



## MARKETS AND PUBLIC VALUES IN HEALTHCARE

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## ABSTRACT

Discussions of the role of markets in healthcare easily lead to unproductive political polarization. Actors arguing in favour of markets as a solution for the quality/cost conundrum are lined up against others, pointing out the risk of markets for the delivery and governance of healthcare. These binary options for either more or less marketization preclude a more empirical analysis of *how* markets, as multiple arrangements, are constructed and what their consequences are for public values like affordability and quality. This paper explores the empirical relationship between markets and public values in healthcare by analyzing the construction of a market for hospital care in the Netherlands, based on a system of diagnosis-treatment combinations (DBC's), and the development of a market for long-term care, based on care-load packages (ZZPs). In both cases we address the *intended* result of care markets according to various policy actors, the visible and invisible *work* done by various actors to make markets work, and the *values* enacted in market practices. Whereas the policy aims of these markets focus on providing choice and increasing the diversity of care institutions, we show that DBC's and ZZPs produce isomorphism and homogenization instead. Furthermore, the strong influence of financial instruments in shaping healthcare markets assume that both cost and quality can be improved, whereas in fact these financial instruments have a profound influence on *how* public values like quality get defined in practice. The discrepancies between pursued values and produced outcomes indicate the problems of conceptualizing the role of the state in defining the public values that markets are obliged to implement, as this removes the crucial normative work in shaping our welfare state to the realm of technical market operationalization. An alternative relationship between state, market and society can be conceived once we *accept* that such values are shaped in practice and that the relationship between policy *aims* and *consequences* can never be fully captured through the logic of implementation. This means that the role of the state should be experimental: it should see market developments as experimental devices aimed at a good composition of public values. The experiments could, for example, focus on market developments that do not assign a privileged status to financial devices and price mechanisms, such as a market for the DBC A segment, where prices are not freely negotiable. Such experiments could allow competition to focus on other public values like quality and maintaining accessibility while at the same time functioning as learning laboratories for reconceiving the role between state, market and society.

*Keywords:* healthcare markets, public values, experimental state, composition.



## 1 INTRODUCTION: RESISTING RHETORIC AND OPENING THE BLACK BOX OF HEALTHCARE MARKETS

Early in 2010, only a week after Queen Beatrix of the Netherlands had accepted the resignation of Labour party ministers and state secretaries, leaving the country in the hands of a caretaker government, former Labour finance minister Wouter Bos announced: “We don’t need to increase the level of marketization in healthcare at the moment. What we do need are hospitals and care professionals cooperating, rather than hospitals and care professionals competing even more with each other” (Bos in Van Dorrestein 2010). Perhaps unsurprisingly, the Dutch Healthcare Authority soon followed up this statement by claiming that it would be warranted to extend that portion of hospital care in which prices are freely negotiable between hospitals and healthcare insurance companies, based on findings extrapolated from the relatively low price increases for such care (NZA 2010). Soon afterwards the interim minister of healthcare, Ab Klink announced that discontinuing this increase would lead to extra expenses that would inherently result in further cost-cutting or increased insurance fees at a later stage (Van den Elsen 2010). His announcement was an attempt to identify the expansion of free price mechanisms in healthcare as an issue coming under his jurisdiction as caretaker minister, rather than as a controversial policy decision that could be postponed until after the elections. However, the Dutch House of Representatives soon set him straight: the extension of free price mechanisms *was* a controversial issue that should not be decided by a caretaker government.

The observation that healthcare markets are highly controversial is common among scholars studying the relationship between markets and society. After the 2008 financial and economic crisis, however, policy makers and politicians in many Western states also began discussing markets in increasingly controversial terms. The controversy surrounding the extension of free price mechanisms in Dutch healthcare is more than just a sign of political polarization in the wake of newly announced elections: it is, rather, a telling example of two tendencies in the debates on healthcare markets. First, it shows how such debates are often framed in polemical terms consisting of binary options: either more marketization or less marketization. Second, it shows that the *evidence* for whether a healthcare market works is often financial in nature, under the assumption that in well-functioning markets, price reflects quality. Public values like quality *are* often part of the *debate* on healthcare markets, but are often based on general and somewhat prophetic claims that apparently need not be empirically substantiated.<sup>1</sup>

Due to these tendencies, the political debate on the marketization of healthcare is replete with rhetorical arguments by proponents and critics of ‘the market’, that monolithic entity whose properties are assumed to be known. It is precisely this ideological take on *the* market in healthcare that obstructs a more empirical analysis of how markets, as multiple arrangements, are actually constructed and what consequences such specific market arrangements have for the *realization* and *interrelation* of *public values* like affordability and quality (Zuiderent-Jerak 2009). Commentators, notably health economists (Schut 2009), have been proposing an empirical analysis of how markets work for decades and, if we allow a tad of whig history, the need to study healthcare markets in all their empirical complexity had already been proposed by Adam Smith in *Wealth of Nations* (Smith 1776 (2000)). Smith argued that the free market would not work well in healthcare due to the relatively high cost of education, which would sit uncomfortably with the low prices obtained by providing medical care at a free market rate (Schut 2003). While a ‘free market’ is preferred by only 8 percent of the members of the American Economic Association (Klein and Stern 2007), *health* economists have been particularly wary when it comes to expecting positive results from liberalizing healthcare per se. As a result, health economists have focused much of their practical and theoretical efforts on constructing a healthcare market that does not depend on an ‘invisible hand’ ascertaining public values once healthcare markets are ‘deregulated’, but that is built upon the notion developed by health economists of ‘regulated’ or ‘managed competition’ (Enthoven 1988; Enthoven and Van de Ven 2007). Though this notion has been of considerable importance in economic studies of the relationship between state and markets, it does tend to operate from the assumption that markets implement politically defined public values. The success or failure of markets in doing so is the main reason for wanting to scrutinize markets empirically. Social studies of markets has a similar empirical focus, but rather than concentrating on the *implementation* of public values, scholars in this field analyze how markets *shape public values in practice* (Callon 1998; Callon, Millo, and Muniesa 2007; MacKenzie, Muniesa, and Siu 2007). This approach thus opens up the domain covering the construction of market practices to the broader sociological enquiry of how different actors interact and what consequences their interactions have for the way public values play out in practice. In this paper, we explore the value of such an approach for the discussion of state, market and society in relation to healthcare markets.

Besides health economists and social scientists, policy makers have also been drawn to the subject of the relationship between the state’s responsibility for ensuring public values and the development of healthcare markets, at least since the 1980s. Besides the rise of new public management (Pollit and Bouckaert 2000) and other forms of neoliberal policy-



making, their interest in market mechanisms to ensure public values has been influenced by prevailing policy theories on public values and the role of governments in guaranteeing them. The reasoning here is that there is a difference between ‘societal’ and ‘public’ values (Van der Grinten 2006). Societal values are those that are desirable for society as a whole, whereas those values become ‘public’ if government needs to intervene to ensure them. It is government that classifies values into one or the other category, and once a value has been classified as ‘public’, governments are required to develop policy measures to make sure it is ensured. So far, so good, but there is no role for markets here. They have been brought back into the mix, however, through the following analytical move: though government has a mandate to *classify* values as ‘public’, the actual work of *ensuring public values can be delegated* to other parties (WRR 2000). In this conceptualization of the governmental role, market arrangements may be an efficient way to ensure public values, as they require minimal state intervention. Reducing state involvement without reducing governmental responsibility was not just an important aim when this theory was developed (the 1980s), it has also served as an attractive and convenient policy model ever since, one assumed to apply equally in the markets for telecom, energy, housing or healthcare.

Perhaps unsurprisingly, policy makers, policy scientists and health economists have been successful companions in designing health policy programs and putting them into practice. Their policy targets, theory and economic operationalization have proven to be a neat match. Whereas in the late 1980s, when Malcolm Ashmore, Michael Mulkey and Trevor Pinch saw health economists as marginalized players, underdogs compared to clinicians and policy makers (Ashmore, Mulkey and Pinch 1989), today such economists are key policy actors, populating influential regulatory agencies throughout Western policy systems.

One of the problems with having public values defined by government and then ensured by other actors is the assumption that, once defined, values remain static in the implementation process. As scholars from social studies of markets have shown, this is far from the case. Repeated studies have indicated that supposed operationalizations are by no means neutral instruments, but instead active agents shaping the very values they are supposed to implement in practice (MacKenzie, Muniesa and Siu 2007; Sjögren and Helgesson 2007; MacKenzie and Millo 2003; Zuiderent-Jerak and Van der Grinten 2009; Callon, Millo and Muniesa 2007). If values are not designed and implemented but are shaped in practice, then we may assume that the theoretically neat solutions of policy scientists are limited and must question how such values are intended and put into practice. Government agencies and other actors are continuously involved in the ongoing process of reconstructing these values in practice but at the same time they operate from a policy theory of public values that

precludes them from taking such co-production processes into account. On the contrary, the policy theory of public values that are defined and conveyed to the operational agents as given values to be implemented severely limits the scope of government agencies to act, once these values have been delegated (Zuiderent-Jerak and Van der Grinten 2009). The inherent policy aim is thereby to ensure public values through a government that is less involved in their operationalization. As this policy aim has proven problematic in empirical terms, the question becomes how state and market relate to each other if their roles are no longer confined to the state defining the public values that markets are obliged to implement.

In healthcare, public values have classically been defined as consisting of the ‘trinity of quality, accessibility and affordability’ of care (Connelly 1991; Van der Grinten 2006). However clear this may seem, the precise meaning of these three values is constantly reshaped depending on the issue at stake (Zuiderent-Jerak and Van der Grinten 2009). Given the limitations of the practical workability of the policy-scientific definition of public values and the role of governments in ensuring them, markets for policy domains such as healthcare do not seem to require the *unambiguous definition* of public values that can then be *ensured through delegation*; instead they require a permanent *composition process* in governance arrangements that are deployed to ensure these values and shape them in practice (Callon 1987; Latour 2007; Zuiderent-Jerak and Van der Grinten 2009). Thereby, ironically, markets sit uncomfortably with notions of deregulation and instead shift the regulatory tasks of policy actors to different sites: active involvement in policy experiments that shape and contribute to public values. This implies an empirical turn to healthcare market practices by policy scientists and policy makers alike, putting at centre stage a study of markets in the making and their consequences in terms of public values.

Studying which values are built into which market arrangements, and analyzing how these relate to prevailing values of care delivery, brings the construction and consequences of markets back into the realm of composing public values. Rather than healthcare markets being an operationalization of public values, pre-defined in a political process, by policy actors and rather than sticking to the promise that markets, under the right conditions and if properly organized, lead to allocative, productive and dynamic efficiency, a focus on *shaping public values in healthcare markets* may show what markets are about and how they deal with values other than efficiency alone. An empirical focus on shaping market practices is utterly different from the politicized and polarized debate on ‘the market’ and the question on whether *the* market is suitable to ensure *the* public values. It is precisely to this study of the composition of public values in healthcare markets that this paper is intended to contribute.

Which research questions come to the fore when studying the making of markets for policy domains such as healthcare and the consequences for public values? After specifying these questions, we analyze two empirical cases: first, the construction of a market for hospital care in the Netherlands, based on a system of diagnosis-treatment combinations (DBC's); and second, the development of a market for long-term care based on care-load packages (ZZPs). These case studies allow us to conclude which values are built into these markets and thereby how these markets play out empirically in terms of the public values they are intended to ensure. This also allows us to tentatively rethink the relation between state, market and society.



## 2 STUDYING MARKETS AND PUBLIC VALUES IN THE MAKING

If we cannot know precisely in advance what markets are and how public values are shaped in practice, the study of them becomes more of a process and less polarized. It allows for an empirical study of healthcare markets that does not put state and market in opposition to each other but, following Bruno Latour and Vincent Antonin Lépinay's rereading of Gabriel Tarde's *Psychologie Économique* (Tarde 1902) opposes those "who believe in miracles of a pre-established harmony and those who refuse to *believe in miracles*" (Latour and Lépinay 2009: 5). Based on this novel opposition, the possible critique to prevailing market practices is not that economically inspired marketization violates the complexity of social practice by reducing it to quantified outcomes, such is often proposed by economic anthropology. This 'counter science' of economics thereby also risks embracing a 'pre-established harmony' and merely claims that economists have the *wrong* harmony in mind. Rather, the critique is that both economists and economic anthropologists may tend to "*not sufficiently quantify* all of the values to which they have access" (ibid.: 12, italics in the original) and to the way the market devices developed and the pursued public values interact and shape each other.

