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PROFESSIONAL POWER PLAY: ORGANIZING MANAGEMENT IN HEALTH CARE

MIRKO NOORDEGRAAF AND MARTIJN VAN DER MEULEN

Because of the managerialization of health care and the rise of health care managers, professionals and managers increasingly 'clash'. To reduce clashes, managerial and professional domains have not only been (re)connected; they have also been restructured. Managers, in particular, have started to make sense of their own 'professionalism'. Health care managers are professionalizing in order to cope with reform consequences. They have established professional associations, which establish educational programmes, journals, and codes of conduct, in order to define and standardize managerial work. By tracing the evolution of a new profession of Dutch health care executives, and by studying its educational underpinnings, this article will analyse whether the professionalization of managers homogenizes occupational definitions and standards. It will show that managerial education masks ideological struggles over the substance of 'good' health care management. Different 'schools' have arisen, producing heterogeneity in executive circles.

INTRODUCTION

In post-Keynesian neo-liberal climates (see, for example, Harvey 2005), successive waves of neo-liberal reform have rationalized health care systems and health care delivery (see, for example, Saltman and Figueras 1998). Since the 1980s and 1990s, health care delivery is increasingly managerialized and 'run as a business' (for example, Clarke and Newman 1997; Pollitt and Bouckaert 2000; Kirkpatrick *et al.* 2005). Professionals on the shop floor, such as doctors, operate within strategic and budgetary frameworks; health care organizations grow in size, become multi-divisional and are run by executive boards; health care purchasers and providers negotiate prices and agree upon contracts. These changes have been accompanied by the rise and proliferation of health care managers and executives, who are responsible for organizing 'managed care' (for example, Scott *et al.* 2000), and establish and run 'professional businesses' (see Brock *et al.* 1999).

In order to do this, health care managers are not only reforming the work of others – such as doctors – they are also changing and professionalizing their own work. By becoming part of distinctive occupational domains or 'professions' that transgress individual organizations, health care managers endeavour to become 'professional' in order to improve health care organizations and health care delivery. By organizing and structuring occupational domains and by establishing occupational standards – through educational programmes, journals, conferences, and codes of conduct that homogenize outlooks and practices – they are taught how to manage such professionals, balance budgets, initiate strategic plans, and deliver better quality for clients. At first sight, this turns health care management into a more standardized and homogeneous occupation. Members 'know' how to manage well.

It is questionable, however, whether the rise of managerial professions standardizes and homogenizes health care management. Since the meaning of managerial work is ambiguous (see, for example, Whitley 1989); since public management calls for, but contests, professional standards (see, for example, Kirkpatrick *et al.* 2005; Ackroyd *et al.* 2007); and since 'good' health care is politicized (see, for example, Giamo 2002; Davies 2006), it

Mirko Noordegraaf is Professor of Public Management and Martijn van der Meulen is a doctoral candidate in the Utrecht School of Governance (USG), University of Utrecht.

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is questionable whether occupational definitions, standards and structures contribute to the rise of an integrated profession. In this article, the rise and evolution of health care manager professions will be studied, in order to answer the question 'whether the professionalization of executives really homogenizes occupational definitions and standards'. We will trace the evolution of a profession of Dutch health care executives – that is, the top managers in health care – who are members of an established professional association, the NVZD. We will especially focus on how its professional members are educated – on how educational programmes arise and evolve – in order to highlight a crucial component of professionalization strategies, namely standardization through education (see, for example, French and Grey 1996). Or to put it more precisely, the definition and standardization of managerial work through the supply of educational programmes, the rise of educational models, the transferral of knowledge and skills, and the spread of managerial images. Although we study educational underpinnings only, and do not study whether individual managers are really affected by education, we will be able to say a lot about the strength of 'professionalization projects' (compare Hodgson 2002, 2005) in an 'age of expertise' (compare Brint 1994). If educational developments produce more heterogeneous standards of managerial work than expected, it follows that occupational control will also be less stable and strict. This also enables us to reinterpret the meaning of professionalism in ambiguous occupational domains such as 'management'.

First we discuss health care reforms that fuelled managerial professionalization. Secondly, we explore theories on professionalism and professionalization projects. Thirdly, we describe the rise of 'management' in Dutch health care, and the evolution of managerial professions in Dutch health care. Fourthly, we analyse the evolution of executive education and trace different 'schools'. Finally, we draw conclusions on the effects of executive education in health care and discuss the consequences for managerial professionalism.

