ISSA Proceedings 2010 - Constituting The “Good Patient” - The Effect Of “Clustered Argumentation” In Dutch Personal Healthcare Budget Policy

1. Introduction[i]

Public policy proposals for radical transformations often draw on a large number of premises. In this paper, we show that argumentation is complicated by what we call a “cluster of arguments”, of which the parts are not evaluated independently, but seem to be either accepted as a whole or rejected as a whole. Our case study examines one such cluster. The case concerns the introduction of a personal budget for healthcare in the Netherlands. This implies that, for particular types of treatments, citizens can opt for receiving a budget that is allocated for their case directly to their bank accounts, rather than receiving care “in kind”. Our analysis is based on a study of the key policy reports that constitute this discussion, as well as on a confrontation with the academic literature.

The focus of our analysis is on how the personal budget policy affects how the patient is constituted as a healthcare actor. The patient seems to be attributed a new role. We argue that discussions on this new role in fact aim to constitute a new subject of healthcare, a “good patient”, to use a term that was introduced by the Dutch Public Health Council (RVZ 2007).

We approach this topic by first presenting the interconnected expectations about the subject, its surroundings and the interaction between subject and surroundings. We build on earlier work on expectations in healthcare policy (Mensink & Birrer 2010). We proceed by analysing the argumentation around problems that were raised by actors in the discussion. Many of the types of argumentation we found can in fact be described as what we will call “evading mechanisms”. Evasion does not point at purposeful attempts to mislead other actors. We merely describe mechanisms that can be observed around a particular argumentation cluster. After going over these mechanisms, we unfold how the "argumentation cluster" of this discussion can be understood. We show how the complexity and interconnectedness of premises leads to ineffective handling of criticism by the discussants.

We use Michel Foucault's work as a starting-point for the discursive constitutions of subjects (see e.g. 1977; 1982; 2008). Acknowledging that a subject is constituted this way counters the modern-liberal idea of the subject as an autonomous free-floating entity. We extend Foucault's usual approach by including arguments that fall outside the dominant discourse, which puts this discourse in a different light.

On the basis of our analysis, we can first ask whether the subject that is sketched in political discussions surrounding the personal budget is deemed realistic. Secondly, we can assess what clustered argumentation implies for the subject, in the light of normative oppositions between the dominant discourse and the "non-dominant statements" we include.

Because of the nature of our analysis, we translated a substantial set of statements to make this Dutch discourse accessible to an English-speaking audience. By giving a detailed analysis of political argumentation, we try to go beyond popular accounts of the personal budget. The argumentation clusters we identify are not universal. Nevertheless, they provide insights into how governments and industry argue to deal with supply and demand driven models of health care delivery. Furthermore, the notion of subjectivity lies at the heart of critical/cultural, rhetorical, and argumentation-based analyses of health care controversies.

2. The good patient

We start by analysing how a new type of patient was proposed in the policy for a personal healthcare budget. We consider this the dominant discourse in this study.

The personal budget was put on the political agenda in the late 1980s (Tweede Kamer 1988)**[ii]**, by advocates for disability rights and a vice-minster of the liberal conservative party (VVD). In 1995, experiments started for certain types of nursing and care. Soon, the budget was drawn into a broader policy discussion regarding the perceived crisis of ever-rising exceptional medical expenses. It was seen as a wedge to break open this supply-oriented system, by granting force to the demand-side. The scheme was fundamentally revised in 2003, and again in 2007, with the introduction of the new, municipally managed Social Support Act (WMO). The latter mainly connected the budget to the discourse of citizen participation in society.

The initiators aimed to use the budget to ‘overcome signalled bottlenecks of organisational nature in the homecare offered to handicapped people, such as insufficiently flexible support, or an excess of care providers’ (1988, p. 14). After introducing the scheme, however, argumentation shifted considerably, incorporating more macro-political elements and societal challenges perceived by subsequent governments.