Both market devices studied in this paper have a strong financial component. This is not to imply that they are *not* about other public values like quality or accessibility; such instruments precisely are expected to ensure quality and access, as well as affordability in the policy aims. However, given our approach in this study, financial instruments would not merely be expected to *ensure* instrumentally the public value of quality but also to *shape* the notion of quality in very specific ways. The reasons for the preference for using market devices with a strong financial aspect is to some extent obvious since, as Tarde points out, they have one crucial advantage: "wealth is something much simpler and more easily measured; for it comprises infinite degrees and very few different types" (Tarde 1902, as cited in Latour and Lépinay 2009: 14). However, if all instruments are not merely the *means* to achieve a pre-defined policy *aim*, but lead instead to specific shaping of the aims, that is the public values, themselves (Latour 1999), our empirical focus should shift from the assumption that financial instruments can be introduced to ensure a broad range of public values, to the consequences these financial market devices have for public values and how financial instruments reshape these values in practice.

To analyze the composition process of public values in market practices, we address three questions. First, what is the *intended* result of care markets according to various policy actors and market builders? They generally have a normative intent that is grounded in specific problems in healthcare settings. Failing to take this normative purpose of healthcare markets

seriously makes sociological enquiry susceptible to the criticism that it fails to resonate with the issues at stake (Zuiderent-Jerak and Berg forthcoming 2010; Latour 2004). Second, what visible and invisible *work* has to be done by various actors to make markets work? One of the main gains of social studies of markets, and their grounding in science and technology studies, is that it brings in the symmetry principle (Bloor 1976), implying that the same kind of explanation should be used to explain the success and failure of markets. A focus on the visible and invisible work (Star and Strauss 1999) of making markets does not privilege success over failure but also analyzes how *intended* effects are achieved in practice. Such work is often left out of the analysis of how markets work, by jumping to their effects that are then quickly classified as ‘normal’ effects of well-functioning markets on the one hand and ‘market failures’ on the other. Focusing on *consequences* rather than on *effects* also brings into the unit of analysis all that various actors need or fail to do to *create* these effects. Opening up the study of the interplay of markets and public values to this broader range of consequences thereby includes an analysis of who benefits and who pays the price of making these markets work. Enabling the articulation of the issue of *cui bono* (Star 1991: 43) brings us to our third question: what *values* are enacted in market practices in healthcare? This question allows us to address how the public values that these markets are supposed to ensure are actually shaped and at what possible cost or benefit and for whom.

Studying the intended results, the work needed to make markets work and the values that are produced in market practices in substantial empirical detail cannot be done overnight. The development, introduction and shaping of healthcare markets takes place over extended periods of time during which reconfiguration of organizations, market mechanisms, professionals and policy makers is ubiquitous. We therefore decided to focus our empirical analysis on two cases in which we already have an extensive and prolonged research relationship. Our combined research strategy revisited data from previously conducted research (2005-2008) including extensive interviews, ethnographic observations and interventionist research in the same organizations under study here.

The study of the market for hospital care was connected to two years of interventionist research (Zuiderent-Jerak 2009) in a large teaching hospital in the Netherlands. During this period, we conducted ethnographic research on one to two days a week which involved one of the researchers (TZJ) in the construction of care trajectories for oncology care, elective surgery and orthopedics that were supposed to bring together quality improvement and a strong position for the hospital. Returning to this hospital was the starting point of this case study, and it allowed us to draw upon existing knowledge about quality improvement developments in the light of the policy change, while also focusing on changes that had

occurred in the intervening years. This study was extended with interviews with a specialist nurse, the innovation manager of the hospital, a medical specialist who also chairs one of the specialisms in the hospital and a division manager. Following this, we conducted interviews with a purchaser for the largest insurer in this hospital's catchment area. We then interviewed the development manager and an economic expert at the Dutch Healthcare Authority and the expert at the Dutch Association of Insurers responsible for developing the DBC purchasing guide (see below).

The study of the market for long-term care was linked to a previous study of six long-term care institutions: two mental care institutes, two for mentally disabled people, and two nursing homes (Grit and De Bont 2007). At the time data were collected through semi-structured, in-depth interviews (n=29) and focus groups (n=2) with executives, managers, professionals and client representatives. In these interviews we focused on new developments such as market-like financing, commercial initiatives and demand-oriented care. Contrary to our initial expectations, the interviews gave the impression that the effects of the developing health care market are found only on the shop floor. During the previous study, the organizations were on the eve of introducing care packages and, some of them, commercial activities. We returned to two of our former case organizations to investigate whether their ideas had become a reality. In the organization for disabled people, we interviewed the project manager for care packages (ZZP), one cluster manager, two location managers, one senior finance advisor and one marketing manager. Here we focused on how the organization dealt with the new market device of care packages or individual-trailing funding (see below). In the organization for elderly care, we interviewed the executive, the medical manager and one care adviser. This organization had serious ambitions to start commercial activities. We wanted to know if these commercial activities had been implemented and what their relation was with care packages.

All interviews were transcribed verbatim and analyzed to explore the consequences of the market mechanisms introduced some years ago and see how these market devices had developed since then. It is this combination of data sources over a longer period of time that allows us to address the issues raised above. As is generally the case in ethnographic studies and other forms of qualitative research, representativeness is not the aim of the study (Cresswell 2003). Rather, this research focuses on a *specific* case which it analyzes in depth to produce precise findings that may function like a 'golden event' (Jensen 2009) in the sense that they are able to produce, through their specificity, interesting insights into practices that would not be captured by more general analyses of larger numbers of cases (Weiss 1977).

In the hospital market case, selection was based on the fact that we had a long-established research relationship with this hospital, which would be helpful in gaining access. The relationship itself was not mere coincidence. This hospital participated in government-initiated quality improvement programs and had indeed been ranked first in the most recent annual overview of hospital quality produced on the basis of performance indicators handed in by hospitals to the Dutch Healthcare Inspectorate. Although repeated studies have shown that these rankings are problematic and cannot be taken face value (Pollit et al. 2010; Pons, Lingsma and Bal 2009), its ranking does indicate that this hospital is committed to quality and thereby provides an interesting site for studying the interaction between market practices and public values. The relevance of this case is further strengthened by the fact that the largest insurer in the region has a reputation among policy makers to be committed to quality as well. This was seen as a risk in one of the interviews as in terms of this case it could prove to be a bias towards showing relatively positive relations between market practices that ensure public values. However, the potential bias is an advantage in this study as it allows us to analyze how markets and public values interact under rather favourable conditions, which increases the pertinence of any problems we may encounter here and also indicates some of the conditions under which public values might be seen to synergize.

In the case of the long-term care market, we selected two organizations that were front-runners in the debate on the introduction of market elements in healthcare. Although not explicitly pro-market, they have tried to react proactively to developments. Their stance towards market mechanisms, critical yet not a complete rejection, can also be seen as an advantage in this study as it allows us to analyze how organizations shape and defend public values after the introduction of a new market device (ZZP) in the long-term care sector. These organizations that were neither 'pro-market' nor 'anti-market' give us an impression of the interrelations between market practices and public values.



### **3 DIAGNOSIS-TREATMENT COMBINATIONS AND MARKETS FOR HOSPITAL CARE**

#### **3.1 What is the intended result?**

Since the 1970s, public expense in healthcare has been on the rise. By the 1980s, the introduction of market mechanisms was already being proposed as a possible solution to turn the tables on increasing costs (Van Egmond and Zuiderent-Jerak submitted). Though attempts at the time and in the following decades were initially unsuccessful, continuous efforts by policy makers to develop such infrastructures as risk adjustment systems for healthcare insurance companies prepared the ground for market mechanism-based changes in the governance of hospital care (Helderman et al. 2005). The notion that the healthcare consumer should have buying or co-paying power and thereby steer quality (Berg, De Brantes and Schellekens 2006) has been heavily criticized for being practically unworkable and theoretically flawed (Jost 2007); Dutch policy makers chose not to put this notion at centre stage in the construction of the Dutch hospital market. Rather, according to the 2006 Healthcare Insurance Act, the construction of the Dutch market for hospital care assumed that acting as proxies for individual citizens, insurance companies can buy good quality care at a reasonable cost on their behalf. This of course seems a perfect example of delegation of the ensuring of public values to private parties, as proposed by policy scientists. However, the process of delegation does not stop here, as ensuring public values is actually delegated one partial step further. As healthcare insurance companies are not automatically expected to want only the best for their clients, citizens are positioned as a countervailing power (Light 2000) by being given the option to choose their insurer. Insurance companies have to accept citizens as their customers and health insurance is compulsory to all citizens to avoid 'free riders' in the system. As not all citizens have equal health risks, this risk adjustment model compensates insurers for inequalities in health risks in their populations. A nationally defined basic package specifies the care that all insurers must provide. It leaves other forms of optional non-basic care to be insured via additional insurance schemes. This differentiation of basic and non-basic care is maintained by the Dutch Healthcare Insurance Board, that proposes changes for approval to government.

In this regulatory arrangement, the role of insurance companies is to negotiate with care providers on the quality and cost of the care they wish to deliver. Such negotiations would ideally lead to selective contracts, with insurance companies contracting only those care providers who provide the best quality at the lowest cost, thereby providing an incentive for other care providers to raise their bar in terms of quality and efficiency. Insurance companies are expected to have 'buying power' as they represent large numbers of citizens and thereby

many potential clients for hospitals. They are expected to apply this power to stimulate quality improvement and cost reductions.

To commodify particular treatments, prior to 2005, diagnosis-treatment combinations (DBC's), a version of diagnosis-related groups, were developed so that the negotiations between insurers and hospitals did not need to be based on individual interventions, but on DBC's that apply to a series of events and are more closely related to trajectories of care delivery. The Dutch Ministry of Health decided that the DBC's would be divided into two groups: an A segment, with pricing fixed on a national level and priced according to budgetary logic; and a B segment, with prices that could be freely negotiated between insurers and hospitals. Though both segments can in principle lead to negotiations between insurers and hospitals, leaving out price has turned the A segment into an unusual market, where negotiations mainly have to focus on quality and volume. Therefore this segment is usually *not* referred to as a healthcare market, whereas the B segment is. Discussions of marketization, such as the one that opened this chapter, focus on extensions to the B segment, equating 'markets' with 'money', which is exactly what Latour and Lépinay criticized. In our analysis, we do not wish to follow the distinction between the B segment as 'market' and the A segment as 'non-market', since this assumes an a priori notion of 'the market' that privileges financial considerations over other ones. However, we will observe that in actual fact many actors follow the definition of the market as a *financial* instrument and thus do not pursue opportunities for negotiation in the A segment. This is highly consequential and turns this segment de facto into an 'almost non-market'. Which brings us to our next question: how and why does this market work?

### **3.2 What makes markets work?**

#### 3.2.1 Care providers at work

In the wake of the developing market arrangements, the Dutch Ministry of Health started a large scale improvement program called 'Better Faster' which would "prepare the hospital sector for the new care system" (Ministry of Health Welfare and Sport 2005). Better Faster supported hospitals in improving patient safety and logistics through a series of national breakthrough collaboratives and other quality improvement programs. Hospitals started analyzing their care processes in terms of waiting time, throughput time, length of stay, number of interventions in the process and number of visits to the outpatient clinic. In effect, the hospitals analyzed how their care processes could be organized differently and how quality improvement could lead to gains not only in terms of organizational efficiency and patient experience but also in terms of the profits that a hospital made on care trajectories or, to put it more euphemistically, what the cost of poor quality was. For this, improvement

teams in hospitals developed business cases that compared current with desired trajectories to calculate the financial implications of their quality improvement efforts.

However, these business cases assumed that hospital financial departments knew the cost of individual interventions, outpatient clinic visits and the cost of staff. This was not the case. For most hospitals it was a huge task to produce costing data and they tended to prioritize calculating the costs of interventions in the B segment over calculating costs that were only relevant to the A segment. However, once available and integrated in these business cases, these costs sparked interesting discussions between hospital management, doctors and quality managers. In many cases quality improvement and cost reduction seemed feasible by reducing length of stay through better pain management or by omitting redundant interventions that were the result of poor coordination between professionals (Pronk 2006; Zuiderent-Jerak 2009). In other cases care processes could be organized as outpatient surgery, but this would lead to a reduction in income compared to admitting a patient overnight, for which another DBC could be used. In such cases there suddenly seemed to be very good medical reasons for not taking a risk and admitting patients for at least one night.