WAVES OF REFORM IN HEALTH CARE

Health care reform is heavily influenced by certain managerialist terms and tools that have become popular in 'neo-liberal' and 'neo-bureaucratic' times (for example, Clarke and Newman 1997; Harvey 2005). Since the 1980s, businesslike reform stories have dominated health care delivery (for health care related oversights, see, for example, Pollitt 1993; Saltman and Figueras 1998; Farrell and Morris 2003). Some of these terms and tools – such as efficiency, planning and control, quality, strategy, results, performance, and accountability – are organizational means for creating better conditions for organizational performance. Some terms and tools – such as competition, quasi-markets, and mergers – are institutional terms for establishing playing fields for multiple health care organizations and other 'stakeholders'. Other terms and tools – such as clinical governance, clinical directors, medical managers, evidence-based medicine, and diagnosis-related treatment – are much more tied to health care and are used to substantiate reform. These ambitions are usually accompanied by more generic ideas about societal change, in which change is also perceived from neo-liberal angles. One expression of this is that health care systems should be turned into rationally responsive businesslike systems.

This story can be refined when actual policy stories and their organizational effects are traced over time in countries such as The Netherlands (see, for example, Meurs and Van der Grinten 2005), but this goes for other countries as well (see Pollitt 1993; Harrison and Pollitt 1994; LeGrand and Bartlett 1993; Harrison 1999, 2004; Hunter 1997; Scott *et al.* 2000; Giamo 2002): neo-liberal reform went through successive waves of reform. In the 1980s

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(1982 in The Netherlands), most policy action centred on financial stringency; it did this by way of organizational changes, cutbacks and efficiency – financial soundness had to be established. In the 1990s (1994 in The Netherlands), policy action focused on integrated rationing. By way of clinical governance models, in The Netherlands known as 'integrated medical-specialist business' (see Biesheuvel Committee 1994), professionalism was tied to organizational considerations – for instance, by introducing medical managers (see also Llewellyn 2002). After the turn of the century, policies started to focus on market dynamics. Starting in 2001 in The Netherlands, policy-makers attempted to force health care organizations to become more responsive to critical customers by strengthening 'managed competition' and advocating entrepreneurial action.

These waves of reform have – increasingly – affected medical professionals and day-to-day service delivery, not in the least because the rationalization-through-managerialization has fuelled the rise of managers and executives. They are held responsible for implementing reform stories. Subsequent 'conflicts' and 'clashes' between managers and organizations on the one hand and professionals on the other have been well documented (see, for example, Realin 1985; Harrison and Pollitt 1994; Harrison 1999, 2004; Flynn 1999; Exworthy and Halford 1999; Freidson 2001; Dent 2003; Farrell and Morris 2003). Medical specialists emphasize their professional knowledge, skills and service orientations to justify professional autonomy, whereas managers try to coordinate and standardize medical activities and to enhance professional output.

Coping with reform consequences

Although strong academic statements about the 'de-professionalization' of health care have accompanied these clashes (see, for example, Broadbent *et al.* 1997; Malin 2000), key participants have found ways to cope with the contradictory pressures that flow from managerial reform. Policy-makers, executives and professionals have found strategies to reduce clashes. Firstly, they have found ways to both link and isolate their respective work domains. Medical specialists are members of medical staffs and participate in organizational management; they are involved in budgetary, planning and strategic processes. Managers use all sorts of control instruments for planning medical activities, controlling budgets and for designing information exchange between insurers and patients. At the same time, professional know how to 'buffer' managerial influences (see, for example, Kirkpatrick *et al.* 2005; Ackroyd *et al.* 2007).

Secondly, professionals and managers have found ways to rethink and reform their respective work domains – for example, in order to institutionalize budgetary and capacity control in health care organizations. Some professionals partly become managers (an example is the 'medical manager') (see, for example, Llewelyn 2002); in addition, professionals find means to link their specialist practices to other specialisms. Other practices affect nursing, resulting in phenomena such as the 'nurse practitioner'. Managers have also introduced 'dual' management systems with both managers and professionals as decision makers (see, for example, Noordegraaf *et al.* 2005).

Thirdly, executives and managers have tried to cope with more competitive and centrifugal forces by relying on means to reconsider and restructure professionalism, not least their own professionalism (see, for example, Davies 2006). As argued above, medical professionalism is reconnected to public discourses by underscoring effectiveness, frugality, and accountability, and executives and managers have started to turn themselves into 'professional' executives and managers. Interestingly, they are using a classical strategy of professionalization (compare Wilensky 1964; Freidson 2001). They

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have formed professional associations with bodies for regulating the profession, which develop educational programmes, publish journals and magazines, organize conferences, and uphold codes of conduct. In this way, managers establish 'professional control' (compare Freidson 2001). The ambition, apparently, is to turn health care management into a new profession, with a distinctive occupational identity, shared definitions and standards, and homogenizing forms of control (see also Fournier 1999). Such ambitions, however, will not automatically produce occupational control, especially in the case of somewhat ambiguous occupational domains such as 'management' (see, for example, Whitley 1989; Grey 1997; Brooks 1999; Mintzberg 2004; Hodgson 2002, 2005), 'public management' and 'health care management' (see, for example, Exworthy and Halford 1999; Farrell and Morris 2003; Duyvendak *et al.* 2006; Ackroyd *et al.* 2007).

