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Professionals between Problem and Demand

(Or: you can't always get what you want…)

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1. Introduction

The focus on demand may present professionals with the dilemma of whether to offer demand-oriented or problem-oriented care, especially where clients claim or avoid care. The emphasis on demand, choice and a client-focused approach can make professionals unsure about their professional 'space' and may even lead to feelings of incompetence. Who is he or she to decide what the 'real' problem is and what is best for the client, and for society? Furthermore, a pure focus on demand is not sufficient when dealing with current social problems and policy objectives.

In this paper we examine the need for a combined focus on problem and demand and on what this means for the relationship between professionals and clients. We review the outcomes of our recent study into the consequences of recent changes in society and in policy objectives on professional practice to show that professionals also need to focus on problems. We also show that a problem focus, a demand focus or a combined focus is needed for different needs and for specific groups of users/clients.

We show that steering demand is a differentiated and articulated concept and that its form is dependent on the perspective and focus. We question whether the market paradigm is good enough for care relations. We use Hirschman's concepts of exit, voice and loyalty to elaborate on and draw conclusions about the position held by professionals and clients both on the level of the relationship between professionals and clients and on the organisational level.

2. Consequences of social issues, needs and policy objectives for professionals in care and social welfare

In a recent study we examined the consequences of current and near future social developments and issues, policy objectives and the changing needs of people on professional practice in care and social welfare in the Netherlands (Van Vliet et al. 2004).

Social developments and issues

Dutch society is characterised by a growing ageing population, more ethnic and cultural diversity, a higher pace of life, and a shrinking welfare state, all combined with an increasing emphasis on one's own responsibility and assertiveness. At the same time, people are becoming more socially concerned and involved, although this involvement does tend to serve one's own interest. These social changes may lead to a number of social problems: diminishing solidarity and tolerance between citizens and groups of citizens; increasing numbers of elderly people and people in need of help who live alone without there being enough informal carers available; a growing number of people who are isolated and lead secluded lives, and furthermore people who have fallen by the wayside and who are not capable of being responsible for themselves. It is precisely these isolated people who require help who have difficulty with formulating their needs and demands and with finding their way to professional help.

Changing policy objectives

In addition to these social changes and problems, the work of professionals is influenced by a number of policy objectives, some of which may be partially determined by external sources, as follows: a more commercial approach with a (pseudo) market mechanism and demand orientation, a territorial and integrated approach, and, last but not least, the development of social care which combines care and welfare facilities at the local level.

Changing needs

The changes and problems mentioned here have consequences for the needs of people. We can make a distinction between different needs: increasing demand for direct, simple or combined services to support daily life activities; greater necessity for an intensive, co-ordinated approach for complex or multiple problems; and finally, more demand for professional support for citizen initiatives, voluntary work and informal and family care.

Changing professional practice

All these changes in problems, needs and goals have consequences for professional practice in care and social work. Professionals must be able to detect and to articulate needs. They require more knowledge of ethnic and social-cultural problems and of methods to promote social integration and combat social exclusion and discrimination. In addition to professionals who deliver services to support daily life activities and provide help for simple demands, we need professionals who are capable of working together in a co-ordinated approach of needs and problems, as well as professionals who are in a position to develop and co-ordinate networks around vulnerable citizens and groups of citizens and who function as an (initial) contact. We do need new kinds of professionals for this combined approach:

On the one hand 'close' professionals with a broad view who function as 'networkers', who take on responsibility and serve as the contact for citizens, volunteers and other professionals. On the other hand we still need specialised professionals capable of applying specific knowledge and competencies for specific groups, problems and demands, but who are also able to practice their specialisation from a broader perspective, as part of a combined or cohesive approach.

Therefore, we need professionals who are not only demand-oriented or only so to a limited extent but who are also able to detect and articulate concrete individual problems as well as wider social problems, who are able to deal with these problems and with the tensions or conflicts between individual and social problems, and between problems and demands. These professionals are able to explore and deliberate on these needs and problems, and consider matters relating to adequate care or support together with the people involved, as well on the individual level of the relation with the client and on the collective level which includes other parties such as family, neighbours, other professionals and policymakers. This places heavy demands on the relationship with the client and the interaction with others who are involved. Professionals must be able to show what they can do, and what they cannot do, and communicate this both to the clients and other stakeholders.