In order to counter these challenges, government used the personal budget as an instrument to attribute a new role to the patient, or citizen. This “new healthcare subject” is expected to bring about the changes that were deemed necessary. We use the Public Health Council’s term “the good patient” to denote this new subject. Nevertheless, we point to a broader set of requirements than the council does. Initially, the term referred to having proper conduct manners, to meet business obligations and to co-operate in treatments (RVZ 2007, p. 7). We draw out the rationale that is provided for the constitution of such a subject, highlighting how this relates to a number of general challenges. The new subject is a rational consumer, who adopts sovereignty over his/her own health. (S)he is supported by government and society in continuously re-evaluating the quality of providers, in order to put pressure on the walls that surround the healthcare institution.

2.1. More control by the citizen on healthcare

The disability rights movement has called for a more influential role of the patient, or citizen. Bulmer, for instance, has formulated the “cash position” most strongly, arguing that ‘cash gives choice and dignity whereas welfare systems enslave’ (Bulmer 2008, p. 47). Many authors take a similar normative stance (see e.g. Morris 2002; Timonen et al. 2006).

Different ministers positioned the subject as a client of healthcare providers – ‘client sovereignty’ (2000a, p. 6) – or as a consumer of healthcare products or services – ‘consumer sovereignty’ (2004a, p. 13). The notion of self-interested sovereignty is central to modern, liberal conception of subjectivity, as Foucault highlighted (Foucault 2008). Already in the 1980s, the then-vice-minister argued that: ‘even though [the organisations of people with a handicap] prefer the term “person-bound budget”, I will still use the term “client-bound budget”, considering the orientation on the person and the community’ (1988, p. 14). However, is a budget more focused on the person if it is called “client-bound” rather than “person bound”?

Alternatively, the subject is positioned in the role of employer of healthcare workers (e.g. 1988; 1998d). In the literature, the notion of a citizen-employed personal assistant is often portrayed as an ideal model (e.g. Morris 2002). It seems, however, that employment is seen as a consequence of accepting the responsibility of a personal budget, rather than an objective that was purposefully sought.

Relations to care providers are primarily conceived of as economic in nature (Kremer 2006). Two types of relations need to be distinguished. First, there are those that always had an economic component, i.e. formal care providers offered a product or service to a citizen, in return for a financial reimbursement that was received from a third party. The change in such relations is that the payment relation changes: the citizen is now handling reimbursement. When it comes to this type of relationship, the main arguments in favour of this new arrangement that are given are: (i) the sense of self-sufficiency and autonomy that it provides (1988; MDW-werkgroep AWBZ 2000b), with a particular focus on choice (1988; 1998c), (ii) the practical possibility of making effective decisions in terms of organising healthcare (1988) and (iii) the expectation that the costs of a personal budget will be lower (1998b).

The second type involves informal care situations, for which, previously, no financial reimbursement was available. When it comes to economising this second category, another set of arguments is provided: (i) informal care is generated on the basis of a ‘legitimate need for care’ (1997, p. 5), (ii) in part of the cases, more expensive professional care can be avoided because of the availability of informal care (1997e; 1998a; RVZ 2005a), (iii) informal care is highly valued by the patient, and is made attractive by being financially rewarded (Ramakers & Van den Wijngaart 2005b), (iv) paying informal care givers opens up a previously non-existent labour market (2005c), (v) two third of budget holders paying for informal care still receive additional unpaid care from the same providers

(Ramakers & Van den Wijngaart 2005a), and (vi) the vice minister stressed that we have to take better care of informal care givers, as there are many known cases of burnouts (2005b). Particularly in the light of the new labour market and the potential of a “free” care surplus, this last issue gains economic relevance: burnouts are expensive for society, as observed in related policy-discussions (TNS NIPO 2004). It is telling that informal carers are described as the ”cement of society”.

2.2. Replacing supply orientation by demand orientation

Supply-oriented healthcare is perceived as undesirably rigid and ineffective. In international comparison, this qualification is particularly attributed to the Netherlands (Timonen et al. 2006). This second challenge is addressed by positioning the new subjectivity of the patient as an element in the transformation to a demand-oriented system. It is argued that ‘[t]he personal budget [is] an important instrument to achieve demand-orientation and increasing flexibility in the Exceptional Medical Expense Act’ (2000, p. 13). This implies ‘the strengthening – in a formal sense – of the position of the client in the chain from demand for care to delivery of care’ (Ministerie van VWS 1999, p. 22).