PROFESSIONALISM: OLD CONCEPTS, NEW MEANINGS

Although, currently, professionals working at the shop floor and 'professional' managers attract a great deal of scholarly attention (see, for example, Reed and Anthony 1992; Brooks 1999; Pollitt 1993; Mintzberg 2004; Noordegraaf 2006), the notion of professionalism is far from new (Noordegraaf 2007). Professionalism has clear medieval antecedents: city guilds in fact can be seen as early professions (Krause 1996). The sociology of professions is a long-established field of academic study (see, for example, Larsson 1977), showing how the 'professional model' has, over the past two centuries, explained work orientations, behaviours and relations of certain high-status workers. The professional model showed how groups of experts, such as medical doctors, lawyers and university professors, controlled their own occupations, both technically and morally. By way of professional associations, which performed definitional and regulatory activities, they institutionalized 'professional control' and 'occupational closure', in order to guard complex case treatment and serve public goals (compare Wilensky 1964; Larson 1977; Freidson 2001).

In its classic sense, professional control is institutionalized in order to structure the application of complex expertise, knowledge and competence in service practices such as medical treatment and teaching. Since people outside the profession have difficulty understanding and evaluating such professional practices, professionals themselves are granted autonomy to organize the application of expertise. This system is supported by the state, which formalizes professional autonomy and grants 'jurisdictions' (see, for example, Abbott 1988; Kraus 1996). Although this 'pure' image of professionalism (compare Noordegraaf 2007) is somewhat uncontested in its traditional consequences, since doctors and lawyers are regarded as exemplary professionals, it does not mean everybody accepts the traditional imagery of 'how' a profession evolves and what motives are at stake.

The pure image of professionalism is reinterpreted in different ways. Authors such as Wilensky (1964) stick to classic, systemic features of professions and professionalization, but they acknowledge that changing times are at odds with ideal-typical imagery. In post-industrial times, 'everyone' wants to 'professionalize', and new, more hybrid forms of professionalism, such as 'program professionalism' arise. Authors such as Abbott (1988) stick to the systemic nature of professionalism, but go further and emphasize the politics of professionalization. Abbott shows how professional jurisdictions – as 'divisions of labour' – result from competitive forces in an 'interacting system' or 'ecology' of (would-be) professions.

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Some, such as Bucher and Strauss (1961) and Schön (1983) do not criticize professionalism as such, but they criticize a systemic view on professionalism, and emphasize the strategic and fragmented nature of professionalism. Bucher and Strauss (1961) showed how 'segments' in and between professional domains compete for control. Schön underscored the inevitability of professional pluralism, sticking to professionalism as 'treating cases', but criticizing the 'Technical Rational' model that is used to structure and organize case treatment. According to Schön, treating cases is a matter of inferential behaviour, which calls for 'reflection in action' that is difficult to control and standardize. Finally, others, although they are much more critical, stick to either systemic or segmented views on professionalism. They might show how professionalization projects symbolize and legitimate managerial work (see, for example, Hodgson 2002, 2005), or how professional systems act as 'disciplinary mechanisms' (see, for example, Grey 1997; Fournier 1999).

Views on professionalism are not only contested in terms of 'how' professionalism is defined and perceived, but also in terms of which professional groups are included and 'who' can qualify as professionals. Discussions about nurses or social workers who try to become more professional on the shop floor differ from discussions about managers, project managers or consultants who want to become professional, because, as argued above, their work is much more intangible and ambiguous (see, for example, Whitley 1989; Grey 1997; Brooks 1999; Hodgson 2005). People who reject the professionalization of managers, such as Whitley (1989) and Mintzberg (2004), do so because they do not see managers as occupational groups that perform identifiable work that can be standardized. People who *do* accept the professionalization of managers (see, for example, Grey 1997; Exworthy and Halford 1999; Duyvendak *et al.* 2006; Davies 2006; Noordegraaf 2007), on the other hand, show how such new occupational groups can establish occupational identities. In understanding how they do this, it is even more necessary to stress political and symbolic processes. Grey (1997), for instance, sees the professionalization of management as possible 'responsibilization' of managers; Hodgson (2005) sees it as a way to, as he says, 'put on' professional 'appearances'.

The combination of professional pluralism, political contestation and symbolic appearances enables us to see the professionalization of work in new ways. Professionalization processes are formed by occupational groups who want to become (more) professional. In order to do so, they see and define themselves as professional groups, and construe associations, educational programmes, journals, codes of conduct, and the like. Although this resembles traditional attempts to institutionalize professionalism (for a comparison of processes, see, for example, Wilensky 1964), we are not obliged to stick to traditional images when the evolution of professionalization processes in ambiguous times is explored. The *de facto* evolution of professional control, often lacking coherence and clarity, and full of strife, can be understood as politically motivated and symbolically construed. Although professional control is 'constructed', once this has taken place, the nature of both 'professional' and 'control' is then viewed differently. Practical aspirations (step-by-step occupational standardization) are decoupled from scholarly understandings (political and symbolic constructions).