Improving care processes and assessing financial consequences were not the only tasks hospitals had to carry out. They also needed to develop ‘dashboards’ for internal steering, to ensure that once a care product had been sold at a low price, it would also be produced accordingly, rather than falling back to the previous situation, which could lead to the hospital facing financial loss. Overviews of the number of visits between colonoscopy and surgery, for example, were readily available and were contrasted with the norm for such care set by the improvement team for this care trajectory (see Figure 3.1).

Even if all of this was achieved, hospitals still had to face the substantial challenge of getting care insurers interested in quality improvement. This turned out to be particularly hard work with insurers who did not always display the expected level of interest during negotiations. As the quality manager of the hospital put it:

It’s up to us to bring everything to do with quality to the negotiating table, and they’re hardly interested. But at the end of the day they do come back with indicators or with the Consumer Quality index, or some other monsters.

**Figure 3.1 Dashboards for steering quality**



Since insurers did not seem to have an a priori focus on quality, the hospital went to some lengths to position quality as a relevant issue, trying to pitch their quality achievements. At times this led to fairly archetypical forms of commodification. The quality manager continues:

We have to put quality on the agenda. They're not asking for it, so we have to present it. In a few areas, and these are increasing, we know we have something extra to offer, a discerning product, so we put on a big song and dance – always spontaneous, not very structured – but quite a show really, just to make sure the insurer notices. Part of the show involves producing brochures on our discerning care product. We have brochures for our departments of obstetrics, gynaecology and paediatrics, nice brochures filled with graphs, protocols and the details needed by various target groups in the insurance company. We show them off, we say, here, take a look at this, this is what our care looks like. That's all part of our repertoire.

*TZJ: And that's clear to the insurer, that you produce those brochures especially for them?*

Yes, absolutely. You couldn't give them to anyone else. No patient would think 'this is about me'. They're offered to and discussed explicitly [with the insurer]. Well, and another string on our bow is, of course, that we always get our specialists to join the discussion. So we have two gynaecologists talking the medical advisor [of the insurance company] through the process right up to the last injection required after delivery, explaining why *that* injection at *that* moment *really* must be included in this DBC. In our experience it takes a specialist to convince a medical adviser. But perhaps this model has already lost its force, because now we're seeing that even gynaecologists have to sacrifice items in their care products.

Despite producing sales brochures and getting medical specialists in on the negotiations and personally specifying quality, it remains hard for a hospital to sell quality in terms that

medical professionals would like to see. In the debate on healthcare markets the fact that negotiations are sometimes more focused on financial aspects than on medical quality is often explained away by the existence of ‘information asymmetry’. If information about quality is not readily available to all parties, the negotiations will focus on the information that is available, and that tends to be of a financial nature since, as we have seen above, financial measures comprise infinite degrees and very few different types. In response to this problem, many actors try to define quality in terms of quality *indicators* with an equal simplicity and transportability that can then be brought into the assessment. As the purchaser of a large insurance company put it:

What quality indicators could we agree on? This is something we focused on immediately in 2005: we went for that quality. And then we invested a lot, especially in the first years, in discovering what care is actually delivered. That was our input, when we negotiating price, to put actual care delivery next to those quality indicators.

The notion of information asymmetry would suppose that once transportable performance indicators are available, they would be taken into account in quality and price negotiations. However, in our case the problem seems to be that even *readily available quality information only becomes part of the equation in very particular instances*. And those instances tend to be where cost, again, is an important factor. As the purchaser put it:

If you want to be a preferred provider, then your price has to be below average. That doesn't mean that as soon as someone else goes ten euro cheaper, they would get moved to pole position. (...) We assume that quality and affordable care can go together. That means that as soon as you [the hospital] do something right but it turns out to be more expensive, we would be less interested than if it happened to be less expensive.

Though beyond the scope of this study, it would be interesting to analyze which hospitals are indeed assigned as preferred partners since this interpretation of quality partly explains why it is so hard for hospitals to bring quality into the negotiation equations. Even when readily available, quality largely becomes relevant only when it saves on costs. If quality always came at a lower cost, there would be no conflict but in that case healthcare could do with simple techniques – purely calculative arrangements – for measuring best quality at lowest cost. As this was the initial assumption for many players in the hospital care market, this market in this hospital ironically worked *better* in terms of negotiating for quality and price in the *early years* based on relatively *poor information* (Zuiderent-Jerak 2009) than it seems to be working now, after a longer period of sometimes frustrating experiences, but based on *better information on quality and cost*. The dashboards on quality and cost parameters per care trajectory that were only managerial dreams in 2007 had actually materialized by 2010 and yet it proved harder to bring quality and cost together in some cases in annual negotiations. On the one hand this is an important finding that problematizes the notion of information asymmetry and brings to the fore the importance of *belief* in making policy instruments

work. On the other hand it shows the importance of sustained analysis of how markets work over time. Beliefs may change due to multifarious reasons, which may have dramatic consequences for how capable market practices are in ensuring public values. One of the reasons this belief may have changed over time is that if insurers purchase quality at a higher cost, it is evidently very hard to sell the higher price on to their insured. We return to this issue below, but for now this situation puts at centre stage the question of what can be done for better care that may come at a higher cost when an insurer defines quality in terms of cost reduction.

According to the representatives of the Dutch Healthcare Authority, three types of innovation will relate differently to the present regulatory arrangements:

There are different forms of innovation. First, if the same quality care gets cheaper, then of course, that's fine. Second, if better quality costs more, then you'd have to pay more and that has to be reflected in the price – or not, but then you'd end up with an insufficient supply. And thirdly, we have breakthrough technologies, which may need to be subsidized.

For the actors involved, the second form of innovation is especially problematic. There seem to be two possible strategies, both of which the hospital is pursuing: creative bookkeeping (not necessarily in the usual pejorative sense of the term) and playing the patient card. Creative bookkeeping has of course become associated with scandals, greed and the misappropriation of funds. Leaving such normative judgements aside, at present hospitals have literally more imaginative bookkeeping strategies, in the sense of creatively ensuring that the costs incurred for delivering additional quality are actually borne by insurance companies. Such creativity sometimes leads to adding up only certain items to then be able to charge a different fee. As a division manager explained:

Outpatients with oesophagus carcinoma get a PET-CT scan. If deemed necessary after this scan assessment, they also get an endo-echo test on the same day. Because of their illness they are quite frail and so we admit them on a day care basis, giving them a bed in to recover in, in between these two big, heavy diagnostic tests. Because of our regional specialization and given the relatively long distances many patients have to travel, day care treatment is all the more important. It's how we reduce the number of hospital visits *and* manage to create a means of recovering some of our additional costs.

Creatively bookkeeping DBCs is a strategy that generally does not get much societal acceptance. The health economists' literature refers to it as 'up coding' (Steinbusch et al. 2007), defined as 'the practice of miscoding and misclassifying patient data to receive higher reimbursements for services provided' (Lorence and Richards 2002: 423). It may be a pragmatic solution and highly understandable given the present complexity of financial streams, but some health economists see it as a 'hospital-acquired disease' (Simborg 1981). One of the main problems with up coding is that there is no countervailing power that

prevents creative bookkeeping from turning into simple money-grabbing. For an inefficiently organized hospital it may be a way of making ends meet, but it is not contributing to the public value of affordable care.

One possible alternative that does not involve up coding would be to play the patient card. In the model of the Dutch hospital care market, the countervailing power would be individual patients who are expected to vote with their feet and change insurer if not satisfied with the way the third-party insurance company is ensuring their interests (Schut 2009: 70). This would encourage the hospital to target patients and their representatives more directly in order to ensure that insurance companies would be willing to broaden their definition of quality. This is exactly what the hospital studied in our case is doing. Besides the extra work that the hospital's care professionals are doing to articulate quality at the negotiating table, this hospital is not focusing all its attention on the insurers. To frame the importance of quality improvement that is so hard to sell to the proxy purchaser of hospital care, this hospital has also chosen to address citizens and other relevant parties through other means, signing a 'contract with society', which includes announcements on highly specific care agreements per diagnosis in local newspapers and the hospital's quality journal. As the quality manager explains:

It started with our anniversary in 2004, 100 years of Atrium, that was our first contract with society. We used the jubilee year to spend many Saturday mornings talking with many patient groups in our auditorium and asking general things like, what do we want from each other? The care guarantees (introduced later on) are actually a specification of what started then. Now our contract with society gets adjusted annually and has become far more specific: What do we deliver to our Parkinson's patients? What can (a patient) count on? When is something not good enough? And what penalty card can you hand in where? We've got the support of a management system on our side: are we still delivering what we agreed to deliver?

However, there are two problems with this strategy: first, as we will see below, it assumes that insurers can sell better quality at a higher cost to individual clients but this requires a trust in insurers that is presently absent; and second, at the end of the day neither the individual patient nor the insurance company actually define where patients go for treatment. In the Netherlands patient referral is organized with general practitioners (GPs) in the gate keeping position. GPs may refer to specific hospitals or even individual doctors and thereby to a large extent define where patients go, on the basis of their long-term relationships with hospitals. Given the fact that currently GPs are among the few actors that see referred patients both go to specified hospitals *and* come back with their stories of what happened, while also having some professional insight into the medical outcomes produced, this may well make GPs crucial actors for qualifying public values in their referrals (Dixon et al. 2010). However, their central role sometimes produces problems for the hospital, insurers *and* patients. This became painfully clear during an incident between the hospital and GPs. At

one point the hospital was surprised because the usual flow of patients for their well-organized oncological trajectories suddenly dried up almost entirely. They soon found out that this problem had nothing to do their care trajectories and everything to do with a totally unrelated conflict between the hospital and local GPs. The hospital had established a diagnostic centre to which GPs were required to refer from now on. This centre was located away from the hospital at some organizational and geographic distance. The president of the local GP association, who had been involved in setting up the previous diagnostic centre that used to be located inside the hospital, was not pleased as he found the previous situation far more suitable and workable. To show his dismay, he urged his medical colleagues to not only take legal action and sue the hospital, but also to follow guerrilla tactics: he proposed boycotting patient referrals to this hospital until the issue was resolved. As the quality manager of the hospital explained:

All of a sudden relations got really tense and, well, it played out in all kinds of ways, both understandable and incomprehensible. It this led to a growing number of referral streams passing us by. The GPs put the pressure on to show we weren't their friends anymore and just how powerful they are. Sometimes Sittard (a competing hospital) had a patient-access time for endoscopies that just beat ours and then Sittard became the only target (for GPs' referrals). But as a matter of fact (Sittard's) whole care trajectory was not as well-organized as ours is. After being diagnosed with that endoscopy, patients were put on hold for months – your worst nightmare – because (Sittard) didn't have our care program over there. Yet all of a sudden that didn't matter (to the GPs). (...) They didn't give their patients access to the things we had organized really well here.

The quality manager admitted that the hospital had also made mistakes but that is beside the point here. More importantly, this event shows how fragile is the notion of the individual patient as a countervailing power that may be a highly coercive force yet not necessarily linked to the expected role of standing up for quality (Silverman 1987; Zuiderent-Jerak, Bal, and Berg forthcoming). Currently the hospital is dividing attention even more for, of course, they cannot shift it entirely away from insurers and society, as these are not *unimportant*, but they, as well as insurers, do need to include GPs in their communications on delivered care and, especially, endeavour to maintain good relations with them to prevent streams of patient referrals becoming the plaything in other political struggles.

### 3.2.2 Insurers at work

We had already come across the insurance companies when we were analyzing the work that hospitals need to do to make the market work and try to overcome what they perceive as its problems. The insurers did make life difficult for the hospitals at times, but in fact the dynamics are more complex than that. Since the introduction of the Healthcare Insurance Act in 2006, insurance companies have been positioned as the main negotiating party for hospitals and, as the Healthcare Inspectorate mainly ensures minimum quality, they have a



key role to play in ensuring public values in hospital care. This is no small task, given that they – in theory – could negotiate on a large number of DBCs. This would require an enormous staff and detailed knowledge of every instance of care delivered at hospitals – a daunting task that obviously is unfeasible for insurers. So one of their core activities in ensuring they can at least negotiate on *some* trajectories rather than get lost in the overall picture is to limit the number of DBCs that they negotiate on. As a purchaser of a large insurance company put it:

We cannot review all DBCs down to the last digit. So we drew up a list of priorities that is based mainly on revenue and volume, let's say a top 20 or a top 15. And we also looked at what we find important, like breast cancer and diabetes. So those aspects were also taken into account. These actually are also large volumes, so that was a good match.

