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Markets and Public Values in Healthcare

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Colophon

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MARKETS AND PUBLIC VALUES IN HEALTHCARE

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Abstract:

Discussions on the role of markets in healthcare easily lead to political and unfruitful polarized positions. Actors arguing in favour of markets as a solution for the quality/cost conundrum entrench themselves against others pointing out the risk of markets for the delivery and governance of healthcare. These binary options of more or less marketization preclude a more empirical analysis of *how* mark*ets*, as multiple arrangements, are constructed and what their consequences are for public values like affordability and quality. To empirically explore the relation between markets and public values in healthcare, in this paper we analyze the construction of a market for hospital care in the Netherlands, based on a system of diagnose-related groups (DBCs), and the development of a market for long term care based on care-load packages (ZZPs). In these 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. We show that where policy aims within these markets focus on providing choice and increasing diversity of care institutions, the instruments of DBCs and ZZPs rather produce isomorphism and homogenization. Furthermore, the strong influence of financial instruments in shaping healthcare markets assume that cost and quality can both be strengthened while it in fact has a profound influence on *how* public values like quality get defined in practice. These translations between values pursued and outcomes produced indicate that conceptualizing the role of the state as defining public values that markets (have to) implement is problematic, as this removes crucial normative work in the shaping of our welfare states to the realm of the technical operationalization of markets. An alternative relation 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 policy *consequences* can never be fully captured through a logic of implementation. This then calls for an experimental role of the state: a state that sees market developments as experimental devices in which the aim is a good composition of public values. We propose this experimentation could for example focus on market developments that do not ascribe a privileged status to financial devices and price-mechanism, such as a market for the DBC A-segment, in which 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 function 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 2010, only one week after the Dutch Queen had accepted the resignation of the Labour party ministers and state secretaries, leaving the Netherlands in the hands of a caretaker government, former finance minister Wouter Bos of the Labour party announced that: "Increasing marketization in healthcare is not needed at this moment. What we need are hospitals and care professionals who cooperate. Rather than hospitals and care professionals who compete even harder with each other" (Bos in: van Dorrestein 2010). Perhaps unsurprisingly, this statement was soon followed by claims of the Dutch Healthcare Authority that a further extension of the part of hospital care for which prices are freely negotiable between hospital and healthcare insurance companies, would be warranted based on extrapolated findings on the relatively low increase of prices for such care (NZa 2010). The interim minister of healthcare, Ab Klink, soon afterwards announced that not continuing with such an 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). He thereby tried to define the expansion of free price-mechanisms in healthcare as an issue that would fall under his care-taking jurisdiction, rather than as a controversial policy decision that would be postponed till after the elections. The Dutch House of Representatives however soon declared the extension of free price-mechanisms as exactly that: controversial and not to be decided upon by a caretaker government.

The observation that healthcare markets are highly controversial has been a rather common one among scholars studying the relations between markets and society. However, after the 2008 financial and economic crisis, policy makers and politicians in many Western states also increasingly discuss markets in controversial terms. The example of the controversy that emerged on 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 a telling example of two tendencies in debates on healthcare markets. First, it shows how debates on market mechanisms in healthcare are often framed in polemic terms that consist of binary options: more marketization or less marketization. Second, it shows that the *evidence* for whether a healthcare market works is often measured in financial terms, 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 slightly prophetic claims that apparently need not be empirically substantiated[i].