This also explains why an emphasis on educational programmes offers a valuable empirical angle for research. All (new) professional associations invest in education and try to set occupational standards through managerial images and competencies, as well as educational models. Educational programmes, however, cannot merely be seen as functional means for transferring knowledge and skills when both work and work contexts

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are ambiguous (see also French and Grey 1996). Since managers like health care managers work in-between professional and political contexts, a dual emphasis on vocational training and technical skills, and on managerial performance, will fall short in making up managerial work (compare French and Grey 1996; see also Davies 2006). From a political and symbolic perspective, education will be about conquering occupational independence in-between professional practices, political interests and outside forces.

We now turn to the professionalization, rise and evolution of Dutch health care executives, and its educational underpinnings, in order to understand how managerial work is standardized in the face of contested managerial reform. This discussion rests upon an empirical study of executive professionalization in Dutch health care, in which the rise and evolution of educational programmes for executives – the top ranking managers in health care organizations, such as hospitals and nursing homes – was studied. This grew out of earlier empirical analyses of health care executives, mostly by way of large-scale surveys, which traced biographical and behavioural data of hundreds of health care executives (Noordegraaf *et al.* 2005). The quantitative material showed widespread participation in educational programmes, largely backed by the Dutch association of health care managers, the NVZD. Most health care executives have followed one or more post-graduate programmes. In the qualitative empirical study, the rise and evolution of the NVZD as professional association, and the construction of educational programmes was analysed. In 2005, 2006 and 2007, policy and organizational documents, as well as research reports, were studied, and around 20 key players in health care and health care associations were interviewed: representatives and members from the NVZD, coordinators of management education programmes (mostly university-based), and academic experts. Documentary analysis and interviews focused on definitions of health care management (businesslike, or other; content of educational programmes), educational models (educational form and process), and occupational standards (certification, careers). In what follows, we will firstly describe the rise of health care management in Dutch health care; secondly, we will trace the NVZD's evolution; thirdly, we analyse the rise and spread of executive education; fourthly, we analyse how different educational programmes have different profiles.

MANAGEMENT IN DUTCH HEALTH CARE

The term 'management' in Dutch health care really exists since the time of the first wave of reform in the 1980s. The tasks associated with management, such as planning, budgeting and coordination did already exist, but these tasks were not labelled as management. Health care managers had other job titles, such as directors, physician-directors, nursing directors, and they could be members of quasi-managerial associations; non-managerial discourses, however, dominated. This changed in the 1980s, when terms such as 'manager' – and later, during the second and third waves of reform, 'executive' and 'leader' – started to be used explicitly; when managerial terms, such as 'account manager' and 'unit manager', were created; and when manager associations appeared.

The institutional separation of health care management, with 'distinct' tasks, work spheres, career patterns and areas of expertise, can be easily illustrated. In a general sense, the divide between professional service spheres and administrative or 'overhead' spheres has increased, first and foremost by the growing number of personnel employed in administrative units. For instance, between 1997 and 2004, the number of full-time employees in management and administration in Dutch general hospitals has grown twice as

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fast in comparison with the total number of employees in hospitals (Dutch Bureau for Statistics 2006). As a percentage, overhead grew from 15 per cent in 1997 to 17 per cent in 2004, despite the large number of hospital mergers and a declining number of beds.

The growth of personnel in administrative spheres coincided with the transfer of tasks. Managerial and coordination tasks such as planning, budgeting, reporting and information exchange, which used to be organized at lower, decentralized levels were centralized. When they remained decentralized, new organizational positions were created, such as medical managers – especially during the second wave of reform (integrated rationing) in the 1990s. In the latter case, obvious links between management and professional service delivery are maintained, but in other cases these links become weaker. Former directors in health care used to be 'primus inter pares', high ranking professionals and part-time directors. During the second and third reform waves, most health care organizations established 'executive boards' with full-time executives, who are supervised by 'boards of overseers'. Executive boards now function as liaison bodies between overseers, medical staff, organizational units, administrative units, and outsiders (insurers, patient organizations, and politicians).

The careers of members of executive boards changed and some interesting patterns have arisen (Noordegraaf *et al.* 2005). Although many executives still come from professional (medical or nursing) domains, many others have never worked in health care delivery, and have been trained as economists or business administrators. Nevertheless, both groups have really become tied to health care. They have management careers in health care, and during their careers they are socialized into the basics and intricacies of health care management. This, again, is stimulated by the fact that health care management is increasingly seen as a distinct area of expertise (backed, as discussed above, by educational programmes). Stolte, the founder of health care management education in The Netherlands, wrote the first text book on health care management in 1983, just after the financial stringency reform wave started (Stolte 1983). Fifteen years later, a full range of health care management programmes has developed.