There is much more to the idea that insurance companies negotiate in the name of their patients than would appear at first glance, for example the fact that insurance companies need to reduce their tasks to a doable level. If insurance companies were delegated the task of ensuring public values, the question would be: what about the other DBCs? For those in the B segment of the Zorgverzekeraars Nederland (ZN), the sector organization representing the providers of care insurance in the Netherlands publishes an annual DBC purchasing guide (Figure 3.2), entitled *Quality as a compass when purchasing care*.

**Figure 3.2 DBC Purchasing Guide 2009**



ZN compiles and publishes this commercially available “guideline for negotiations between healthcare insurers and secondary care providers” (<http://www.bsl.nl/shop/dbcinkoopgids-2009-segment-2-9789031360925.html>) with various other actors, including scientific

medical associations, and structures their cooperation around the use of clinical practice guidelines. Furthermore, performance indicators developed on a national level are directly integrated and the opinions of patient associations on several diseases are taken into account. The purchasing guide was developed as an immediate response to the new role insurers play when negotiating with hospitals on the content and price of care. As the respondent of the Dutch Association of Insurers stated:

That's the history of the purchasing guide. When (the previous minister of Health) Bomhof said: 'go and negotiate on this now', insurers had to negotiate on, say, cataracts. But what is good care for cataracts, actually? What is good care? Do we have an indicator for that? That was the trigger for the discussion, and that's why the first purchasing guide was developed for the B segment, because there you have to negotiate on a product that doesn't come with a price tag. So you have to know: what is that product actually? What does it look like?

This purchasing guide frames to a large extent what negotiations focus on and defines what would be good standards for care that is not being negotiated. The purchaser explained:

Initially we produced a tool for the purchasers, based on ZN care profiles developed at ZN's expertise centre along with their medical advisors and the professional associations. It isn't quite a norm-setting profile. It's an aid for purchasers.

*TZJ: You mean the purchasing guide?*

Yes, the purchasing guide. So that is an important tool for us, and based on what we ask - we call them 'clever questions', perhaps they are stupid questions but we're hoping for clever answers. Those are the questions we ask the hospitals. We do so in writing, and then we initially have a quality meeting, as we call it, and there we discuss the care profiles. And then we also ask the hospital for its care profiles, at least for our priorities. And based on the profiles they give us, and together with our medical advisor, we combine their profiles with the ZN profiles or with our own CZ profiles and then we start to ask questions or we have a meeting. Then we see if, based on those profiles, they can deliver the level of care that we actually want, and if not, why not.

This DBC purchasing guide is an interesting market device for several reasons. First, it seems indispensable in reducing the enormous work of healthcare insurance companies to doable proportions. Second, though this framing is crucial for a pragmatically functioning hospital care market, the idea that public values are delegated to insurance companies, who act on behalf of their insured customer/citizen-hybrids, seems in need of respecification. With its hybrid form of doctors, patients and guidelines, this hot potato seems to have landed on ZN's plate. This raises questions about the form and place where public values are indeed shaped and what gets brought into this de facto national framing of quality of care.

For those DBCs that do fall inside their negotiation scope, insurance companies do not need to rely on DBC purchasing guide profiles or the blandishments of medical specialists. They have their own DBC profiles and the support of their own medical advisors in the negotiations. Although the advisors have to deal with a selection of DBCs, the range of topics is still broad.

We have medical advisors linked to a hospital and we tend to bring them along to a meeting. They are more general advisors, so not really specialized in cardiology or another specialism. In our medical advisory group there are of course some specialists, people who have a specific interest in certain disciplines. That's how we build up expertise in this matter.

While insurers try to develop specific expertise in the main care trajectories, it is of course hard for them to match the level of expertise possessed by care professionals sitting at the negotiation table to discuss the kinds of details outlined above. As for the medical specialists, in their definition of quality, as the saying goes, the devil is in the details, and this is bound to lead to a substantial discrepancy in how care can be discussed at the negotiation table. As one medical specialist put it:

If you look at medical advisors, what their particular background is and what an incredibly wide range they have to cover, it's not surprising that it's simply not doable to cover the entire range of specialized medical care. They don't get further than the folder of ZN profiles: the purchasing guide and that's it. That, of course, is pretty marginal, but it's not hard to exceed, especially because the purchasing guide is not always attuned to the most recent guidelines and developments in medical research.

This may indicate even more strongly the importance of the purchasing guide, as already it may not be doable for insurance companies to bring to the table the expertise required to ensure public values in care negotiations. But before we can draw this conclusion, the framing of the guide needs further scrutiny.

One way the purchasing guide deals with the overwhelming number of theoretically negotiable DBCs is to cluster them. As the ZN respondent explained:

Let's take a simple example: cataract. There are now three DBCs: one in outpatient clinics, one as day treatment and one with admission. You can say, all right, you can assign three prices to that, or you can say – and that always has been our primary aim – all well and good: let's put them all in one basket and make a combined profile. So we reduce these three to one. There are three different codes, from outpatient, day treatment and admission, but as far as we're concerned, you can put one price to this [cluster]. That's one way we made it doable.

Besides clustering, another way of simplifying negotiations on large numbers of DBCs is to specify which can be excluded. The same ZN respondent explains:

Wherever it says 'no' [non-negotiable] we said: we don't make a profile for that. This actually means two things. *Either* it's nonsense: this DBC shouldn't even be listed, meaning: price equals zero. *Or* it is so rare: we're not going to negotiate, you give your price and I'll see if I think: Ouch, let go of my arm'. (...) So that's how we've approached it. We looked at how many DBCs there are in the B segment – something like 10,000 – and we've been able to reduce these to let's say 200. Then again, our focus has always been on high volume DBCs.

In the interesting quest for doability, DBCs are increasingly selected and combined in clusters. This of course introduces a more general notion of the representativeness of certain DBCs for quality of care. A relatively small number of 'baskets' covers a large percentage of delivered

care, especially in certain types of treatment such as eye care. Thereby, the purchasing guide assumes that a smaller number of DBCs can be used in negotiations, all the while still pursuing quality on a larger scale:

At some point I can start to discuss eye care. Someone who's good in cataract procedures, wouldn't that person be good in glaucoma procedures as well? (...) Once I know the core points, where I can say, well that's organized well, then the rest will follow.

This assumption is highly understandable in the light of the creation of a doable healthcare market, but it raises questions based on the observations of quality improvement researchers that improvement to one stream of care is often at the expense of other patient groups. This phenomenon, generally referred to as 'carve out' (Silvester et al. 2004) has been particularly noted in eye care where the dominance of cataract often leads to well-organized treatment 'paths' that are completely isolated from other forms of eye care. Yet, even negotiating on only 200 DBCs, as opposed to 10,000, remains simply undoable for insurance companies, given the capacity this would require, or would at least come at a huge burden and potential cost.

A further negotiating specificity is that whereas the insurer is expected to have a certain 'buying power', this is not always the case. Sometimes the hospitals voice their concerns about insurers pushing them to take the lowest price for a DBC, but on other occasions the insurer has to settle for whatever price is offered because for the hospital it is simply uninteresting to negotiate with an insurer that has only a few patients a year in that care trajectory.

We have about 35 hospitals for whom we are the market leader, we have a substantial market share in the B segment for some 11 other hospitals and for the remaining hospitals, about 55, we have a minor market share. In this last category, we discuss quality the least. Basically we just ask for a quote, or we do it the other way around; we look at the prices and where we see strange amounts, that gives us in principle a way in, and we ask for clarification: 'So how come you are so much more expensive?' That's how we reverse it.

But we also get faced with (hospitals) that are more of a nuisance. During last year's negotiations we told one hospital, "Listen, your price is way too high." Then they said "Yeah, so what?" So we said "Well, then we won't contract you" and then they said "Why would you do that, because then we'll put signs up on the notice boards that say: Warning! If you are insured with CZ, you'll probably have to pay for your own treatment. But around the corner you'll find a booth where you can change your insurer to Achmea." That's the kind of threat we face. Not that we are sensitive about it.

We have already indicated that if hospitals want to keep an eye on where patient streams are going, they need to watch GPs at least as much as insurers. However, insurers do have 'care negotiation' services that can help their clients reach the right care professional.

We act as a care intermediary and that's an important aspect, but you shouldn't overestimate it in terms of volume.

*TZJ: How big a percentage of your patient population are we talking about here?*

I think [we get] at most 5 percent, often because they have to wait too long, but quite often because they simply want good care. We have a good network, and a good feeling for what hospitals deliver. Of course there are signs, like this hospital here is better than the one over there, but to objectify all of this reliably, we are working on mapping (the situation) clearly.

Although this insurer is doing their best to develop expertise and increase their share in referring patients, they know they are still far from being a central player in steering patient streams (Boonen 2009) – which, given their definition of quality (that comes at a lower cost) is perhaps unsurprising. As the purchaser phrased it:

We still have some work to do to improve our image. We're still not perceived as an insurer that is knowledgeable about quality, that knows where to find the best care. They (the clients) are suspicious too, because if we recommend something it will probably be because it's cheap rather than good.

While image is the problem that insurers want to work on, selectively contracting certain hospitals may produce exactly the opposite result. A respondent from the Dutch Healthcare Authority explained:

There is this not-so credible threat that insurers won't give hospitals a contract. It has to do with the fact that when insurers play hardball in negotiations, they risk not getting a contract. Then they need to explain this to their insured, meaning: you can't go to that hospital any more, or if you do, you will have to contribute a substantial part of the cost. This damages reputation and works against the purchase profit.

Ironically, the negotiation infrastructure may at times be more consequential and less problem-ridden than the actual negotiations themselves. This became clear when the ZN respondent told us about the unexpected use of the purchasing guide that is not only an instrument for insurers, but also for hospital directors:

The board of directors at (a large hospital in the western conurbation of the country) took this guide to their doctors, saying: "Well, look here!" And within a week admission length was cut by two days. (...) (The guide gave the directors) something on paper that isn't theirs but has objective credibility, they didn't make it up. It's the professional organizations saying what they think things should look like on average. So they took the guide to their specialists and said: "Looks like you're deviating from the norm. You *can*, but then we'd like to know why." Apparently there was no valid reason, so this guide produced results: wonderful!

In this sense the purchasing guide sets a de facto norm, even though it was not designed to function as a formal national norm. Apparently, the threat of future negotiation combined with a standard set partly by doctors themselves can produce quality gains without the need for actual negotiation.

As we have shown in this section, the hospital has had to do lots of work to shape public values in the market for hospital care. The challenge for insurers – to make the market function through all kinds of work that usually is made invisible – seems no less daunting and the results for both themselves and the relation between markets and public values no less ambiguous. Having analyzed some of the work various actors carry out in the market for hospital care, let us now return to the question of which values are produced.