3. Demand steering and demand orientation

Steering demand has become a central concept in the modernisation of (health) care and welfare services in the Netherlands. The goal is obvious: demand must lead when defining the supply. And who could be against that goal? However, it is slightly suspicious that different terms are used to describe this goal, as follows: demand led, demand steered, demand oriented, person or client centred, needs assessment…. Questions arise as to who the demanders are and as to what demands we are talking about. Who determines what the demanders and the demands are? Are demands always obvious and clear and the same for everyone? Who does the steering and how? In this section we examine the concept of steering demand. In fact this concept covers two possibly conflicting terms: demand and steering.

Demands and demanders

Demand is a collective noun and covers a range of diverging demands such as needs, claims, wishes, expectations, etc.. And behind the actual demands there may be different, possibly conflicting, needs, wishes and expectations that one is not immediately aware of.

Who are viewed as demanders, which demands are defined and who determines them depends on the view or perspective we take. We can look at demands from different points of view or perspectives (Noordegraaf & Grit, 2004).

- A private perspective. People are viewed as consumers. Steering demand takes place through market mechanisms.
- A professional perspective. People are viewed as clients. Steering demand takes place through adequate professional judgement and professionalisation of clients (e.g. through client councils and patient organisations).
- A political or institutional perspective. People are viewed as citizens. Demand steering is not primarily directed at the optimisation of the services but at empowerment and at participation of people.

Table 1 Different perspectives and orientations on demand

Perspective	Orientation
Private	People as consumers
Professional	People as clients
Political	People as citizens

Steering

Demand steering can be distinguished from demand orientation (e.g. Noordegraaf & Grit, 2004; Oudenampsen, 2002). Demand orientation refers to the joint effort of a professional and a client to get the help that meets the wishes and expectations of the client which, at the same time, complies with professional standards. Demand steering facilitates demand orientation by the way the care is organised and financed. Demand orientation refers to the level of organisations and the relationship between professionals and clients, whereas demand steering refers to the level of institutions and systems.

Three levels or types of steering demand can be distinguished (e.g. Noordegraaf & Grit, 2004):

- Steering of the demand. Influencing the demand of the people by providing comprehensive information (public relations and marketing).
- Steering for the demand. Representatives, e.g. health care insurers, try to match demand and supply by negotiating with providers and conducting market research in order to distinguish client groups.
- Steering by the demand. Direct demands of individual demanders are leading for the production and supply of services.

In this description the ideal endpoint is the market mechanism, i.e. steering by the demand from a private point of view. The question is whether this is desirable and possible for all the people who need care but have problems in defining or articulating their demands or have no obvious demands at all.

Demand or problem?

What should be done when there does not seem to be any demand or any obvious demand to steer of, for or by? Professional questions and difficulties arise when there is a problem, but when there is no obvious demand (1), or when there is a demand, but there seems to be no obvious problem (2). In the first case it will be clear to professionals, policymakers, and citizens etc. that an individual or a group is in serious trouble, but these people who avoid care do not ask for the help they really need. What is even worse is that there are many socially isolated people with serious problems who are not visible because they do not cause any trouble, and neither do they ask for help. In the second case it is not clear to us which problems underlie the demand. In both cases we first need a problem-orientation before we can define the needs and the supply. In the first case: why does someone with an obvious problem not have a demand, at least one that is clear to us? In the second case: what is viewed as the problem behind the demand and why is that problem not clear to us?

From demand to need orientation

In this paper we make a distinction between demand-steered care on the political/institutional level directed at people as citizens; demand-oriented care on the professional level, and demand-driven care on the private level from a consumer point of view. Both demand steering and demand orientation are necessary on the organisational level. We focus in particular on the professional level of demand orientation. We prefer to see demand orientation as a process rather than as a state in which actual demands and problems need further exploration and the underlying needs, rather than the demands, are central (Van Vliet, 2002). The process refers to a mutual exploration of the demands and problems and to a definition of the needs as well as of what is supplied, both in the individual professional-client relationship and collectively on the organisational and institutional level. The question is whether the language of the market paradigm is good enough for analysing the process of care and the different roles of the professional and the client in this process.