PROFESSIONALIZATION OF DUTCH HEALTH CARE MANAGERS

The institutional separation of management in health care is not enough for us to be able to speak of a 'profession'. It requires the development of professional associations that transcend executive boards and organizational boundaries, bringing together people who perform 'similar' work and share ideas about their occupation. It also requires such associations to define, standardize and organize organizational control. Both features are clearly visible when it comes to Dutch health care executives.

The highest ranking Dutch executives have their own 'professional association', the NVDZ (Dutch Association of Hospital Directors – Association of Executives in Health Care), which explicitly aims 'to enhance the professional practice of its members', that is, executives in health care (NVZD 2005a). Coverage is extensive; around 40 per cent of all health care executives are members covering 90 per cent of health care delivery. In order to succeed, at the beginning of the 1990s, the NVZD started to cooperate with a university (Erasmus University Rotterdam) and in 1996 an academic chair was established. The holder of this chair, Pauline Meurs, a professor of 'management of health care organizations' started to set up educational programmes for NVZD members. In addition, the NVZD publishes a monthly professional journal (ZM-magazine), and organizes meetings, conferences and symposia, during which new books, brochures and protocols are presented.

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Finally, it upholds a professional code of conduct, as an 'ethical guide for good and incorruptible executives' (NVZD 2005b) and the NVZD has formulated a Governance Code, in order to circumscribe 'good' health care management.

All of this resembles features of classic professions. However, the NVZD does not automatically function in the same way. According to the NVZD director, the main reason for membership was not 'professional necessity', as an entrance requirement, but a special 'union facility', namely mediation in legal (and salary) issues. Although coverage at top levels is strong, levels just below executive boards have only recently started to organize management. In 2006 an association of middle-managers in health care (VHMZ) was established. So the NVZD operates as a 'closed-shop', since it is restricted to the highest-ranking executive board members. At the same time, it would not qualify as a closed occupational domain, since membership is voluntary; since reasons for becoming member are variable; and since boundaries are flexible. New executive groups, such as public health executives, were accepted, and NVZD members can become members of other manager associations, within or outside health care. Finally, member careers might be influenced by, but careers are not dependent on the NVZD and success is not pre-determined. In terms of career paths, career moves, educational histories, and managerial outlooks, individual members show little consistency. Individuals might become executives without educational qualifications, and they might switch to other health sectors.

Nevertheless, as indicated above, membership is extensive, and the NVZD is known as a lively association which means something for its members. It also plays a role in national policy debates, for example, on executive salaries. NVZD rules, standards and facilities are maintained and have effects, because they are beneficial to members, not only substantively, but symbolically as well – in spite of the fact that its regulatory force is relatively weak. The NVZD's code of conduct, for instance, functions as a 'symbol' or 'reference instrument' for executives – in order, many argue, to show the outside world that they are subjected to 'rules of good governance'. This is a good example of 'soft control', voluntary and beneficiary, latently standardizing managerial work, but without strong coercive means. Educational trajectories and programmes are even better examples of such forms of 'soft control', since their effects on standardization might even be greater.

EDUCATION FOR DUTCH HEALTH CARE EXECUTIVES

Dutch health care management education has roots that date back to the beginning of the 1960s. These historical antecedents have affected the way programmes look many years later. Dutch health care management education can be classified as affecting two possible target groups and two possible levels of higher education. High-school graduates can become students at universities or schools for Higher Vocational Education, some of which offer health care management programmes. In addition to such graduate education, post-graduate or executive education refers to programmes specifically designed for practitioners with work experience. Universities focus on more abstract theories and gear their programmes more towards the analysis of policy and strategic issues; schools for Higher Vocational Education offer their students more practical tuition, preparing them for more operational tasks. Table 1 gives an overview of the organization of Dutch health care management education.

In order to understand the executive professionalization project we focus on post-graduate programmes. We concentrate on academic programmes because these programmes seem to

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TABLE 1 *Educational programmes for Dutch health care management*

		Level of education	
		Academic	**Vocational**
Target groups	*Graduate education* (young students)	Two universities: 1. 'Health Sciences' (Health Policy and Management) at Erasmus University Rotterdam 2. 'General Health Sciences' at the University of Maastricht	12 programmes 'Management in Health Care', including 3 full-time bachelors*
	Post-graduate education (managers with work experience)	Three universities, two business schools and several private institutes (consultants, trainers)	Four schools for Higher Vocational Education: 'Advanced Study', especially for nurses

*Figures from Schoolweb (http://studiekeuze.schoolweb.nl).

be the most important for high-ranking Dutch executives (compare Noordegraaf *et al.* 2005). The major institutions offering post-graduate academic management education are CMDz of Erasmus University Rotterdam, TIAS Business School, and TRANZO at the University of Tilburg. These institutions offer programmes of at least one year (part-time), specifically designed for and aimed at top-level managers and executives in health care.