### 3.3 Values in this market

One aspect of the healthcare market that has come explicitly to the fore is that public values tend to get framed in the light of financial devices. Quality gets improved through these devices, but generally only the quality that comes at a lower cost. Interestingly, all actors, whether based in hospitals, insurance companies or agencies like ZN, grant an ontologically privileged status to the *price* mechanism to ensure public values. For those aspects of care not included in the DBC B segment, there is no purchasing guide. Insurers indicate that quality is only quality if it includes efficiency gains and hospitals point out that quality not associated with a financial advantage cannot be sold – in neither the A nor the B segment. In the case studied here, attempts to improve quality of care that does not fit the insurers' definition has led to strong debates between hospital management and care professionals, with the professionals at times pursuing quality improvement and regional specialization that has proven to be a management puzzle for a hospital that while it may be committed to quality improvement also has a business to run. This was, for example, the case with oesophagus carcinoma in this hospital. There had been a strong impulse on a national level to centralize the treatment of this form of cancer in a smaller number of hospitals, or at least select a number of surgeons to carry out the operations. Clinical evidence shows that patient mortality has a direct inverse relation to the number of operations carried out by surgeons (Birkmeyer et al. 2003). The Dutch Healthcare Inspectorate turned this finding into a performance indicator, setting as a minimum norm that a surgeon has to carry out this operation at least 10 times a year. The professionals in this hospital took up this challenge and informed their colleagues in the region that they were specializing in this type of surgery. They would organize a well-run care trajectory for them, as they had done for other trajectories, and agreed that their colleagues would refer these patients to them. Thereby these surgeons did exactly what any quality-committed healthcare inspector could have hoped for. They could be expected literally to be saving lives through this improvement. However, their strategy seemed in perfect opposition to the management strategy emerging at the same to deal with current market arrangements. As the quality manager explained:

There is one promising strategy: reducing the products you lose money on. This is what just about everyone on the market is doing. We do it too, but perhaps we're the last ones to start

because it goes against our nature so much: we see surgeons cheerfully bringing in their next target, their regional function. We're probably already one of the largest centres in the country (for oesophagus carcinoma), hooray. We've had no OR mortality since we picked this up two years ago and we didn't start any procedures where, because of progression or metastasis, we couldn't do anything anyway, which indicates careful diagnostics. Well, if *that* is the measure, then our surgeons are doing a fantastic job: in fact this makes all of us (here) really happy. Now, however, we have a dominant development, where (managerial) divisions certainly play a role. 'Bleeders and feeders': what is draining (our resources) and how can we get it stop. Besides zip codes there is a range of options (used to select who gets into treatment). Now already, the next 'bleeder' won't get in. So the next issue like oesophagus will be opposed by many (managers) in the hospital. So when some enthusiastic professional says: "I can do it! We have a good ICU (intensive care unit) and I'll get it together on the ward as well, we can do it together! Can I do it?", We'll say "No way!", that's what we'll say. We're already saying it.

On the one hand this is a typical problem of the budget-driven system with prices set at the national level without differentiating for quality. However, *because* of the looming expansion of the B segment, there is some reluctance to make changes in the specification of A segment DBCs. Where DBC maintenance is no longer carried out for the A segment in the present arrangement, quality coming at a higher cost simply cannot be sold, even though such quality might perfectly fit the definition of the Dutch Healthcare Inspectorate and be praised in the international quality improvement literature.

If this situation only applied to the A segment, it could easily be read as a plea for extending the B segment, where the price mechanism *does* operate and could be used to get a better price for a product of better quality. However, hospitals are not that positive about developments in the B segment either. As the division manager put it:

Look at what's happening with the prices in the first batch of B segment DBCs, it's quite interesting. In the last four to five years these prices have been harmonizing and stabilizing. You can see a national race to the bottom and I expect this to happen with future batches as well. And then you could have a marvellous care program with all kinds of treatment and service activities, but it's very unsure if this would lead to higher price. So especially for the B segment we end up with a national fixed price. We are not allowed to discuss [price] with other hospitals, because then we'd immediately get the NMA (the Netherlands Competition Authority) breathing down our necks as care providers developing provider power. But those insurers deal with so many hospitals they know exactly what the average price is.

What this respondent is pointing out here is that, in his opinion, the value of cost reduction is built into the present market through a price mechanism that frames quality in a particular way. As a consequence of this situation – remarkably similar in both A and B segments – it is harder to sell good quality than to divest expensive care. Ironically, whereas the aim of the 'bleeders and feeders' policy was to get healthcare organizations increasingly competing for the favour of the insurance companies on the basis of differential quality, in fact they are become *more alike* at not always an optimal level. No respondents concluded that market devices in relation to public values were not working at all, though numerous difficulties were

discussed. When a purchaser was asked how his work has changed over the 28 years he has spent working for his insurance company, he replied:

Well, what really has changed is that we're getting a bit more of a view on quality. Hospitals are also focussed far more on it. Not that long ago, about six to eight years ago, we were really negotiating only on price, and the extra money they wanted. And they wanted to show us that they were seeing more patients. We would ask: "Why are you seeing more patients?" or "Why do you have waiting lists?", and based on their answers, we'd assess if they needed extra money to deal with bottlenecks. Nobody was looking at where we should solve the problem. So we don't have much of that discussion now. What we also faced, in the beginning, that we were unable to discuss quality. We'd say: "We want to talk to you about quality", and they'd say: "That's none of your business! Who are you? Just pay the bills and don't interfere with other things". But now you see medical specialists, especially, really enjoying talking to insurers about what they do and what the quality (of their work) is. And then there are those who are very enthusiastic, who want us to know that they really are good or better or special. There is a much stronger willingness to do that, and also to be open about what they do and why they do it. Things have become far more transparent than they were about six years ago.

So negotiations on quality seem to have started, most certainly a major gain for hospitals, patients, insurers and policy makers alike. But according to the respondents in this study, through the central positioning of price mechanisms, these negotiations may be shaping the definition of quality as positively related to cost reduction.

Given our approach, all the advantages we have described cannot be described as consequences of 'the market' nor can the problems be classified as 'market failures', for this would separate 'the market' as a pure entity from the complexity of market *practices*. Rather, we take all that is going on in the present market for hospital care as a plethora of *consequences* that cannot be separated from 'the market' in its typically ideal form. Given such an analysis of the market for hospital care we note some of the difficulties for the market for public values in hospital care, and will return to this in the conclusions. First, however, let us turn to our next empirical case: the development of care-load packages for care for the disabled.



## 4 CARE-LOAD PACKAGES AND LONG -TERM CARE

### 4.1 What is the intended result?

Since 1999, the Dutch Ministry of Health has been trying to develop a system of entitlements and payments for long-term care that is no longer based on the average client, but attuned to the individual needs of each client (TK 26631, nr 1, 1999; TK 26631, nr. 14, 2001). This implies that ‘products’ delivered by providers will be given a ‘price tag’, as in a normal market. AWBZ (General Exceptional Medical Expenses Act) had to be updated in order to increase the number of options available to clients. The supply-oriented long-term care system was no longer equipped to serve today’s public:

The public is emancipated and has made clear that it wants to find meaning in life for itself and be responsible for doing so. Anticipating this societal development is the biggest problem when it comes to modernizing the AWBZ. It requires redesigning the system so that it complies with the public’s demands for more freedom of choice, more options, more of a say and more participation. (TK 26631, nr. 14, 2001: 1)

The Ministry of Health wanted to develop new financial rules for the AWBZ with the intention of increasing the customer’s choice and voice. According to the Ministry of Health, flexible entitlements, and hence individual-linked payments, are needed to achieve tailor-made care. However, entitlements should not be described in such abstract terms that clients could not determine whether they were getting ‘value for money’ (TK 26631, nr 1, 1999: 24).

In 2007, after a long period of preparation, the Ministry of Health introduced care packages (zorgzwaartepakketten - ZZP), individual-trailing budgets for the long-term care of patients with chronic illnesses, disabled patients or those in geriatric care. Individual ‘indications’ and budgets are designed to provide patients with greater choice and control over their support arrangements. Introducing individual-trailing or ‘client-linked’ budgets has had consequences for providers who are now paid on the basis of output and are thus actively encouraged to attract and hold on to clients, since clients have more exit options. The idea is that if clients are better informed about their rights or their budget (because they have a stronger position vis-à-vis their provider), they will have a better chance of satisfying their own particular needs and wishes. For instance, clients can choose between being given a 30 min bath or two 15 min showers, as stated in the ZZP user guide, prepared in collaboration with the National Patients Organization, the Association of Dutch Insurers and the Dutch Ministry of Health (PWC 2009). Care packages were introduced in the AWBZ on 1 January 2009.

In the new scheme, the indication is tailored to the individual client and used as a basis for the ZP. For 2010, 52 care packages (ZZPs) were defined for the three sectors of intramural care, 10 for nursing homes, 13 for people with psychiatric problems and 29 for people with a mental disability. Entitlements are broadly defined. A ZP describes which functions, including a global indication of hours per week, will be delivered, such as support (BG), personal care (PV), nursing (VP), behaviour regulation, daytime activities and treatment. In a draft version of the ZP, entitlements were more strictly defined, with exact hours per function specified. Another important aspect of the new system is that it permits substitution of activities. In the example in figure 4.1 the client can, for instance, substitute support with personal care.

**Figure 4.1 Example of a care package: ZP3 VG (VG = mental disability)**

Functies en tijd per cliënt per week						
Woonzorg			Dagbesteding	Behandelaars (BH)	Totaaltijd	
Functie	BG	PV	VP	Indien dagbesteding: Gem. aantal dagdelen: 9 Gem. groepsgrootte: 7	Bij de zorgverlening is/zijn (een) behandelaar(s) betrokken. Dit is circa 1,2 uur.	Exclusief dagbesteding: 11,5 tot 14,0 uur Inclusief dagbesteding: 16,0 tot 19,5 uur
	Ja	ja	nee			
Gemiddeld: 11,5 uur						

With client-linked or individual-trailing funding the budget follows the client, even if they switch to a different care provider, for example. The idea is that in this new system clients can switch more easily to another provider or make use of different providers (more choice).

According to the Ministry of Health, a system of output finance will drive providers to improve the quality of care and to become more client-oriented:

Individual-trailing funding plays a major role in focusing on a client's care needs and the associated care plan. I expect individual-trailing funding for care in kind to act as an incentive for care providers to provide effective, good quality care in the form of a care arrangement that meets the client's preferences, since the funding is not based on the institution but on the client with a particular care need. (VWS 12 June 2009: 12)

The client-linked budget is not the same as a personal budget (PGB), which clients can manage themselves and which is paid out to them. In recent publications, the ministry states explicitly that individual funding should not lead to a fully individualised model of care in which each and every client can and must demand their 'rights'.

We must avoid creating a claim culture and giving rise to calculating behaviour, which would lead to a situation in which it is primarily articulate citizens who are able to demand their rights. This is not in the spirit of the AWBZ, which serves many vulnerable groups who are not always in a position to exercise proper control over their own lives. The advantage of a model that is not fully individualised is that care (whether provided in an institution or not) is often offered on a collective or group basis. This enables added value to be achieved in the quality of

care (health, well-being and independence). Care is also delivered on a group basis in small-scale housing and care facilities. This offers scope for solidarity and substitution in an institution. (VWS 12 June 2009: 12)

Thus, even though ZZPs were developed partly to empower the user of care, the ministry does not want them to lead to claim-happy calculative clients. The basic idea is that tailor-made finance should lead more easily to tailor-made care than the old funding system.

## **4.2 What makes markets work?**

According to many of our respondents, the long-term care sector, especially its intramural part, is not a real market, since here is hardly any competition, insufficient choice, more demand than supply, and providers often have no latitude to negotiate on prices.

There is some limited market function but if you just look at the intramural section, then to be honest you must say there's really none at all. It's still a matter of scarcity. A client still cannot choose which provider he wants to obtain care from. And we have to deal with rates which vary in actual fact by only tiny amounts, between 98 and 100 percent. (Senior adviser, organization for disabled people)

A main reason for the existence of scarcity of care, or waiting lists, is that the Ministry of Health did not cancel production ceilings for the AWBZ regions. Therefore care offices sign production contracts with providers on the basis of their production ceiling. Although the Ministry has chosen a demand-oriented finance system, it still uses supply-oriented rationing mechanisms (production ceilings and maximum tariffs) to protect the overall macro budget for health care.

Now let us look at how the new market-oriented financial regime is driving healthcare providers to change their behaviour and how it impacts on the position of clients. While the provider has little room to negotiate on price and volume with care offices, the introduction of price tags has had an effect on the internal organization of the provider and the relationship between the provider and client.<sup>2</sup> In the next sections, we describe how providers have dealt with the new market device known as ZZPs.