4. Is the market paradigm good enough for care relations?

From different angles the question arises as to whether the market paradigm is good enough for care relations. Annemarie Mol (2004) describes how market language fails to comprehend the process of health care, and more specifically care for the chronically ill, and the positions of the professional and the patient. She concludes that the care has its own language and logic. Care is not a product but a process which is, by definition, a personal matter between the professional and the patient and in which products are the means for improving this process. The caring process is not limited but open-ended. Care is not a transaction but an interaction between the patient and the professional to improve health as far as possible, and to attain a certain quality of life. The product in this process is of secondary importance. Mol analyses how care relations are intentionally person-centred. An important difference with the logic of the market is that patients who have no interest in health are still a target group. People who need help cannot be given up. In care relations, the enticing of potential clients is not an option, with the exception of cosmetic surgery, but is this illness?

Mol illustrates this by describing the relationship between the diabetes nurse and diabetic patients. The diabetes nurse gives advice and has some practical solutions for patients when it comes to living with diabetes. The chronically ill must learn to care for their own well-being, but being chronically ill also means that they have to live with uncertainty. In the view of the diabetes nurse, the patient is not a passive actor in this process but an active participant, who is responsible for his or her own well-being. But what about public responsibility? How can collective arrangements and the specific nature of modern care relations be combined? In the opinion of Mol, the question is not what to choose and how to choose, but how to live and how to die. Care is an individual process that takes place in the consultation room where the opportunities for standardisation are limited and are of secondary importance to the professional-client relationship.

Mol's description sometimes seems to present an idealised picture. The criticism of the reform movements of patients and professionals seems long gone. However, the question still remains of how to conceptualise the relations between the patient and the professional so that there is room for improvement. What does this mean for the market paradigm? Perhaps it means that the market language is good

enough for regulating the relations between care institutions, care insurers and the government. Another question is whether Mol's description is also suitable for relations that are less enduring and more short term. Mol concludes that, on the level of the relations between patients and professionals, the care must develop its own language and concepts in order to understand the position of patients and professionals and the choices that must be made.

However, the question of public responsibility remains unanswered. Mol's argument seems to increase the room for the responsibility of the professional and the client and to restrict public responsibility to ethical questions. This is something that would be unacceptable to the Dutch government. But if public responsibility has to be broader, the question remains as to how the professional will account for his choices and to whom?

Exit, voice and loyalty

In his classic but still topical study (Exit, voice and loyalty, 1970), Hirschman criticises the classic economic theory. In many markets there is no pure competition. Health care markets in particular, where few care deliverers are active, tend to be monopolistic. For most people health care is a scarce good. National and local government play an important role. These markets have been called quasi markets by some economists (Bartlett & Legrand, 1993). Quasi markets differ in certain respects from other markets, and profit maximisation is still an exception. Most care deliverers try to develop strong ties with their patients.. Most clients are not free to spend their budget as they want to; more often than not a budget has been earmarked, or other agents, such as the insurer or local government, buy care. There is some competition but it concentrates on reputation, and on the labour market etc..

Hirschmann wonders what would happen if, in such a market, relations between clients and a health institution were disturbed. He differentiates three kinds of reactions. The client can go to a different care deliver (the exit-option) should that other option be present, attractive and the client well-informed. If clients do not have an exit option, or if they are not well-informed, they can decide to make the institution aware of their discontent and hope that it will lead to improvement. They can do this either in an individual way (by making a complaint) or they can join an organisation. In this way clients invest in a relationship on which they come to depend. This kind of reaction is more plausible when clients have feelings of loyalty towards the professionals they know or towards the institution. Hirschman is convinced that the voice option is, in the end, more beneficial for both parties because the organisation can learn from critical clients. The exit option does not lead to a learning process because the institution does not know why the client made this kind of choice. These arguments lead to a positive appreciation of the role of diverse organisations of patients in health care and the role of individual learning processes between the professional and the client.

Conclusion: the shared responsibility of professionals and clients and the role of learning organisations

Market language has a limited meaning for understanding the relationship between the professional and the client. The care professionals and client organisations have to develop their own language when processes of learning and respect for the shared responsibility in the care process are the most important. An important condition for this learning process is a clear view of the responsibility of the professionals and the clients in the promotion of their well-being. Procedures and instruments are needed to promote learning professionals and learning clients both on the relational and the organisational level in which the language of the care process can be further developed to underpin and legitimate need-oriented care.

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