The first educational course for such executives (although at that time they were not named as such) was developed in Tilburg in 1961. It grew out of the 1959 World Health Organisation (WHO) symposium in Edinburgh (Festen 1978, p. 8), attended by the Dutch delegate Stolte. Trained as a doctor, Stolte became a physician director and also a leading figure in the domain of hospital policy and organization. He delivered several speeches on hospital organization at a time when hospitals were growing more complex. In 1961, Stolte set up his own course on 'Hospital Policy', in cooperation with corporatist hospital associations and several (public) health education institutions that already offered 'in-company training'. Stolte's aim was to 'activate' administrators in leading hospital positions and to teach them 'not to take things for granted' (Festen 1978, p. 9). Although Stolte retired many years ago, and his course underwent institutional and curriculum changes, the so-called 'Stolte's course' still exists today.

In the 1960s and 1970s, many health directors followed Stolte's course, during which the technicalities of organizational management were taught, with particular emphasis on planning (compare Stolte 1983). After Stolte's retirement, the new director emphasized 'non-rational' dimensions of management and focused on the 'personal side' of the 'managing director-in-action'. When this new programme started to lose its market position, a new director was appointed in 1992 and it became, as one respondent called it, 'less postmodern'. The course still focused, however, on the more 'personal aspects' of management in order to counteract the 'instrumental effects' of the first (and second) waves of reform. During the second and third reform waves, the new director was asked to develop a new programme in order to prepare managers and directors for what was seen to be the upcoming health markets. Inspired by American examples of post-graduate education, the director developed a more technical programme, a 'Master of Health Administration' (MHA) programme.

Although the Stolte course was the first, other courses and programmes followed. This was caused mostly by the waves of managerial reform and the increasing demand for

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executive education but arguably partly caused by changes in the Stolte course itself. The strengthening of a profession, represented by the NVZD, underpinned this. Partly because of NVZD back-up, today, CMDz offers the largest number of courses and also what might be termed the most 'visible' courses. In 2003, CMDz was established as an organizational unit within iBMG, the School for Policy and Management in Health Care at Erasmus University Rotterdam (EUR), which also provides graduate bachelor and master programmes. CMDz grew out of the successful 'Master Class', set up in 1996, in close cooperation with the NVDZ.

In the beginning of the 1980s, the founders of the Institute for Policy and Management in Health Care (iBMG) already had plans for a post-graduate curriculum. It would aim at 'additional schooling of specialists (medical, economist, statistic, et cetera), who want to link their own discipline to general problems of health care delivery' (Committee Public Health School 1979). After several failed attempts and after a new professor (a former consultant) entered the scene, the NVDZ and the iBMG agreed to cooperate in order to provide an educational programme for NVZD members. In 1996, the first Master Class began. Since then, the programme has been successful and new programmes for other target groups were introduced – one of the reasons being to form an organizational unit, CMDz: a 'Top Class' for high potential managers; the course 'Juvenile Health Care' for youth care directors and managers; the course 'Supervisors' for supervisory councils; the course 'Financial Health Administration' for financial managers; and 'Values in Health Care', together with the Dutch School for Public Administration (NSOB). After running some ten courses, the Master Class changed its name to 'Care for Europe', although it maintained its format (intensive workshops) and its target group (experienced high-ranking executives). In 2005, two new master programmes were set up, 'Health Information Management', and – with a 'sexy title', as one respondent said – an 'MBA Health'.

In Tilburg, some smaller programmes have been set up, with specific target groups. Many of these programmes are organized by TRANZO, a research institute within the Department of Social Sciences of Tilburg University, which maintains close relations with several umbrella organizations, associations and provincial and regional councils. One of the respondents labelled this web of interactions 'a giant corporatist mafia', based on the double roles of its key players, but he also valued it as a conglomerate. Interdependencies assure the following: (1) practical relevance; (2) a wide group of relevant guest lecturers; and (3) extensive marketing potential. Since 2000, the board of the University of Tilburg resumed an interest in post-graduate educational activities because of their commercial value. Of these post-graduate courses, health programmes turned out to be the most profitable. They were channelled through TIAS (the Tilburg Institute for Academic Studies), the institute for post-graduate education. Because TRANZO and its partners were afraid that interdisciplinary research programmes would be harmed by commercial motives, they withdrew, except for the Master of Health Administration (MHA) programme.

To complete the picture of post-graduate academic management education, IBO, the Institute for Business Administration Education (the commercial branch of Groningen University) offers a one-year course in Health Care Business Administration. This course focuses on business administration themes such as entrepreneurship and results-oriented management, and on businesslike health themes such as 'integrated care'. In addition, the Department of General Health Sciences at Maastricht University offers a programme for International Health Care Services. Finally, a joint venture of NVZ, the Dutch Association of Hospitals and Nyenrode University, a private, business-oriented university, tried

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to but did not succeed in establishing an 'Academy' for hospital managers and executives. According to one respondent, hospital managers have a tendency to act in 'egalitarian' ways, so, in the opinion of this respondent, this academy was 'no smart idea', since this separate and 'elitist bastion' would frustrate developments of 'transmuralization', 'regional cooperation' and 'mutual learning'.