In this role, individual citizens are deemed to be supported by mediating agencies and organisations that represent their interests in discussions with healthcare providers and insurance companies (2001l; MDW-werkgroep AWBZ 2000a). The same is noted internationally (Spandler 2004). With respect to mediating agencies, citizens are attributed the “agent-role” of monitoring the qualities of their services (College Voor Zorgverzekeringen 2009b).

2.3. Reducing the role of government

Bulmer formulates the third challenge as: getting rid of ‘long-term, inflexible, public-sector-style contracts’ (2008, p. 48). This is done by reshuffling the relation between government and the new subject. Government will do no more than to set the framework conditions within which the citizen interacts with other players in the healthcare system, or market as it is typically called. Government relates to the citizen mainly in terms of providing support, and in terms of taking responsibility for cases that can impossibly be handled by citizens themselves (2005f). This does not imply, however, that government withdraws; government and the active citizen have a relationship of collaboration (2007e), which is based on support, rather than on a form of dependency (2004b, p. 9).

A number of framework conditions are mentioned. First, in order for citizens to be able to monitor price and quality, information should be available (2001k) for the system to be sufficiently transparent (MDW-werkgroep AWBZ 2000c), particularly in the form of benchmarks (2001c; 2004d). Second, sovereignty should be restricted to certain types of care (autism, for instance, is to be excluded) (2000d). A strict demand is that the budget only be used for intended “spending goals” (2001b), and on care providers who meet certain minimal quality criteria (MDW-werkgroep AWBZ 2000d). Ex post evaluation is proposed to assess whether these demands have been met (2001a). Finally, a “money back” policy, or complaint procedure should be created (2004c).

2.4. Reciprocity between citizen and society

Government perceives that it can no longer take full responsibility for steering society, and care in particular. The citizen’s responsibility is extended to the macro-level by positioning him/her as an active participant of a wider civil society. First of all, ‘citizens and their organisations’ are considered the makers of civil society (2004a, p. 9). At the same time, they stand in a reciprocal relation to it: citizens may expect the support of their surroundings in terms of receiving care from, for instance, family members and voluntary community activities, but at the same time they should return such favours by assuming an active participatory role in these same surroundings (2007d; 2009c). Reciprocity is also expected in relation to government: in return for its support, government expects citizens to adopt what they call ‘good patientship’, a term coined by the Public Health Council (RVZ), which implies that ‘the client bears responsibility: for a healthy lifestyle, for actively participating during his treatment and for judging, and giving feedback on, the care that was consumed’ (2004, p. 2).

Ideas about participation are even put into practice by introducing a so-called “participation budget” (2006b), for instance for arranging transportation, education and labour integration. The vice-minister states that government appeals to people’s “carrying capacity” (2005, p. 7), and that ‘self-organisation, social adhesion and personal responsibility are the starting-point for a stronger social structure’ (2005, p. 8).

2.5. Cost containment

The constitution of the subject as specified above is supposed to meet the challenge of cost containment (Kerff 1998; Houtepen & Meulen 2000). Certain studies suggest that direct payments are more cost effective than other financing models (Spandler 2004), for instance because overheads would be lower (Timonen et al. 2006).

The new subject is positioned as a rational economic actor; it is argued that ‘[r]equesting and managing a personal budget requires entrepreneurship’ (2009a, p. 3). In such a role, the citizen is the primary responsible actor when it comes to monitoring price (Ministerie van VWS 2001) and quality (2001h). Demand orientation is introduced on the basis of the general assumption that it ‘contributes to quality, effectiveness and efficiency’ (2001a, p. 4). The assumption regarding the positive effects of focusing on demand is based on the reliance on incentives, both for those who request and those who supply care. With respect to the latter, the argument is that ‘if the individual can decide for him or herself from which provider to purchase a product or service, an incentive arises for the provider to make a better product’ (2001b, p. 4). It is expected that ‘providers have to compete for the customer’s favour on the basis of price and quality’ (2001, p. 2). Research reflects this way of thinking (Carmichael & Brown 2002). When it comes to incentives for citizens, the argument is that they will be more restrictive in their spending if they manage the budget themselves.

