Chapter 17
A Client Perspective on E–Health:
Illustrated with an Example from The Netherlands

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ABSTRACT
After the Second World War democratization, information technology and globalization changed healthcare. Democratization made that clients from an object of treatment by professionals became active participants in taking care of health. Globalization brought the free market place closer to choices clients made for services. Information technology accelerated the way knowledge was accumulated and communicated by medical sciences, medical practitioners and clients. In research studies indications are found that healthcare facilitated by information technology (E-health) improved the care. However the evidence was not quite strong, also because the used research designs were not always suited for E-health. An overview of research designs leads to the conclusion that action-research is more suited for E-health, particularly when clients are taken serious as partners in healthcare. An example of action-research in mental healthcare in The Netherlands illustrates this. It also shows that a partnership between professionals and clients can be beneficial for both actors.

A HISTORICAL PRELUDE TO E-HEALTH
Healthcare in our modern Western European societies has been developed in a long social tradition. It took some time, for example in the Netherlands, before the foundation of the welfare state was laid into solid laws as a product of the negotiation between a ruling class and the labor class. And it was only after the Second World War that the laws for social security were completed by a law (1947) that obliged everyone in the Dutch society to take a health insurance. Private insurance companies, at one hand created for the rich, on the other hand founded by trade unions for the poor, became state
regulated. It was also after this Second World War 
that the flourishing economy made it possible 
for the state to go from a policy that took care of 
well-fare (a minimum income for example) to a 
policy that focused on well-being (for example 
taking care of leisure time).

This paradigm shift from welfare to well-being 
was supported by science. Earlier in history the 
medical sciences extended their skill and knowl-
edge from physical healthcare to mental health-
care. Moreover later on psychiatry extended her 
medical domain to a social domain: social psy-
chiatry was born. In the fifties of our late century 
social support activities had been regarded and 
reconstructed by American researchers (Lewin, 
1948; Benne et al 1976) as ‘social engineering’ 
with the aid of knowledge from the social sciences. 
The practice of social support was reflected and 
guided in a scientific way. In Europe the scientific 
reflection of social support led to such disciplines 
as social medicine, community based psychiatry, 
social pedagogy, organizational psychology, adult 
education and disciplines for leisure time (studying 
cultural and touristic activities). The old mission 
of the labor class was taken seriously by some of 
those pioneers who focused their work on values 
such as emancipation and democratization.

This led in the seventies of the 20th century to 
a booming business of public activities for social 
support, by employees of: healthcare, social work, 
cultural work, community development and adult 
education.

With the prosperous economy society de-
veloped the luxury of democratization. Clients of 
the social services were invited to take part in 
this emancipation of citizens. The government 
for instance made laws in which institutions for 
social services were compelled to involve clients 
in their board. Such an atmosphere stimulated 
clients, for example in healthcare, to go public 
and openly ventilate, sometimes invited by 
media, their grievances. Research of the quality 
of healthcare revealed that there was still a lot 
to win. In mental healthcare, patients were still 
without rights, isolated in isolation cells, unwill-
ingly treated with old fashioned methods such as 
electro-shocks, complaining about side-effects 
of medicines. A confederation of clients of the 
mental healthcare has been founded in those 
times. Clients participated more and more in the 
decision making of institutions of social services 
and sometimes. They sometimes worked together 
with professionals that wanted to reform the sta-

tus quo of the social services. In psychiatry, for 
example, an alliance of anti-psychiatry between 
professionals and clients was formed against 
the medicalization (Ilich, 1975) and isolation of 
abnormal behavior in psychiatric hospitals. Was 
that abnormal behavior also not caused by a dys-
functional social environment, and would it not be 
better to change that environment as well? From 
an object of treatment of professionals, patients 
became a participant in the process of recovery 
of themselves and the environment. Patients and 
their relatives, stimulated by the state, got involved 
in healthcare policy making.

Professionals as such were ambivalent about 
this situation. They welcomed the participation of 
clients, but were also afraid to get out of power. 
However soon they retained and by using tech-

nologies of informatization they strengthened 
their instruments of administration and control. 
At the end of the 20th century when the ideology 
of the free market became stronger (the state 
drawing back from economy) healthcare was left 
to the free market. That had the consequence that 
patients became weak actors in a complex free 
market system that operated businesslike and was 
mostly controlled by professionals and insurance 
companies. Also the globalization of this system 
made it more complex for patients. Patients in 
the Netherlands who were put on a waiting queue 
discovered that in neighboring countries they could 
get help immediately. That introduced in theory 
more possibilities and choices for patients. But it 
also turned out in practice slippery because of lack 
of adequate information and unknown financial 
interests of globalizing professionals.