### **4.2.1 More registrations in ambulatory care**

Care packages are divided in parts so that clients can use different providers, thus increasing customer freedom. This means the provider has to register client activity in various separate administration systems, each with its own registration rules. According to one respondent, administration has become more complex and intensive because for one client the organization occasionally has to show accountability to various care offices. In his opinion,

the new policy rules for production contracts with purchasing care offices are unnecessarily complicated:

Now you get care-purchasing offices that say ‘we don’t buy ZZPs with day activities for clients’, whereas these clients are entitled. That means for this one client you have to account for a ZZP without day activities, but because the client is indicated for day activities, you still have to score and account for day activities but now in a different way. So for this one client you have to show accountability at least twice, when in fact it could be done just the once. Next, you probably have to justify capital expenses and transport costs, too. And, if you have the bad luck to be confronted with region-exceeding traffic – if the client lives in the DWO region, for instance he falls under DWO, but he’s also getting day care in the Haaglanden region as well; we do get those kinds of clients – then you’d have to account for 1) ZZP without day activities, 2) day activities by DWO and 3) day activities by Haaglanden plus 4) all related transport and capital expenses. Who says it couldn’t be made more simple? But then of course you’d have to deal with the fact that every care office has its own accountability template. (Senior financial adviser, organization for disabled people)

Thus a provider is prepared to make agreements with these special clients for a ZZP that includes daytime activities and allows clients to also use organizations other than the provider’s own for these activities. In this case the provider then sub-contracts the daytime activities. This solution prevents loss of funds when the client does not go fulltime to a day centre; some substitution between residence and daytime activities is allowed for ZZPs with daytime activities, but not for ZZPs without. Output finance has special consequences for the administration of ambulatory forms of care and daytime activities: more registration of hours or day parts. Respondents who work at residential locations say that they experience no serious differences with the old system of administration.

#### 4.2.2 More attention for business processes at location level

The individual funding system has increased insight into business processes and made aspects more transparent. Providers are better equipped to benchmark locations internally. They can compare locations in terms of economic performance and such aspects as quality, absence due to sickness, and if locations are faced with over- or underproduction issues. Using the ZZP tool, providers can see how their location performs compared to other locations in the same cluster:

If you saw underproduction and overspending in one location, well then you’d have to deal with a reinforcing effect. Then you’d call that location to account one day, depending on the degree of underproduction and overspending. On the other hand, you could of course have locations doing very well: overproduction and under spending. You’d think that would be perfect. But okay, you’ve got to be strong, you’d still have to, let’s say, check if the quality is the same sort of perfect.... (Senior financial adviser, organization for disabled people)

The improved transparency of results at location level is driving providers to adjust supply better to the indication. Responsibility for budgetary control has shifted partly from the organizational level down to lower levels. To balance their books, organizations used to

shuffle funds between their various budgets (substitution). The departments that did not spend their entire budget could compensate for the departments that did overspend their allocations. The organization for people with a mental disability in our case study doesn't rule out every form of substitution. Nowadays, however, locations are more aware of their business results and realize that substitution has become less acceptable than it was in the past.<sup>3</sup>

#### 4.2.3 Making ZZPs fit the location level

In the new financial scheme, all clients bring their own budget based on the ZZP entitlements. To create a workable situation, the provider does not strive for complete transparency of ZZP spending (in Euros) for the client, except for some information on duration, including collective hours. It creates some latitude for professionals and caregivers to anticipate fluctuations in daily needs. When professionals draw up the plan that defines the care due to the recipient client, they don't normally look after the ZZP directly. In that sense, caregivers are kept at a distance from the ZZPs. It doesn't mean that caregivers haven't noticed anything of the introduction of ZZPs.

The organization for people with a mental disability expects, for instance, that during the yearly evaluation of the care plan the personal counsellor or location manager will check if the (new) care plan still fits the current indication or if a re-indication is necessary. Re-indication should also be considered by staff when the client's circumstances alter. Increasingly, staff have begun to realize that a good indication is important for the budget and thus for the workforce at their location.

Another consequence of the new financial structure is the clustering of similar types of clients. For instance, in the past, different degrees of disability were placed in one group. The provider wants to stop combinations of ZZP 1-2 and ZZP 5-7 clients, as the caregiver or professional level should be attuned to the heaviest client type. It is more efficient to cluster the same type of clients in one group. The provider doesn't rule out the possibility that clients will be moved to another location.<sup>4</sup> One of the cluster managers explained that clients are no longer allowed to choose from every possible location. His organization had taken on the same policy as hospitals have, where patients must leave Intensive Care as soon as they have recovered enough to go to another, cheaper ward:

Yes, that actually happens here. We have a big, professional team to deal with the complex clients, the heavyweights. They can deal with the lighter clients too but then you wouldn't get enough money for that place. That's the only incentive. In the past, we took things easier, because then the costs were paid out of the margins. Anyway, parents have problems with that, of course, so that's where the tension is. If parents think this is the ideal location, and we have

to say “Sorry, not according to the indication”, Well yes, that’s difficult (Cluster manager, organization for disabled people).

Similarly, location managers are better at checking if a new client fits in with the location’s staff. Locations with highly qualified staff look more critically at the intake if the client has received heavyweight indications in the ZZP. On the other hand, location managers are sometimes pressured from above to accept clients with heavy indications, who they would rather not accept:

Sometimes you get something like ‘This client has ZZP 7, that brings in the money, so we’re placing him with you’. Then I say: ‘Hold your horses! First let me check the fit.’ Then I go and check that before I come back and say, ‘Okay, can do, it fits well.’ I just want to know first if it really is possible. Sometimes that means getting into fierce discussions. (Location manager, organization for disabled people)

Another development is that small-scale locations are no longer considered feasible because of management costs. In the provider’s new policy, locations should house at least 24 residents, unless the head of the location is connected to not only that location. The idea is to build smaller units of six persons in one location. The new financial structure stimulates the provider to cluster the same type of clients in order to save on overhead and staff costs. Client clustering is also done for marketing purposes. The provider has begun developing product groups or service-market combinations, which can be used to attract new clients.

Individual care funding was driven by the idea that clients themselves are better at determining whether they get value for money. However, providers need functional accountability. Complete transparency of individual ZZP spending would require extensive registration of total hours or fixed hours/activity. Collective accountability at location level is easier for providers, especially in situations where clients live in groups and receive collective care. Moreover, the accountability to care offices and other stakeholders is easier for groups with the same type of clients and ZZPs. These solutions simplify accountability for how an organization spends individual ZZPs. As the cluster manager of an organization for the mentally disabled says: “There is more pressure on accountability, so we have to look at how we can make things more clear.”

Not all these consequences are directly caused by the individual funding system (ZZPs). According to the provider’s financial adviser, lower budgets also necessitate the organization to develop more efficient ways of providing care or to take more notice of the business process. Nevertheless, ZZPs help the provider to make more transparent which locations are inefficient and need to change their organization of care.

#### 4.2.4 Thinking again in terms of limitations instead of possibilities

The quality of an indication is very important in an individual funding system. According to the location manager, personal counsellors must describe disabilities in stronger terms in order to fit the indication to the client, and nowadays that involves resurrecting an outmoded way of describing the clients' needs. To achieve a 'good' indication when they prepare an application for a care package, counsellors have to make a paradigm shift in attitude, transforming 'possibilities' back into 'limitations'. This is a difficult, uncomfortable shift for some:

Some personal counsellors have managed the turn back to looking more critically at limitations quite easily. Others, however, are stuck on the idea that you should start out from the good things, what the client can do, and not from what he can't. They are good at noting what the client can do, but they forget that the client can do all of that because of the support he is getting. I'd hear someone really struggling with an indication. He'd say: 'I don't get it, the client can still do this.' So, I'd have to say: 'Sure, but think away all the support the client is getting. Can he still do it then?' (Location manager A, organization for the disabled)

Interestingly, such solutions are not interpreted as a form of 'upcoding' or fraud, but as a way of guaranteeing that clients receive the care they need. Similarly, making this paradigm shift in the course of an indication request can be interpreted as part of the professional responsibility for organizing adequate care for the client.

Some clients also have problems with this new way of thought. For instance, people with a non-congenital brain injury (NAH) receive a 'better' indication if they are labelled under mental disability (VG) instead of physical disability (LG). According to one of the respondents, this is partly a flaw of the system, which allows a lower budget for physical disability (LG) than for mental disability (VG). People with a NAH now receive LG ZZPs, but in practice they also experience cognitive problems. However, there is resistance to the VG qualification, which is interpreted as a stigma.<sup>5</sup> These examples show that the individual funding system creates a tension between the symbolic meaning and the financial interest of labels or applications.

#### 4.2.5 More clarity to clients about the received care

The development of product groups or service-market combinations suggests some form of standardization. However, this is only minimal standardization, since the provider is not in search of standardization in terms of concrete activities, hours or euros. ZZPs are used only to describe in general terms what the client can and cannot expect from the provider.

Respondents mention that ZZPs have the advantage of making clearer and more plain which care will or won't be delivered by the provider. The ZZP can be used as a tool to start a dialogue with clients or to check if 'you put your money where your mouth is' (i.e. if you can

actually achieve what you advocate). According to the financial adviser of one of the organizations, the provider can now better substantiate what is possible:

That was just not possible in the old system. Then it was just an indication for residence and for care. Okay, so then you get emancipated clients who think that everything normal is possible. So now you can make clear that much is possible, yes, but within limits, like you can only opt for something at a given moment. That applies to everyone, yes, you and me too. It's like, look, if I buy a new car that means at a given moment I can't buy, let's say, a new bike or new audio equipment. I mean, I can only spend my euro once. You see? In that sense you can make things more transparent. (Financial adviser, organization for the disabled)

However, according to our respondents, client representatives almost never start a discussion about the amount or quality of care using the ZZP as an aid. Mostly they are interested if the care is all right and how things are going for him. Clients do not use, or very seldom use the ZZP as an instrument for demand-driven care. At the moment, few clients or representatives deliberately select providers, although one provider has noted internally that some partly outdated locations are not so popular anymore. Moreover, there are a few choices like the option to choose between a 15 min shower or a 30 min bath. Most respondents expect that this will increase in the future. However, there are client groups for whom the ideal of more choice will not apply, for instance people with autistic disorder in the highest ZZPs who need a clearly defined structure in their life. Or, for example, nursing home clientele who have reached an age that no longer demands a luxury lifestyle. The demand for extras or luxury, such as a large apartment, happens before this stage of life.

Interestingly enough, individual funding tends to strengthen the position of the supplier, too. As shown above, ZZPs clarify which services should or should not be delivered. In other words, with the aid of these financial instruments, care can be better attuned to the providers' possible options. It also becomes easier to determine when client demands are not 'reasonable' and when to say 'no' to clients. Under the guise of demand-orientation, clients are disciplined to fit their demands to the ZZP they receive.

ZZPs thus act as a countervailing force against providers who are not sufficiently client-oriented. On the other hand, providers can also use the same market device to reinforce their own position vis-a-vis demanding clients. That providers retain a degree of power is inherent in the policy since the Ministry Health wanted to prevent claiming or calculative behaviour among clients. However, should providers gain more power than clients then the policy would be counterproductive. Tailor-made finance is not automatically the same as tailor-made care.



#### 4.2.6 More care with the aid of private initiatives

Since long-term care is publicly financed by the AWBZ, many clients or their advisers expect everything to be delivered by the provider. That is not always the case. For instance, providers don't have enough personnel to cope with clients who want to go outside as soon as the weather is fine. Providers have two options to increase the level of care: (1) informal care and volunteers or (2) privately paid services. This section discusses to what extent providers use these two forms of private initiative and how ZZPs are related to these private options.

##### *The increasing role of informal carers and volunteers*

At the moment, the provider solves special requests such as going for walks outside with the aid of volunteers. Informal carers and volunteers are very important for improving client well-being and the availability of special services. This provider has, for instance, a fleet of vans that are financed by fundraising and run by 40 volunteers. These vans taxi people to day activities, are used for collective pleasure trips and can be ordered personally by clients (e.g. for visiting family members). In the last case clients have only to pay for the petrol. Another special project is the own boat financed by the provider's Friends of the Foundation and run by pensioned skippers. The provider is very proud on this specially adapted boat - it has a lift - which can take on board up to ten people confined to wheelchairs. This creates plenty of well-being, according to one of the respondents. Again, people have only to pay the fuel costs. Respondents agree that the role of volunteers and informal carers has become more important:

I think that they are so important for the client. Volunteers and informal carers can offer things we can't manage due to lack of time and financial deficits because a part of the ZZPs has been cut back in order to focus on the core of care. That means the extras are seldom possible. It is very important for clients who need these little extras, but not everyone does need them. And, it's also important for us, because when the client is satisfied, it's fine for us too. It works out easier for all if he has a nice day (Care adviser, organization for elderly care).

The care adviser says that his staff value informal carers highly. Nevertheless, they still hesitate to ask explicitly for more help from informal carers, because most people expect the institution to do everything. The chief executive of the provider also suggests that professionals would find it hard to transfer their responsibility for the client to someone else.

I find that we underutilize the opportunities for informal care. Especially in-house, you see an attitude of 'this is our patient and we do everything'. Some change really is necessary in my view. Our staff on the work floor should be learning far more on how to deal with informal care (Executive, organization for elderly care).