3. Analysis of critique within the discourse

As noted in the introduction, our approach differs from Foucault’s. We also include statements that contradict or criticise the assumptions or expectations that we described in the previous section. The documents that constitute these policy discussions include numerous perceived problems in association with the argumentation highlighted above. We first provide a short overview of the problems that are noted by critics, before exploring the argumentation about them. We examine both criticism by parties that penetrated parliamentary discussions, and academic critique that stayed outside parliamentary circles. Even though we present issues as “singular” problems here, they are in fact interconnected. We return to the “cluster” of problems below.

3.1. Singled-out problems

The main problem for the “good patient”, both in the Netherlands and in other countries (Glendinning et al. 2001; Carmichael & Brown 2002; Rummery 2006), is the administrative overload to which (s)he is exposed (2001f), even after fundamental revisions, which were particularly designed to diminish such burdens (2004; 2004k; 2007b). Overload particularly occurs when budget holders formally employ care workers (Van den Wijngaart & Ramakers 2004).

Another problem is that the support network of representative organisations is not yet in place (2002b). A number of councils that represent insurance clients are hardly functional, if at all (2001j); local organisations are not yet in place (2004m). Also scholars note that, for instance, ‘user co-operatives are only likely to work for a small proportion of claimants and would exacerbate a culture in which some claimants are winners at the expense of others who become losers’ (Lyon 2005, p. 247). Transparency is considered inadequate, even though it is not concretely specified what is lacking; the vice-minister perceives an ‘excess of financial partitions’ (2004b), referring to administrative separations between different parts of the healthcare system. In addition, there have been cases in which brokering agencies were criticised for committing fraud, or for offering low service quality (Research voor Beleid 2009). As a result of this, the “countervailing power” that citizens can generate is considered strongly limited (2001i; RVZ 2005b),

Even though the quality of care that was purchased with a personal budget is generally considered high in the Netherlands (2006a), the fact that citizens are made responsible has created an ongoing concern nonetheless (2000c; 2004j; College Voor Zorgverzekeringen 2004; IBO 2006b). With respect to threats to quality, the literature notes a lack of training of personal assistants (Pickard et al. 2003; Kremer 2006) and a devaluation of professional care and care standards (Knijn & Verhagen 2007). The capability of citizens to behave as rational consumers and assess quality is questioned as well (Kremer 2006; Knijn & Verhagen 2007; Prideaux et al. 2009); at best, they are considered quasi-consumers by some (Glendinning et al. 2001). This goes back to the ambiguous issue of patients’ “health literacy”, which we mentioned in the introduction (Rubinelli et al. 2009).

Since its inception, the personal budget has become a popular option for funding informal caregivers who had previously been unpaid (1997c; 1998f; 2001e), which has also been noted internationally (Askheim 2005; Kremer 2006). This issue is referred to as the monetisation of informal care (2004i; 2005a; Ramakers & Van den Wijngaart 2005c). This has made public spending grow, which seems to be in direct conflict with one of the original objectives: cost containment. Something similar may be argued when it comes to the risk of fraud or abuse (Askheim 2005; Kremer 2006; Ellis 2007). In the Netherlands, fraud is estimated to occur in 1-5% of the cases (2004h).

A problem that is indirectly related to the empowered role of the subject is the position of care providers (Ungerson 1997; 2004). Scholars have reported bad working conditions and an overwhelming sense of responsibility (Spandler 2004), overburdening and exploitations of informal carers (Kremer 2006; Rummery 2006) and carers being trapped in short-term contracts (Kremer 2006; Leece 2010). In the Netherlands, the topic entered political discussion in the second half of the past decade. The minister acknowledged the problem that many employees of traditional home care organisations lost their jobs (2007c). In addition, many skilled care providers have been forced to accept contracts for unskilled work (2007f).

