, commonly known as the Netherlands Institute for Social Research and the Council for Public Health and Society. We enjoy ourselves together and you give me so much support, in the same way as our third *Musketeer*, Ronnie van Diemen. To Laurens de Graaf, whose unflagging enthusiasm and keenness - both substantive and when linking research with practice - are a continual source of inspiration and support. My past and present PhD students also give me so much support. Those 'PhD weekends' were always intended to promote your research. The fact that I was able to discuss this lecture with you during the last PhD weekend this summer proves that we have all grown up and become adults. Let's carry on the way we are doing.

I left the world of politics in 2013, but I cherish all the friendships I had at that time and the mirrors we held up to the aldermen of the municipal council and to the cabinet from the Senate. Always endorsing critical arguments, but with commitment and ideals. I thank the PvdA (Dutch Labour Party) for assigning these roles to me. The fact that the welfare state and the PvdA form an inextricable part of my life may possibly tell you something about what the Netherlands used to be like when I was growing up. And the fact that I now have the honour of being head of the Netherlands Institute for Social Research, which has been playing a major role in monitoring Dutch citizens' well-being ever since I was born in 1973, has completed the circle as far as I am concerned. My generation grew up in prosperity, with a great many opportunities for a good life. And this means we owe a debt to previous and future generations.

At the SCP, we set ourselves the ultimate objective to use our scientific knowledge to contribute to better government policy and a better society. I am not a visitation committee, but in my view, you achieve this ultimate objective every single day. I look forward to working with you to build this further during the coming years.

And now I am an administrator as well as a researcher, which is really a lot more complicated than studying it! So I would like to thank Rob Bijl who is standing right next to me. Together with our colleagues, we will make sure that Dutch people, politicians and policy-makers keep looking in that mirror. We will carry out this honourable mission to provide countervailing power with all the dedication and conviction at our disposal.

But we will not succeed without support. Trix, Julia, Somaie, Jenny, Victor, Janneke, Lot, Anne, Ljuba and Henry are absolutely indispensable for me. You know more about me than Marhijn thinks. Let's keep it that way. I would like to thank all of you for always being close at hand in good times as well as in sad times. This includes Eva and Antoinette who mould my conscience and keep me on the right track. And I would like to thank Mirjam, Mérove, Alice, Rob, Roland, Lieke, Jeroen, Maarten, Thomas, Jules, Sophie, Tim, Tom, Laurens and Pauline for all their comments on previous drafts of this lecture. My grateful thanks to Wouter, Marjolijn, Anouk, Stasja, Irma, Hester and Vimala for the fantastic support they gave me for this lecture. There are so many more people I would like to say 'thank you' to, unfortunately I cannot mention them all individually. So I'll just say: Thank you, everyone!

To Werner Brouwer: I'd like to thank you for your keen spirit, your unflagging enthusiasm and resolute action. You are always there for everyone, you never let them down. I ought to have given you this bottle of port a hundred times over. But today I can finally hand it over to you.

To Roland Bal: Thank you for your confidence in me. I often have the luck to be in your company on Fridays and this invariably means I start the weekend full of new insights. I'd like to thank you for your personal, substantive and dedicated leadership. This makes our section our home base.

A very special thank you to my parents for all the opportunities they gave me and just for being the people they are. I love you very much. And many thanks to Barrie, Cora, Jeroen, Timon, my family and my in-laws, without whom I would not be

standing here today. The fact that my best mate and my friends are here again today is fantastic, in fact it's nothing short of a miracle.

And finally, my beloved Marhijn. You weren't able to be here at my last lecture, which is actually the only justification for me to be standing here a second time. So today I'd like to link the love of my life with everything I love in life.

DIXI: I have spoken.

# Summary

## **Signed, sealed and delivering: paving the way to a new social contract in healthcare**

The social contract in Dutch healthcare consists of a system of agreements between government, societal organisations and citizens, governing the accessibility, efficiency and quality of care. In order to protect citizens against social and health risks they share power and responsibilities in welfare state arrangements. These arrangements, as well as the experiences of patients and clients within them, are central to *Signed, sealed and delivering*.

Welfare state governance in the Netherlands can be characterised by a mixed model of central government regulation, regulated market forces and professional autonomy. The recent decentralisation of care responsibilities to local government, as well as the wider call for citizens to take responsibility for their own care, lead to a shift in focus from risk protection to investments in the resources that facilitate societal participation. The international welfare state debate calls this the change from a more protective welfare state to a more active welfare state (or investment state).