Respondents explain that budget constraints make it more difficult to offer more than 'basic care'. We should acknowledge that these developments, including the current debate on separate care and residential services, could also lead to a re-framing of what 'basic care' is.

Some activities would then be reframed from ‘care’ into ‘well-being’, which could imply that they no longer belong to the publicly financed health care system.

### *Cautious development of privately funded extras*

Private finance creates another option to offer more than is possible on a budget funded by the AWBZ. We researched an organization for elderly care, which a few years ago wanted to develop ‘plus’ packages with more extras. Commercial activities are seen as an attractive improvement to the healthcare system, especially because they are presented as extra options above the current care packages. That is why they are called ‘plus’ packages. The executive of that organization said in 2007 that he wanted to develop products that could make life more pleasant for his residents:

If people say “I’d like to...” then we can say, yes that’s possible, but it means extra effort for the staff. We can arrange it for you but it will cost such-and-such amount. If they say ‘We want our Mum (or Dad) to have an hour’s walk outside every day’ then we’d have to say sorry, that’s not included in the standard care package, but we can do something about it. We’ll arrange it for you, but it means having to send you a ‘plus’ package bill (Executive, interview 2007).

In contrast to this provider’s ambitions, the supply of plus packages or commercial activities is developing very slowly. According to our respondents, there is only a limited range of products and services, such as foods and beverages, laundry service, bedside TVs and party site rentals for birthdays. Services with out-of-pocket expenses are mostly offered to other people and not so often to their own clients. To date clients have not shown much demand for more ‘plus’ services (Care adviser, interview).

Offering paid extras in the publicly funded part of the market is a complicated matter, because clients and their advisers still expect everything to be delivered by the provider (Care adviser, interview). Clearly, people in the neighbourhood have to pay for services.

Organizations wanting to introduce plus packages must make clear the difference between what falls under standard care and what is regarded as extra care. If you give clients the option to buy extras, then you cannot deliver these extras as part of your regular care. ZZPs can be used to clarify the limits of publicly funded institutional care.

However, the Dutch publicly financed system of long-term care does not have a tradition of paying for services, except for income-related contributions to residential care. Clients and staff expect that everything required to improve quality of life should be deliverable within the boundaries of the provider’s budget. Caregivers broadly define activities that could be part of ‘normal care’ depending on the individual situation of the client, such as going to a supermarket to buy something for the client or doing the client’s banking for them. A system of plus packages requires a clear dichotomy between basic care and other services; however

vague demarcations can also lead to good care (Grit and De Bont 2010). The difference between care and other services is not always clear. Is assistance for walking outdoors part of basic care or is it the responsibility of the family, volunteers or other private initiatives? The medical manager says that these kinds of activities also improve the well-being and health of clients – clients, for instance, sleep better when they go outside for exercise and fresh air.

Staff say they find it hard being allowed to offer some clients a specific service and then having to say no to other clients who cannot afford this service. One of the respondents expects staff would find it difficult to start asking for payments for people who want to walk outside with the aid of professionals twice a week.

I guess that staff would find it a pity. If someone has no money he can't go outside. Anyway, it gives people something else to think about. Staff are inclined to treat everyone the same way. I think that'd they find it a pity and annoying that some could pay while others couldn't. (Care adviser, organization for elderly care)

This doesn't mean that differences are not accepted in the institution. It is already normal routine for outsiders to pay for services. In the same way, if residents call a taxi, nobody would protest in terms of financial inequality. Or, if the family can make a difference, staff will react positively to the active members 'because then the nice daughter or nice son will come in to do that and it becomes a habit' (Care adviser, interview). Problems arise if employees themselves have to make differences in, for instance, opportunities to go outside:

It feels different when one of the staff is paid to come in and do that. It's different from someone calling a taxi to go out. (..) In principle staff have no problems with volunteers, but in my opinion, if we set differences ourselves, through the payment factor, that would make it really hard for the staff. I don't have much problem with that, but for most staff it would be really difficult, because they would see the people left behind, sitting at the table (Care adviser, organization for elderly care).

Although setting differences is complicated for the provider, respondents see some opportunities if the provider can make clear that a difference involves more than just basic care. Asking for contributions to the cost of a concert is more acceptable than asking to pay for assistance on outdoor walks. The first example can be presented as a non-care extra and something that people ordinarily would have to pay for. But when extra paid services come close to professional care, ethical objections will arise. According to the respondents, caregivers would rather not have different classes of care. Interestingly, again individual funding could be used to make the distinctions more clear between basic care and the extras that people would have to pay for.

I think you need to explain the distinction, that it's something extra on top of the normal package, in discussions concerned with the transfer to ZZPs. You need to make the difference clear between what you need and what else you would like, and what to do if that little bit extra goes beyond the basic package. Now we have a good reason to explain all this, you can make it

clear now with the help of those ZZPs. It gives people the choice. But you also hear, it's not fair, what about if you have no money, how do you deal with that? These more ethical questions also play a role. Then again, you could say, 'But my car is smaller than yours. That's not fair either.' It's tricky, still very complicated (Care adviser, organization for elderly care).

Before offering extra paid services, the provider needs more insight into their business processes. For instance, the executive wants to know what a provider is supposed to do, according to the AWBZ, because in her view a provider should not deliver privately financed extra services if they could be included in basic care. This is a complex matter, since professionals and caregivers are traditionally not bothered much by the role of money and are inclined to do as much as possible for their clients. The new financial system of ZZPs is used to make more transparent what should be part of the publicly financed compartment and hence what can be offered by plus packages.

Well, all our people are actually doing a tremendous job, making things transparent. Once we know that, we can look for what fits into the publicly financed part and also work out what would we'd like to do extra and what we should ask for this. Actually we were supposed to make the turn [to ZZPs] this year. However, it's such a complex matter that we said let's postpone it to 2011 and use 2010 to analyse what we actually deliver, how our care arrangements fits to ZZPs and where we have some latitude (Executive, organization elderly care).

Despite the fact that the ZZP market device was developed for the publicly funded part of long-term care, providers are using it to trigger and initiate private initiatives.

### **4.3 Values in this market**

#### **4.3.1 Two forms of internal solidarity**

Traditionally, providers employed a form of internal solidarity through financial substitution, where departments with spare money (unspent budget) compensated for departments that had overspent theirs. This solidarity was needed since the provider received an average budget for every client. Introducing individual funding has not abolished internal solidarity; it does, however, give providers space for other interpretations of solidarity.

The provider for people with a mental disability in our study has opted to maintain this solidarity both within the provider and at location level. There is room for substitution between locations in specific situations, although this mechanism will be used less often than in the past. In our previous study, the provider was concerned that substitution would no longer be possible in the future. They anticipated that under spending would no longer be accepted in the individual funding system. If the right to care has become defined by patient budgets, any shifting of funds between budgets could increasingly be interpreted as in

conflict with the rights of individuals and thus unwittingly gain the connotation of trickery, even fraud:

You know, we used to shunt budget money around our departments and between patients. Nowadays you couldn't get away with that. If I did try it, I wouldn't be able to explain my expenditures to the accountant or to clients. I'd run into accounting problems. (Division manager, care organization for the mentally disabled 2007)

Nowadays, the provider has chosen to keep intact some form of substitution at the level of the organization. One respondent explained that their organization is prepared to defend the fact that something must be deducted from the care package in order to give specific groups the care they need. He considers this a part of their societal responsibility: "We find it important that we can give extra care when someone needs extra help. (..) You can explain that story."

This organization tempers the problem of a 'wrong' indication by lessening the requirement that the indications of every ZZP group should fit in with the location's budget or by a long, smooth and careful transition to a way of working more in accordance with the level of individual funding. This is preventing problems of accessibility or a lowering of the quality of care for some specific groups, like NAH-clients and people with extreme care needs.

Another provider, the Gemiva-SVG Groep, has opted for solidarity only at the location level. This group realizes that the new ZZP financing system means that some locations will receive more money, whereas others will have to sacrifice some of their budget.

If it turned out that one of our locations needed to tighten their belt, then we would have to cooperate. It's the government that says these clients have to make do with less care than what they've received up till now. And if this results in a deficit of care for the client, we'll have to check if, together with the client, we can get a stronger indication. But if that's not possible, then it's been a democratic decision –approved by parliament – that we have to allocate scarce AWBZ money in this way and no other. The opposite is of course true too. If clients have the right to more intensive care in a location then the budget will rise as well, so that we can and will deliver that too! (De Gemiva- SVG Groep Newsletter, October 2008).

In this example, solidarity is placed partly outside the organization: the degree of solidarity is the responsibility of society or its representatives, that is: parliament. In that sense, individual funding decreases the latitude and responsibility of the provider.

#### 4.3.2 Another form of distributive justice

People receive an indication based on need. However, when people with an indication (ZZP) go to the provider, the care package is transformed partly from a 'need' into an 'economic demand'. This happens not so much on the individual level, but at the collective level of the location. Within the collective location, equality of 'demand' will then become an important

consideration, besides equality of need. Every demand for care, as described in the indication, is taken equally seriously by the healthcare organization. Since every demand based on indication or budget is taken equally seriously, shuffling budgets between locations is considered inappropriate. As we have shown already, this idea has not been entirely implemented in our case study.

Our study shows that *distributive justice* could get a new meaning with the introduction of market elements in healthcare, differing significantly from the old meaning of distributing care through organizations. In the internal allocation of resources, the distributing principle of ‘need’ is more or less transformed into the principle of ‘economic demand’. This happens only at the level of the location; within the location, care can still be distributed according to the principle of need. However, one of our respondents anticipates that in the future supply will be fitted more closely to the indication. This already happens in a moderate, indirect way, because people with the same care packages are clustered more often together in one group and these group care packages thus become more relevant to the supply of care.

The increased transparency influences the distribution of resources too. Individual funding could prevent the situation arising where the loudest voices receive the most care. For that reason, some respondents agree that the new version of allocation is fairer than the old.

#### 4.3.3 Collaboration of market mechanisms and new initiatives of civil society

Interestingly, the trend toward more market mechanisms seems to go hand in hand with the stimulation of new initiatives from civil society or the social network. Care packages can also be used to make clearer what is part of institutional care and what could (or should) be done by the family or volunteers. Now the caregiver can more easily ask family members to accompany the client (with a relatively low ZZP) when he or she needs to visit the doctor. Or, the location can show that its staff cannot not do everything needed for the welfare of the client. ZZPs can be used as a form of ‘expectation management’, which could trigger family members to become more active. In the last decade, providers have developed a more active volunteer policy.<sup>6</sup>

Moreover, some respondents acknowledge that an active pool of volunteers could be a positive message in the marketing strategy of the provider. Besides professionals, volunteers could create an advantage to competitors. The executive of the organization for elderly care explains how the provider became more aware of this competitive element:

In the past, we didn’t do it, because we hadn’t had our new boat for that long. For years we just had the old boat and all those vans too. You didn’t promote these extras, you just did them.

People talked about them and in the region people did know about the extra things we did, but we didn't promote them [as a competitive advantage] for our image. Nowadays, we do far more of that in all our public relations as well (Executive, organization for elderly care).

In the same way, selling services (meals, drinks, leisure activities) to local people is becoming far more a part of the marketing strategy to attract potential clients. Respondents say that locations did not open up their doors in order to generate huge direct revenues (sales). They were opened for ideological reasons, to bring society into the institution: 'We are far more than just one of the buildings in the neighbourhood'. Nevertheless, the move has had an indirect effect in terms of the market; it is good marketing strategy.

Both trends – stronger roles played by the market and civil society -- fit a more moderate role for government, allowing more space for private initiatives. However, note that encouraging the inclusion of civil society is not the only consequence of this retreat by the state. The positive effects are also caused by introducing market mechanisms in health care.





## 5 CONCLUSIONS ON MAKING MARKETS FOR PUBLIC VALUES

As we hope to have shown, the market practices under study have complex relations to public values. What ‘the market’ is and what ‘public values’ are, is never clear in any fixed or static sense. Rather, these emergent domains co-construct each other. Our approach of studying the process of the composition of market practices and public values, and not explaining away either their positive impact as ‘natural’ effects of well-functioning markets or their problems as ‘market failures’, has allowed us to analyze the *work* that many actors need to do to produce such effects. It also opens up the study of markets as ‘political issues’ (Barry and Slater 2002: 287) as it allows us to analyze the ways in which markets and public values shape each other. If market devices shape public values in specific ways, rather than merely implementing pre-defined values, the composition of market practices is an empirical domain directly relevant to the state. Government agents will want to understand how this shaping occurs, with what consequences and possible alternatives to remedy undesired shaping.