DUTCH 'SCHOOLS' AND THEIR IDEOLOGICAL PROFILES

Despite common objectives such as 'educating health care managers', 'supporting executives', 'transferring applicable knowledge, insights and experiences', and 'making management more effective', the evolution of health care management education shows a complicated evolution. This evolution fits a more political, symbolic reading of professionalization processes taking place amidst ambiguous circumstances. Different institutions and programmes have distinctive profiles, with unique 'selling points', different managerial images and academic models. They are also backed by different 'strategic alliances' with other parties, including associations such as the NVZD. Even within one and the same institution, different programmes might have different profiles. This appears to be a matter of both financial considerations, since programmes must be profitable and institutions search for market niches, as well as of personal considerations, since people who lay the groundwork for new programmes have come up with new ideas. Some programmes, for instance, favour more 'classic' academic schooling; others have a 'postmodern' twist, which often changes when new programme managers and academic directors become involved. This happened most clearly in the 'Stolte Course', but also in Rotterdam, where different programme leaders have established different programmes. This is not just a matter of financial and personal decisions, however; programmes show trade-offs that are influenced by educational considerations, which in themselves are set against the background of reform waves.

These trade-offs have a lot to do with 'substance' in terms of general academic orientations as well as the specific themes and courses offered. Some programmes 'go with the flow' of reform waves and focus on business methods for health care management; others 'go against the tide', emphasizing the shortcomings of managerialist and market-based methods. Consequently, some programmes start from business administration and generic organizational science; others are grounded in (critical) organization theory, public administration and political science. This is shown by themes and courses offered; they are about specific, technical themes, or about broader themes and strategic perspectives. It matches French and Grey's (1996) and Davies' (2006) distinction between 'vocational' and 'liberal' education.

These trade-offs also have to do with 'form' in terms of educational 'philosophies', group composition and didactic methods. Some programmes try to improve 'cognitive' capabilities; others try to strengthen 'experiential' competencies. Partly influenced by the number and nature of participants, didactic methods and lecturing styles range from interactive, more informal, small group meetings, to large-scale, unidirectional, and more formal lectures. Groups might be small, identifiable target groups, regulated by institutions such as the NVZD, or courses might be open to everybody interested in health care management. Finally, these trade-offs have to do with 'process', not only with the length of educational processes, but also with educational outcomes. Programmes might directly focus on improving individual qualifications (by providing MBA-titles, and the like); or on improving careers or, more indirectly, on strengthening executive qualifications to improve management.

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In the face of common objectives to 'produce' well educated and trained health care managers, then, all post-graduate academic programmes make different decisions, and they adapt these decisions over time, against the background of waves of reform. CMDz, for example, offers several programmes for different audiences, some of which are strictly defined due to links with the NVZD (most specifically the 'Master Class'). CMDz programmes balance academic knowledge transfer with 'action learning' and 'intervision'. Its academic roots are in (critical) organization theory, organizational sociology and public administration. TRANZO has less predefined target groups, but distinguishes itself by its 'invitational' programmes and courses for medical specialists who want to start a (part-time) career in management. Its programmes are sensitive to health care specificities, and critical of businesslike health care management. TIAS, in contrast, has a rather open target group of managers in health care and other organizations, and its Masters programme predominantly focuses on corporate and strategic issues. IBO's target group is even more open, and its programmes are about applying business perspectives in different settings.

The above discussion shows the existence of different 'schools' of health care management, literally and figuratively, in The Netherlands. These schools in turn affect the evolution of a professional 'cadre' of health care managers and executives. In addition to substance, form and process, the 'professional' profiles of educational programmes are important for this. This is even less a matter of financial and personal considerations than those discussed above – it represents 'professional pluralism' in terms of different perspectives on health care and different views on health care managers.

Firstly, the question is whether programmes are designed for individual executives, or for the executive function in health care. Programmes might be designed for improving the qualifications and careers of individuals in health care, or they might be about improving health care management. This is obvious when formal programme rhetoric is encountered. IBO, for instance, specifies five educational objectives, which are all about 'personal needs', underscored by the use of the Dutch word 'U', the formal 'you'. One objective is about 'career perspectives of participants'. The Master Class of CMDz, on the other hand, presents five objectives, without mentioning the individual as beneficiary. It pays more attention to 'professional organizations', 'social trends' and 'challenges for organizing'. In a more institutional sense, this distinction is reinforced by educational outcomes. Programmes might lead to certificates that express individual qualifications; or they might lead to certificates that represent professional qualifications, backed by professional associations such as the NVZD.