Even though it is not specifically mentioned as a problem, it is often acknowledged that difference in capacities of the citizen leads to inequality and/or social exclusion. The international literature pays more attention to this issue (e.g. Lyon 2005; Rummery 2006). It is pointed out, for instance, that there are relatively many budget holders with a higher education background (1997b; 2009b). On top of that, the skills of the applicant in terms of formulating the request for care have an influence on the amount that is awarded (1999; IBO 2006a).

It is worth noting that scholars have articulated a number of problematic issues that have played only a minor role in Dutch political discussions, if at all. These issues are of a different nature than the fairly practical points that we addressed above. First, it is argued that, with an individualised set-up like the personal budget, economies of scale are likely to be lost compared to collective service provision (Spandler 2004; Lyon 2005). Second, the notion of the economic nature of the relations that we discussed is problematised. In a much-discussed paper, Ungerson argues that:
'"empowerment" is becoming two-pronged: the community care legislation gives disabled people *procedural rights* to an assessment, although not to services; the direct payments legislation will give disabled people the means to enter a *market* for care where they can operate *contractual rights*' (Ungerson 1997, p. 47, original italics).

The Dutch system is particularly mentioned as an example of 'fully commodified "informal" care' (Ungerson 2004, p. 197; see also Timonen et al. 2006; Knijn & Verhagen 2007), which is reported to be problematic for part of the users. It is articulated, for instance, how 'market logic intrudes into family logic' (Kremer

2006, p. 396). Furthermore, some have pointed out that, in different countries, funding has proven inadequate and that ‘it is vital that the real costs of living with a disability are recognised’ (Carmichael & Brown 2002, p. 807). Particularly market logic is reported to have a detrimental effect on the amount of funding awarded (Spandler 2004; Scourfield 2005). Finally, different scholars have pointed at the ‘consequences of a state that wanted a market of care but at the same time introduced control’ (Kremer 2006, p. 392; see also Ellis 2007; Priestley et al. 2007; Prideaux et al. 2009).

3.2. Argumentative responses to problems

We have found many ways to argue about such problems. Rather than going over every problem one by one, we go over the different argumentative mechanisms. We have mainly observed mechanisms that effectively evaded problems that are noted by actors in this discussion. This does not necessarily imply that such evasion stems from an intention to not address an issue. We do not discuss motivations, only practices.

3.2.1. Stating, rather than solving problems

The most common way of dealing with problems in the documents that constitute the policy discussion is to acknowledge them, establish their importance, and then move on without offering argumentation or solution. All of the problems mentioned above have been handled this way several times over the past years. Particularly the issues of administrative burdens, limited skilfulness of budget holders, quality of care and the lack of a proper infrastructure are dealt with in this manner.

3.2.2. Offering partial, but insufficient solutions

In case suggestions are offered, they are often insufficient. By this, we mean that the problem in question keeps on being signalled. We provide a number of examples. When it comes to administrative overload and the limited, or unequally distributed capacities of budget holders, it has been proposed that a personal budget may be refused (1997a) or that a negative recommendation may be given to a particular applicant (2009a). This approach is not just restricted to the Netherlands (Priestley et al. 2007). Alternatively, a facilitating agency would be formed, of which citizens can make use voluntarily (2001d), and an instructive DVD will be prepared (2009d). The international call for simplifying application procedures (Leece & Leece 2006) is also recognised in the Netherlands (2002a). Monetisation and abuse are to be addressed by creating more objective indications (1997f) and control instruments (2000b), by reclaiming budgets in case of abuse, by obeying informal care providers to show that they have limited other activities for being able to provide (paid) care (2004l). Abuse by agencies is addressed by restricting payment of the personal budget to the budget holder's bank account and by creating a behavioural code for agencies (2009e). In spite of these efforts, we continued to observe subsequent worries about the same issues.