Due to these tendencies, the political debate on 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 mark*ets*, 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). Analyzing empirically how markets work has been proposed for decades, most notably by health economists (Schut 2009), and, if we permit a tad of whig history, the need for studying healthcare markets in all their empirical complexity was already proposed by Adam Smith in the *Wealth of Nations* (Smith 1776 (2000)). Smith stated that the free market would not work well in healthcare due to the relatively high cost of education that would sit uncomfortably with low prices for providing medical care at free market rate (Schut 2003). While the 'free market' anyway is the preferred notion for only 8% of the members of the American Economic Association (Klein and Stern 2007), *health* economists have been particularly weary of expecting positive results of liberalizing healthcare per se. As a result, many practical and theoretical efforts of health economists have focused on the construction of a healthcare market that does not depend on the '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 proven of no little importance in economic studies of the relation between state and markets, it does tend to operate from the assumption that markets implement public values that have been defined by politics. The success or failure of markets in doing so thereby is the main reason for scrutinizing markets empirically. The social studies of markets have a similar empirical focus, but rather than focusing 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 thereby opens up the domain of the construction of market practices to a broader sociological enquiry of how different actors interact and what consequences these interactions have for the way public values play out in practice. In this paper we wish to explore what the value of such an approach is for the discussion on state, market and society in relation to healthcare markets.

Besides this sustained interest by health economists and the increasing interest from the social studies of markets, the relation between the responsibility of the state for ensuring public values and the development of (healthcare) markets have enjoyed substantial interest of policy-makers at least since the 1980's. Besides the rise of new public management (Pollit and

Bouckaert 2000) and other forms of neoliberal policy-making, the interest in market mechanisms to ensure public values has been influenced by a definition among policy scientists of public values and the role of governments in guaranteeing them. The reasoning here is that first, 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 these values become 'public' if government needs to intervene to ensure them. Government does this classification and once values are classified 'public', governments are required to develop policy measures to make sure these values are ensured. So far, so good, but markets do not play a role here. Markets have however been brought back in through the following analytical move: though government has a mandate to *classify* values as 'public', actually *ensuring them can be delegated* to other parties (WRR 2000). In this conceptualization of the role of the government in ensuring public values, market arrangements may be an efficient way to do so as it requires minimal state intervention. Reducing state involvement without reducing government responsibility was not only an important policy aim during the time this policy theory was developed (the 1980's), it has also been an attractive and convenient policy model ever since, that was assumed equally applicable on markets for telecom, energy, housing or healthcare.

It is perhaps unsurprising that policy makers, policy scientists and (health) economists have been successful companions in designing health policy programs and putting them into practice. The policy wish, the policy theory, and the economic operationalization proved to match quite neatly and where Malcolm Ashmore, Michael Mulkay and Tervor Pinch in the late 1980's could still analyse how health economists were rather marginalized players acting from an underdog position towards clinicians and policy makers (Ashmore, Mulkay, and Pinch 1989), such economists have now become central policy actors, populating influential regulatory agencies throughout Western policy systems.

One of the problems with this approach of public values that are defined by government but can then be assured by other actors is that it assumes that, once defined, public values are implemented and remain static in that process. As social studies of markets have shown, this seems rather far from what happens in practice; repeated studies analyzed how the supposed operationalisations are far from neutral instruments that implement public values, but rather are active agents that shape what those very values are 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 their operationalization, this points to the limitations of the theoretically neat solution of policy scientists and calls for the question how such values were intended and how they are being practically operationalized. Government agencies and other actors are continuously involved in the ongoing process of reconstructing these values in practice but at the same time operate from a policy theory of public values that precludes them from taking such co-production processes systematically into account. On the contrary; the policy theory of public values that are defined, given to the operational agents as given values to be implemented makes the acting space of government agencies extremely limited, once these values have been delegated (Zuiderent-Jerak and van der Grinten 2009). The policy aim inherent in this approach thereby is that the assurance of public values can be realized through a government that is less involved in their operationalization. As this policy aim has proven empirically problematic, the question becomes how state and market relate to each other if their roles are no longer confined to the state defining public values that markets (have 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 these 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*; they rather require a permanent *process of composition* in the governance arrangements that are deployed for ensuring these values and shaping them in practice (Callon 1987; Latour 2007; Zuiderent-Jerak and van der Grinten 2009). Ironically, markets thereby sit uncomfortably with notions of de-regulation and rather shift the regulatory tasks of policy actors to different sites: the active involvement in policy experiments that shape and contribute to public values. This implies an empirical turn to healthcare market practices of both policy scientists and policy makers, putting 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 by policy actors of public values that are pre-defined in a political process, 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 the *shaping of public* *values in healthcare markets* may show what markets are about and how they deal with other values than efficiency alone. Such an empirical focus on the shaping of 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 exactly to the study of the composition of public values in healthcare markets that this paper will contribute.