In the Netherlands these changes also address a reform from a highly centralised package of agreements to more individual and local variation in care and support provision. Although central management still plays an important role, now stakeholders in local and regional networks themselves have to focus much more on agreeing what good quality care is, and who receives it. This requires balancing public, private and professional interests and demands in the organisation and management of local healthcare arrangements and processes. The involvement of patients, clients and their social environment is crucial for achieving good care and for living up to their expectations.

So the social contract and the relationships between its partners show several shifts at the same time: away from a static and centrally organised social contract towards a more dynamic and networked search process. Away from rigid relationships towards more fluid relationships. Away from reciprocity based on statutory rights towards reciprocity based on connections between ever-changing partners and a widening-out of care to include other social services. Away from thinking in terms of the logics of government, market and society towards thinking in terms of legitimate trust. Away from a welfare state that protects through social security entitlements, towards an investment state that aims to strengthen resources. Away from knowledge development for policy and practice, towards a more intensive dialogue between policy, science and care practices.

The question is whether, in a fragmented and network society characterised by so much negotiation, we can still speak of 'a social contract' in 'the healthcare sector' or 'the welfare state'. Rather, what we are seeing appears to be a 'system of social contracts'. And the key point is whether, to cite Rousseau, this continues to be an

*inclusive* social contract. In order to prevent exclusion and polarisation between groups in society much more insight is needed into the experiences of citizens, for example through more feedback and dialogue and a well-established knowledge infrastructure.

*Signed, sealed and delivering* means in retrospect that the Dutch welfare state is still centrally managed and regulated on the basis of both solidarity and freedom of choice, but with relative and increasing autonomy for citizens and the other actors involved, such as local governments. When significant groups are no longer convinced of the benefit of their solidarity or no longer understand the changing system, public support for it will drain away. Proclaiming greater freedom of choice or personal responsibility does not provide a full answer to that. In fact, we see it may even undermine the public's inclination to collectively share social risks and responsibilities. It may also strengthen the inequalities between people who are in a position to make choices by themselves and those who are dependent on others.

So *Signed, sealed and delivering* is also active and forward-looking, demonstrating commitment to finding new forms of (local) risk-sharing, participation and dialogue in an era when the differences between the *haves* and the *have nots* are widening. The combination of socio-economic differences with less social cohesion and increasing socio-cultural polarisation may enhance feelings of not being part of society and not benefiting from the social contract. The division between the *cans* and the *cannots*, between those who are really able to participate in a more complex society (sometimes with some support) and those who are not, becomes more visible. That could undermine the welfare state as a whole, and certainly the confidence in the way that care is arranged and managed.

Activating citizens rather than protecting them requires a broader approach to health and social care, but also connections between care and local traditions and existing networks in which people already have a say. For example in neighbourhood care or volunteer networks. This is a matter of investing in individual resources and in solidarity within communities, as well as of national and local government policy and support. Local policy-making will need to redirect its focus more towards learning and improving outcomes – in other words, what works when it comes to providing good care and support? National-level support will also be needed when it comes to training and education, knowledge sharing and safeguarding fundamental social rights. The research agenda presented here addresses both the functioning of this local welfare state, as well as the experiences of citizens.

This Inaugural Address focuses firstly on the origins of the social contract in healthcare, the changes that have occurred in the way it works, and the way it is perceived by citizens. We will then explore how the social contract is reflected in today's care practices, along which fixed points it could evolve and which management philosophy may be appropriate for the welfare state as we move forward. It concludes by outlining an agenda for research and education.

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The social contract in care traditionally comprises a system of agreements between the government, civil society organisations and the people on accessibility, efficiency and quality of the care provided. *Signed, sealed and delivering* focuses on the care schemes and perceptions arising from this combined action.

The Dutch welfare state is characterised by a mixed administrative model of central government control, regulated market forces and professional self-management whose objective is to protect citizens against social risks. The decentralisation of care-related tasks to municipalities and the call for greater personal responsibility on the part of citizens means that today, the emphasis is more on investing in resources that enable people to participate in society.

How does this combined action function in current care practices, and what are its outcomes for e.g. the differences between the *cans* and *cannots*? How will this affect citizens' expectations from the government and civil society organisations, as well as their willingness to share social risks collectively and support the social contract?

In *Signed, sealed and delivering*, Kim Putters examines the road leading to new types of risk sharing, involvement and dialogue between local and central government institutions, civil society organisations, citizens and science.