3.2.3. Ambiguity

We understand ambiguity as a vague use of terms. As the Council of State pointed out, for instance, it is fairly unclear what "participation of all citizens" means (2005e). In spite of the vice-minister's clarifications, it remains unclear what is intended exactly. On the one hand, it seems to refer to participation in the care and support process, in the sense of charity or volunteer work (2004n), but often the vaguer concept of participation in society is allured to. Mostly, this is argued to be inspired by values such as empowerment for people with a disability or chronic illness, but also participation in policy making (2005g) and labour participation (2006c) are mentioned. It is noted that local governments, which will execute this policy, should further specify the definition of participation.

3.2.4. Conditionality

There are many ways in which conditionality plays a role in this policy discussion, not only in the Netherlands (Ellis 2007; Priestley et al. 2007). By conditionality we mean that certain conditions need to be met in order for a policy to be executed. We juxtapose this with the unrestricted adoption of the policy on the basis of the *assumption* that these conditions are met. Most interesting are cases in which certain attributes are described as both a condition and an assumption. Even though it is sometimes acknowledged that positioning an attribute as a condition implies a serious limitation, this does not stop politicians from formulating it as a general assumption as well. With respect to sovereignty, it is argued that the 'starting-point of the personal budget is that the budget owner is reasonably capable of judging the quality of care (consumer sovereignty)' (2004b, p. 13). This statement puts the emphasis very differently from saying that sovereignty is 'not equally applicable to everyone and everything' (2000b, p. 6). The emphasis of the latter formulation is on conditionality, which is lacking in the former. Similarly, it is argued that 'requesting and managing a personal budget requires entrepreneurship' (2009b, p. 3). The question whether this requirement is reasonable was posed in 2009 only, almost 15 years after launching the first experiments. Responsibility is another example. When the personal budget entered the discussion in the late 1980s, the ability to take responsibility was a condition (1988), suggesting that there would be some sort of judgment of this ability. Later on, more emphasis was placed on the argument that accepting a personal budget implies accepting responsibility (1998e), i.e. without a judgment of ability.

3.2.5. Shifting the responsibility for unsolved problems

Another common mechanism is that responsibility for unsolved problems is passed on to another actor; local governments and the individual citizen are the most common candidates for this. In terms of major challenges – inadequate societal participation and excess costs – the Public Health Council posed the question: ‘How will we handle this?’ The answer given was: ‘[b]y making the municipality responsible for the societal participation of people with a disability’ (RVZ 2005, p. 2). In particular, ‘[r]ealising a social support infrastructure with adequate societal facilities falls under the responsibility of local government. This responsibility should most certainly remain where it is’ (2002, p. 4).

The citizen is first responsible for assessing the amount of budget that it is needed: ‘if desired, an applicant for a personal budget for mental disability can try to manage with a lower norm amount than for which he could receive an indication’ (1997, p. 7). This implies that (s)he can try to purchase a cheaper treatment than what is deemed necessary by experts. It seems to make sense to measure quality from the citizen’s perspective (2004a), but should “client satisfaction” be the main indicator for quality (Van den Wijngaart & Ramakers 2004)? When it comes to administrative burdens, government opted for a procedure that gives more freedom, but more burdens at the same time (2001g). Concerning burdens for care providers, regulations were adapted: ‘By this change in the law, the citizen can be confronted with these burdens. This in fact implies a shift of burdens to the right place’ (2008, p. 8). Whereas lowering burdens was one of the prime objectives of a major revision of the scheme, in 80% of the cases these remained the same or actually increased (2004e). The conclusion, surprisingly, was that the objective had partially been reached (Van den Wijngaart & Ramakers 2004). As a reply, the vice minister argued that citizens should not only expect taking the benefits, but also the hardships (2004g). Taking into consideration that less skilful citizens not only need to hire consultants to deal with the ever-increasing burdens of complexity, but that, in addition, they are expected to monitor the potentially abusive behaviour of such consultants (College Voor Zorgverzekeringen 2009a), we may wonder how this relates to the freedom that the scheme was meant to promote.