In order to do so, we will first specify which research questions come to the fore when studying the making of markets for policy domains such as healthcare and its consequences for public values. In the light of these questions, we will analyze two empirical cases, being first, the construction of a market for hospital care in the Netherlands, based on a system of diagnose-related groups (DBCs), and second, the development of a market for long term care based on care-load packages (ZZPs). These cases will allow us to conclude which values are built into these markets and how these markets are thereby empirically playing out in terms of the public values they were intended to ensure. This will also allow us to tentatively reconceive the relation between state, market and society in the light of these cases.

2 Studying Markets and Public Values in the Making

If we cannot know exactly in advance what markets are and how public values are shaped in practice, the study of them becomes more processual 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 re-reading 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, p. 5). Based on this refreshing 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 as 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 have a tendency to "*not sufficiently quantify* all of the values to which they have access" (ibid., p. 12, italics in the original) and to the way the market devices developed and public values pursued interact and shape each other.

The market devices we study in this paper both have a strong financial component. This is not to say that they thereby are *not* about other public values like quality or accessibility; such instruments are exactly expected to ensure quality and access, as well as affordability in the policy aims. However, given our approach in this study, financial instruments would be expected to not merely instrumentally *ensure* the public value of quality but also to *shape* the notion of quality in very specific ways. The reasons for the preference of using market devices with a strong financial aspect is to some extent obvious since, as Tarde pointed 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, p. 14). However, if all instruments are not merely instrumental *means* to achieve a pre-defined policy *aim*, but rather lead to the 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 re-shape these values in practice.

To analyze the process of the construction of public values in market practices, we will 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 critique that 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 the social studies of markets and its grounding in science and technology studies, is that it brings in the symmetry principle (Bloor 1976), implying that the same kind of explanations should be used to explain 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 analyses also 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 pays the price of making these markets work. Enabling the articulation of the issue of *cui bono* (Star 1991, pg. 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 were 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 in which reconfiguration of organizations, market mechanisms, professionals and policy-makers is ubiquitous. We therefore decided to focus our empirical analysis on two cases to which we already have an extensive and prolonged research relationship. We used a combined research strategy of revisiting data from previous years of research (2005-2008) in which we conducted extensive interviews, ethnographic observations and interventionist research in the 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 these two years, ethnographic research was carried out for one to two days a week in which one of the researchers (TZJ) was involved in the construction of care trajectories for oncology care and for 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 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 recent years. This study was extended with interviews with a specialized 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 these interviews in the hospital, we conducted interviews with a purchaser of the largest insurer in the area of this hospital. Further, we interviewed the development manager and an economic expert at the Dutch Healthcare Authority and the responsible 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 former research 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 that 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. In the former research, organizations were on the eve of the introduction of care packages and, some of them, commercial activities. We returned to two of our former case organizations to research if their former ideas have already crystallized out. In the organization for disabled people, we interviewed the project manager care packages (ZZP), one cluster manager, two location managers, one senior advisor finance and one staff member marketing. We focused here on how the organization has 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 cure manager and one care adviser. This organization has had serious ambitions to start with commercial activities and we wanted to know if they were implemented and what the relation is between care packages and commercial activities.