In our analysis, market practices in the hospital care and long-term care market shape specific public values through the development of such devices as DBCs and ZZPS. In both cases the aim seems to be to increase choice either for the individual client (ZZPS) or both clients and insurance companies (DBC). The increased choice should then provide incentives for quality improvement and diversification of hospitals or institutions for care of the disabled. Ironically, our case studies show that rather than facilitating diversification, both options may be producing the very opposite result: organizational isomorphism (Powell and DiMaggio 1991). Also, they may be leading to specific operationalization of the public value of quality that is shaped predominantly in terms of the financial instrument. In the hospital market, quality used to be barely on the agenda in discussions between hospital representatives and insurance companies but has now become an issue of considerable focus during their negotiations. However, what quality *is*, has shifted substantially through market arrangements in which actors privilege price mechanisms and assume those to be easily quantifiable proxies for other public values. At present, quality is easily defined solely in terms of cost-savings, leading to substantial gains in the affordability of care and reduction of length of stay in most hospitals, which is a substantial improvement, given that each unnecessary day in a hospital is both a societal cost and a risk for patients. Yet, this specific definition of quality sits uncomfortably with notions of quality that do *not* involve cost-savings. In our cases, other definitions of quality were not only voiced by care professionals, but also captured, for example, in the performance indicators of the Dutch Healthcare Inspectorate. This demonstrates that the fact that quality has come to be defined as cost-

saving is not merely a consequence of a lack of quality information and the oft-encountered issue of ‘information asymmetry’. Even where information on quality *is* readily available during negotiations, price seems to dominantly shape what *counts* – in that very literal, calculative sense – as quality. Information may be available but still not have any consequence if financial aspects are so much easier to calculate and other quality aspects are both more slippery and less convenient to some actors. This result is not unique to this market arrangement: financial aspects were even more confining in times of fixed budgets that tended to be consumed towards the end of the year and could lead to closing down operation theatres for some surgical procedures until the start of the new financial year. It is hard to imagine a more dominant link between quality and its definition by financial aspects.

The point therefore is not that that these new market devices have made an issue of price or money. Nor do we want to pose it as problematic that public values are shaped in the practice of operationalizing them in market devices: means *always* change and translate the aims they are supposed to ensure. This we consider a fact of life. But if it is the case, it points crucially to the greater importance of the composition of public values over and above their implementation through market or other policy arrangements. The composition of markets for public values cannot operate under the assumption of a clear distinction between aims and means (Latour 1999). Such distinctions remove crucial normative work in the shaping of our welfare states to the realm of the technical operationalization of public values.

As we have shown, the market devices studied here have at times positively shaped the relation between such public values as affordability, quality and access. Long waiting lists that were so common under the budget-driven system have virtually disappeared. Quality that comes at a lower cost is put centre stage, which, as the purchaser of the insurance company pointed out, is a substantial change in comparison to the situation before the introduction of DBCs. In elderly care, the value of solidarity in the form of voluntary service to disabled clients is substantially strengthened *through* the development of the financial instrument of ZZPs. This consequence puts civil society not in opposition to the market of care for the disabled but strengthens that value through market arrangements. Still, at other times, financial instruments reshape quality in ways that sit uncomfortably with prevailing notions of quality, which is why we stress the importance of empirically scrutinizing such translation effects and the relatively greater importance of the composition rather than the implementation of healthcare markets.

One of the findings we encountered in our research is that in practice these market devices sometimes seem to *undo* the very aspects that they were supposed to *strengthen* according to

the policy aims. Market devices have often been regarded as shaping the setting in line with the policy aims and assumptions under which they are expected to operate – generally captured under the heading of ‘performative’ market mechanisms (MacKenzie 2004; MacKenzie, Muniesa and Siu 2007). However, the market devices we studied often made the practices under which they were supposed to operate *less* favourable to the policy aims – a phenomenon that has been called ‘counter performative’ (MacKenzie 2007). In the case of DBCs one of the policy ambitions was to achieve diversity through hospital specialization that would be aimed at outperforming competitors. Ironically, the practice of keeping in ‘feeders’ and getting rid of ‘bleeders’, combined with the definition of quality as cost-saving and the semi-standards of the national DBC purchasing guide actually make hospitals more similar than more diverse. This shows that the current isomorphism is not merely institutional or a failure of the market as intended by policy makers; it is built into the financing structures and negotiation infrastructure of hospital care. Also, it may be necessary to make negotiations doable.

Similarly, the care-load packages (ZZPs) that were supposed to lead to increased choice for disabled clients in practice resulted in homogenization of care units that require similar care-loads in one group to be cost effective in their care delivery and staffing. Of course this could be seen as beneficial in terms of cost assessment, as this centralizes more qualified and expensive personnel. While the policy intended client choice to drive competition, quality is less likely to materialize if clients have fewer institutions to choose from. Even if these limited options are not seen as a *reduction* of choice but merely as a *different framing* that leads to more affordable care on a macro level, geographical proximity to their dear ones, one of the core aspects of quality persistently shown to be crucial to disabled clients, has been reduced. A definition of quality that excludes distance to the benefit of cost may be a convenient outcome on the level of affordability of care. Yet, at present, it is a somewhat unintended outcome of the ZZP instrument that may require further scrutiny and a more explicit decision on whether this kind of trade-off should indeed be made between this aspect of quality and the affordability of care. Moreover, other actors also use the same instruments that should empower users. Individual-trailing budgets are designed to give clients greater choice and control over their support arrangements; however these budgets can also be used by providers to say ‘No’ to the over demanding client; thus becoming a mechanism of managing demand. Care is tailor-made to the cluster of individual ZZPs in the location.

Through this empirical analysis of the shaping of public values in market practices, we now return to one of the core questions in this study. Public values are not ‘defined’ by politics, ‘formulated’ in policy aims and ‘implemented’ by policy actors. They are shaped in a dynamic

process of interaction between policy instruments such as market devices and prevailing values in healthcare practices. The question this crucially raises is, what is the role for the state in the composition of public values and healthcare markets? Realizing that public values are shaped in practice should, in our view, not lead to repoliticization of policy domains. Direct involvement by politicians in the shaping of healthcare markets tends to lead to the problems associated with ‘incident politics’. Besides, calls for democratization through participatory instruments are cumbersome in practice and theoretically problematic (Berg 1998). They presume that the composition of markets that ultimately are meant to ensure public values can be completely regulated and controlled, which empirically speaking seems hard to imagine.

An alternative role for the state in the composition of market devices and public values is to *accept* that such values are shaped in practice and that therefore the relationship between policy *aims* and *consequences* can never be fully captured through the logic of implementation. For this the process is too unpredictable and the consequences too unforeseen. Such dynamic unpredictability is better captured in an experimental role for the state. A state would thereby see market devices not as an operationalization of policy aims, but see market developments as experimental devices in which the aim is a good composition of public values. A general outline of these values will guide both the experiment and its set-up, but the consequences will need some kind of ‘formative evaluation’ (Øvretveit 1998), in which the produce of evaluation is not postponed till the end of the experiment, but is fed back into the experiment through ongoing adjustments to the setting and the devices deployed.

If we were to reconceptualize the Dutch policy initiatives in making markets for public values a real-time experiment, this would perhaps turn the present study into a part of the ongoing formative evaluation and allow us to draw upon our findings to see what adjustments in the experimental setting may be interesting and productive. In that light, our finding of the strong influence of financial instruments in shaping public values like quality may be a good case in point. Given that finding, and drawing upon the existing economic literature about non-price competition (Gaynor and Vogt 1999; Gaynor 2006; Pope 1989; Hammer 1999), it would be interesting to experiment with market developments that do not ascribe a privileged status to financial devices and price mechanism. As we have shown, the *de facto* privileged ontological status for price as a mechanism has often resulted in a reconfiguration of other public values in the light of this dominant focus on price. This often produces problems for these other values and points to the limitations of price-based market devices: they are calculatively convenient but at times counterproductive in terms of the policy aims

and the public values they were to ensure. We therefore propose to experiment with markets for public values in healthcare wherein affordability is ensured in various ways, thus creating more space for composing other public values in fuller scope. In this light, the DBC A segment may be precisely one of the most promising domains of developing a market for hospital care that ensures affordability through macro price-setting, allowing the composition of the market and its competition to focus on such other public values as quality and maintaining accessibility. The experiment of developing markets for this care sector could hereby move away from extending the B segment and provide an interesting new natural experiment in constructing a market that puts other public values more centre stage. Of course there are substantial basic requirements for this experiment to stand any chance of success. DBCs would have to be set at a high enough level to cover minimal costs and obviously it will not be a technocratic exercise to establish what these minimal costs are as this is highly dependent on quality assumptions as well. Yet, in principle this would not be any harder a task for government than it is for insurance companies, though it would of course require a more dynamic maintenance of A segment DBCs than found at present. This new twist to the experiment in market devices and public values is encouraged by the fact that ZN is presently discussing the development of a DBC purchasing guide for the A segment, which would obviously be required to frame an outline of quality without setting this as a formal norm. The A segment DBCs would need to be moved out of the present budgetary structure of inpatient days to make use of the commodification of DBCs as related to actual care processes but again in principle this would be no more complicated than for B segment DBCs. Collective negotiations between insurers would be problematic and would probably need to be prohibited, just as they are now for the B segment.

Another interesting field for experimentation would be the inclusion of the role of GPs in the steering of patient streams. GPs in the Netherlands are positioned so that their referral practices produce specific definitions of quality. Their gate keeping role makes them crucial players in a market for hospital care and the composition of public values in that market. Despite their decisive role in steering patient streams, GPs have largely been overlooked by all the players in the construction of a market for hospital care. We suggest that this is largely due to the fact that they fall under a separate financing structure, which makes them invisible when privileging financial tools in the construction of markets for such policy domains as healthcare. However, this very *absence* of financial incentives may make them particularly interesting players in the composition of a market for public values if affordability can be ensured through other governance arrangements. In this experimentation lessons could be learned from the situation in the United States of America, with its health maintenance organizations (HMOs). In the same way, information agents such as the GP can also be

included in the long-term care market such as MEE (Association for support of people with a disability), which already advises clients or their advocates to increase their ability to live independently. However their role is not so much to offer support and aid by making a choice for a provider but rather to offer help in drawing up a care plan. Information and advice are probably more helpful for the empowerment of care users than such financial devices as individual tracking budgets.

Such suggestions about shaping markets for public values are not to be taken as design suggestions aimed to 'fix' markets for public values. Instead they point to tentative ways of exploring experimental grounds for the task of composing rather than implementing public values. Given our findings, quantifying public values using one and the same measure of financial worth to analyze all the others seems to place substantial limitations on the experiment. Moving the quantification of public values away from this close-to-perfect financial measuring device will require many different and not always equally neat 'value meters' that would make actors' value judgements 'visible and readable' (Latour and Lépinay 2009: 16). Such value meters may prove to be crucial cognitive equipment for the Thinking State (Latour 2007) and for the shift to an experimental state actively involved in the composition of public values.

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## NOTES

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- <sup>1</sup> Such as the recent claim by Pieter Kalbfleisch, board member of the Netherlands Competition Authority (NMa), that ‘without market mechanisms there is no innovation in healthcare’ (Gibbels 2010). The evidence for such claims tends to be anecdotal.
- <sup>2</sup> The new financial regime has serious consequences for one of our case studies, an organization for the mentally disabled. In contrast to many providers, total budget has decreased for this provider. Besides being a correction for regional financial differences, the lower budget was the consequence of specific characteristics of the provider’s supply, such as relatively many low-scale locations and the chosen target group, non-congenital brain injury (more on these problems later).
- <sup>3</sup> A location manager said that she is more alert when all potential benefits are secured. A PB client pays only for short-stay accommodation and not for help with showering. After this the tariff is adjusted.
- <sup>4</sup> We should note that in the past providers also moved clients for ideological reasons (participation in society).
- <sup>5</sup> The provider raised this matter at the VGN, the national association of organizations for the disabled.
- <sup>6</sup> However, some groups find it difficult to attract volunteers.