3.2.6. Implicitly contradicting the stated objectives

The introduction of new control mechanisms seems to contradict the original principle of patient sovereignty. Already a couple of years after introducing the scheme, it was stated that ‘implementing demand-orientation ought to be accompanied by strengthening the set of supervisory instruments’ (2000a). For instance, house visits are proposed as a mechanism of proper coordination (2007g). Cost control has led to the lowering of budgets in later updates of the scheme (Van den Wijngaart & Ramakers 2004), regulations for using personal budgets for paying informal care have been sharpened (2004f) and the part of the budget (€2500) that was previously exempted from evaluation was cancelled (2007a). Using a title like ‘Liberating Frameworks’ (Raad voor Maatschappelijke Ontwikkeling 2002) for a crucial report in this discourse is telling in this respect.

3.2.7. Leaving underlying arguments unspecified

A final issue relates to not making underlying argumentation explicit; we take the example of monetisation and abuse. Considering that cost containment is always presented as a prime challenge, it seems awkward that few measures are taken to control this. What does the argument look like? First, the negative perception of the issue is downscaled by saying that the scheme is perhaps not ‘waterproof’ (2004, p. 15), but that abuse only happens on a very limited scale (1-5%). Another option is to establish a favourable definition of monetisation, stating that if a personal budget is awarded in a situation in which informal care was previously delivered unpaid, there is still a ‘legitimate need for care’ (1997d). The vice-minister’s argument was: ‘We find it normal to pay care providers for delivered services, then why should we not find it normal to pay informal carers for delivering formally required care’ (2005, p. 3). She accepts a narrower definition of monetisation that only considers cases in which the personal budget makes informal caregivers unwilling to continue providing unpaid care (2005d). Even though this is in part speculation, the underlying argument seems to be that new markets may open up and that unpaid care will still be provided on top of paid care.

3.3 Clusters of problems

As said, the “singular” problems are interconnected through measures that are supported by different forms of argumentation. In this section, we provide a few examples to indicate to what extents problems are “clustered”. Through a description of these clusters, and the evading mechanisms that surround them, we try to highlight a particular form of discursive formation. We still use the singular problems as an “entry point” to the cluster.

When it comes to *administrative burdens* for the citizen, the existence of the new market for brokering agencies and personal budget consultants is put forward as a *partial solution*. As we have seen, however, this solution raises the problem of potential abuse by such organisations; citizens are now also responsible for *monitoring the quality* of service that they deliver. This new problem is dealt with by two different ways of argumentation: first of all, a *partial solution* is offered by creating a quality mark for such organisations, and secondly, government simply states that it *cannot take responsibility*. The fact that such agencies need to be paid for creates *inequality* between citizens who have the skills to manage a personal budget themselves and citizens who don’t. If payment is an issue, assistance of family members is offered as a *partial solution*. Even though issues of inequality are hardly discussed at all, it is argued that selecting care in kind would be a *solution* for those with limited capacities. This option, however, places the responsibility for deciding on the *quality of care* with the patient, which was considered as an issue of concern in the first place. At this point, government *restates the original ideology* by arguing that this is part of the citizen’s responsibility, while remaining *ambiguous* about the question whether capacities for handling responsibility are assumed or considered a condition.

Moving on to the problem of the citizen as the prime responsible for the quality of care as an entry point, the argument is that the receiver of care is the most capable to decide what happens to him or her. As we have seen, the way to do this was to *stage a measuring tool* that used citizen satisfaction as the main indicator of quality. This seems problematic, considering that further medical indicators or long-term perspectives are *not considered directly*. A further argument used is that it is necessary to move the monitoring of quality to the demand side if we want to *move from a supply-oriented to a demand-oriented system*. This brings us back to the earlier question regarding the skills of the citizen. That question evokes the elements of the problem cluster discussed in the previous paragraph.

The question of “system innovation” from supply to demand highlights the lack of a supporting infrastructure. It is *assumed* that self-organisation is the best way to form a stronger social structure. In practice, however, it turns out that citizens neither form collectives, nor are they represented by patient organisations sufficiently. Still, the responsibility for organising this is partially *shifted to the citizen*, even though government states that such an infrastructure is *required* for achieving system change, considering that citizens will not be able to gain sufficient strength otherwise. A partial solution is to *make local governments co-responsible* for creating this infrastructure, while referring to the *ambiguous* term "participation" as a basis for this. However, this applies only to the social support act, which is just a small part of the entire healthcare sector; therefore, this is certainly *not a complete solution*.