Secondly, how health care is perceived in programmes might vary. For some programmes, health care is a 'normal' sector, which has to be treated and managed 'normally', most importantly by using businesslike and market-based methods. For other programmes, health care is something 'special', and outside or 'alien' forces must be recognized, as well as being buffered. This basic divide runs through the programmes that were analysed, and it is also observed by many respondents. IBO and TIAS are put 'on one side', and CMDz and TRANZO 'on the other'. One of the respondents used the distinction between 'Rhineland' and 'Anglo-Saxon models' for this. The Rhineland model sees health care management as a separate and distinct form of management, which could benefit from business administration, but should not be equated with that. The Anglo-Saxon model, on the other hand, sees health care management as complex, but is convinced it should not really differ from business management in terms of goals and methods. Health care managers should behave as 'normal' businessmen.

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Although such a divide between businesslike and critical ideologies in health care education is not absolute, it contains an important truth. Against the background of certain waves of reform, the professionalization of health care managers and the education of executives is viewed and institutionalized in heterogeneous ways. Different schools of health care management not only embody different educational models (in terms of form and process); they also embody different images of health care executives, and different ideas about occupational standards, ranging from certification to competencies. This mirrors broader reform movements and ideological controversies over the nature and future of health care. Because different schools have different ideological profiles, the professionalization project has an inevitable political dimension, and contributes to heterogeneity in health care management definitions and standards, despite homogenizing ambitions. The divide between businesslike and critical ideologies is summarized in table 2.

CONCLUSIONS

At first sight, executive professionalization in health care appears to produce a 'cadre' of professional managers who are part of an organized occupational domain and are increasingly seen as 'professional' managers who work in managerialized health care. Together with other mechanisms of professional control, educating managers and executives appears to strengthen occupational control. As managerial work is defined and standardized, and knowledge and skills are transferred, we can expect health care management to become more homogeneous. This is stimulated by the managerialization of health care services, and the spread of managers. Health care management is organized to cope with reform consequences and to find effective ways to deliver health care.

Executive professionalization is not what it seems, however, especially when its educational underpinnings are analysed. Educational programmes, which have blossomed in the past two decades, provide no clear 'instruments' for defining and standardizing work. Different educational programmes really are different, not just in terms of how they are organized, what themes and courses they offer, and the kinds of qualifications they offer, but also in terms of their educational and ideological profiles. These profiles grow out of the interweaving of personal, financial, educational and ideological considerations, carried by educational institutions, professional associations, and other parties. Behind the façade of occupational homogeneity, there is educational heterogeneity, reflecting ideological struggles over the nature and future of health care. Although our research did not examine how educational programmes really affect members, let alone how other professional mechanisms affect occupational control, this conclusion says a lot. When crucial associational constructs such as education are heterogeneous, individual and organizational behaviour can be expected to be all the more heterogeneous. In that sense, the search for standards reinforces ambiguities. To put it another way, when educational

TABLE 2 *An 'ideological' divide in Dutch health care management education*

	Businesslike 'schools'	**Critical 'schools'**
Health care sector is seen as:	Normal sector	Distinctive sector
Management methods come from:	Business administration, economics	Organization theory, organizational sociology, political science
Programmes are valuable for:	Individual executives	Executive function
Dutch examples:	TIAS, IBO	CMDz, TRANZO

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programmes cope with ambiguous work and contexts, the ambiguities of work and contexts become manifest.

In line with a more political and symbolic reading of professionalization projects – combining professional pluralism, politics of professionalization, and symbolism – this comes as no surprise. Professionalization is no neutral phenomenon, because big personal, financial and organizational stakes are at play, and because political and professional circumstances offer many ambiguities. How professionalization projects evolve, who is involved, and what outcomes are produced cannot be seen as a functional improvement of systems, but as a search by occupational 'segments' for appropriate and legitimate systems. This does not mean terms such as 'professionalism' are outdated. The institutional separation of 'management' and its search for legitimate positions within systems can be aligned with theoretical contours of professionalism. How the various segments are educated will deviate from the classic model of professionalism, however. Professionalization will have to be seen as 'projects' that are full of 'power play', which are the cause and consequence of bigger events, such as bigger waves of health care reform.

What is surprising in Dutch health care, then, are the following. First and foremost is the wide-ranging coverage of the NVZD, covering around 90 per cent of Dutch health care delivery, despite heterogeneous activities and affiliations. Furthermore, the appearance of 'friendly fragmentation' in executive circles, with executives who have – and are taught to have – different views on health care, but who are all members of the NVZD, visit the same conferences, read the same magazines and brochures, and formally subscribe to the same code of conduct. Despite a big 'businesslike versus critical' divide, both 'camps' interact a great deal. Although this will not be unique for The Netherlands, it might be reinforced by Dutch corporatist roots and a 'hybrid' health care system, with an intricate intermingling of state, market and civil society. Although power play surrounds executive professionalization, even this power play can be 'professional'.

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