If we look at the issue of monetisation, we have seen that the basic argument was that informal care is provided on the basis of a *legitimate* demand of care. This is based on *redefining* what monetisation is, thereby *downscaling* the number of cases that meet the definition. Still, it seems problematic from the point of view of government's objective of *cost containment*. Even though it is not clearly articulated, it seems there is an *underlying argumentation*, i.e. paying informal care has positive economic effects as well. Whether these benefits outweigh expenditures remains *ambiguous*, however. The notion that monetisation might grow in the future is not articulated. The *solution* that is offered is to increase supervision to single out cases in which monetisation ought to be considered abuse, in line with the new definition. Such an increase in control is again *at odds with the original principle of sovereignty*. The argument here, however, is that this should be regarded as part of new "liberating frameworks", a fairly *ambiguous* term.

4. Discussion and conclusions

Even though our main focus has been on the problems that we have identified, it needs to be said that several of these issues have been contested or relativised in the literature. A few examples: first, training has been effective in handling administrative overload. In addition, many receivers of direct payments have voiced the opinion that they gladly accept this load, compared to the downsides of the previous system (Carmichael & Brown 2002). Third, quality of care has definitely improved in certain respects (Carmichael & Brown 2002); satisfaction is obviously not completely unrelated to quality. Similarly, there are many known cases of care workers that were happily employed by holders of a personal budget (Kremer 2006; Leece 2010). Just as market logic has a potential "dark side", so does “family logic”: ‘[f]amily care may be based on “warmth”, but it is parochial and arbitrary at the same time’ (Knijn & Verhagen 2007, p. 468). With respect to the issue of monetisation, finally, it is suggested by some that informal carers do not in fact change their behaviour because of the financial benefit, but that they appreciate their increase in income and recognition nonetheless (Ungerson 2004).

Personalised healthcare is not a black and white issue. Our conclusion is similar to what other have argued with respect to the question of attributing “skills” to the patient (Rubinelli et al. 2009). On the one hand, “health literacy” is promoted in the framework of patient empowerment. On the other hand, critics argue that it may be undesirable for the patient to take place on the doctor’s chair. We do not suggest that personal budgets be cancelled because of the problems we found. Rather, it makes sense to investigate how to better deal with criticism in complex and interconnected arguments. On the basis of our analysis, we conclude that “clustered argumentation” is associated with mechanisms that evade problems that are raised. This would provide an interesting, but ambiguous case for theorists and practitioners working on the basis of the notion of political responsibility. How could we deal with the question of accountability in such cases?

Returning to the question we posed in the introduction: it seems reasonable to question how realistic the subject is that is portrayed in the dominant discourse. The use of the “cluster of argumentation” and “evading mechanisms” concepts highlights more than just the question of how realistic a particular subject is. We have tried to make clear that clustered argumentation is a discursive formation that makes certain things transparent and others opaque. Even though we do not comment on the question of intentionality, we have tried to highlight how clusters are accompanied by mechanisms that effectively imply that criticism is evaded. We may wonder whether the new subject will really be a “good patient”. Is (s)he indeed a cash-supported, rational sovereign, who constantly shuffles relations with care givers and is putting pressure to break rigid healthcare institutions? On the basis of the problems that participants in the policy discussion raised, another image of the patient-subject appears. It could also be an overburdened individual, constantly involved in unequal power relations, suspect in the eyes of government and society, and, therefore, increasingly constrained. This points at an entirely different type of subject, a “problematised subject”, so to say. This forms an interesting reflection on Foucault’s work on subjectivity.

NOTES

[i] Translations of Dutch documents were performed by the authors

[ii] Most documents analysed in this study are (vice-)ministerial statements to the Dutch assembly; references in which we do not specify an author or organisational author should be considered as such (Tweede Kamer)

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