All interviews were transcribed verbatim and analyzed to further explore the consequences of market mechanisms that were introduced some years ago and to see how the market devices have further 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 analyses 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 case of the hospital market the selection was based on a the fact that we had a long-established research relationship to this hospital, which would be helpful in getting access, but that relationship itself was not a mere coincidence. This hospital participated in government-initiated quality improvement programs. Furthermore, in the most recent annual overview of quality in hospitals that is produced on the basis of performance-indicators that hospitals hand in to the Dutch Healthcare Inspectorate, this hospital was ranked first. Repeated studies have shown that these rankings are problematic and cannot be taken face-value (Pollit et al. 2010; Pons, Lingsma, and Bal 2009), but it does indicate that this is a hospital that 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 if further strengthened by the fact that the largest insurer in the region has a reputation among policy makers to be quite committed to quality as well, which was even seen as a risk in one of the interviews as this could prove to be a bias in terms of this case showing relatively positive relations between market practices that ensure public values. This potential bias is however seen as 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 about the introduction of market elements in healthcare. Even though they were not explicitly pro-market, they have tried to react pro-actively on the developments. Their critical stance towards market mechanisms, however without a complete rejection of them, 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 Diagnose-Related Groups and Markets for Hospital Care

3.1 What is the intended result?

Since the 1970's, public expenses in healthcare have been on the rise and already since the late 1980's, the introduction of market mechanisms was proposed as a possible solution to turn the tables on increasing costs (van Egmond and Zuiderent-Jerak submitted). Though attempts at the time and over the following decades were initially unsuccessful, continuous efforts by policy makers to develop infrastructures like risk adjustment systems for healthcare insurance companies, prepared the ground for changes in the governance of hospital care that were based on market mechanisms (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 critiqued for being practically unworkable and theoretically flawed (Jost 2007); Dutch policy makers chose not to put this notion 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 insurance companies act as proxies for individual citizens who can buy good quality care at a reasonable cost on behalf of citizens. This of course seems a perfect example of the delegation to private parties for assuring public values, as proposed by policy-scientists. However, the process of delegation does not stop here, as assuring public values is actually partially delegated one step further. As healthcare insurance companies are not automatically expected to only want what is 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' of the system. As not all citizens have equal health risks, the above mentioned risk-adjustment model compensates insurers for inequalities in health risks in their populations. Furthermore, there is a nationally defined basic package that specifies the care that all insurers must provide and that leaves other forms of care to be insured via optional additional insurance schemes. This differentiation of basic and non-basic care is proposed by the Dutch Healthcare Insurance Board and approved by government.

Within this regulatory arrangement, the role of the insurance companies is to negotiate with care providers about the quality and cost of the care they wish to deliver. Such negotiations would ideally lead to selective contracts, in which insurance companies would only contract 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 do so in an efficient way. Insurance companies are expected to have 'buying power' as they represent a large number of citizens and thereby many potential clients for hospitals. They are also expected to apply this power to stimulate quality improvement and cost reductions.

To commodify particular treatments, prior to 2005, diagnose-treatment combinations (DBCs), a version of diagnose-related groups, have been developed so that the negotiations between insurers and hospitals did not need to be based on individual interventions, but on such DBCs 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 DBCs would be divided into two groups: an A-segment, of which the prices would be fixed on a national level and that are priced based on a budgetary logic, and a B-segment, for which prices could be freely negotiated between insurers and hospitals. Though both segments could in principle lead to negotiations between insurers and hospitals, leaving out price turns the A-segment into an unusual market, where negotiations would mainly have to focus on quality and volume. It is therefore that this segment is usually *not* referred to as a healthcare market, whereas the B-segment is. Discussions on marketization as the one that opened this chapter, focus on the extension of the B-segment, thereby equalizing 'markets' with 'money', which was exactly what Latour and Lépinay critiqued. So for our analysis, we do not wish to follow this distinction between B-segment as 'market' and A-segment as 'nonmarket', as this assumes an a priori notion of 'the market' that privileges financial considerations over other ones. However, we will see that the fact that many actors follow the definition of the market as a *financial* instrument and thereby do not pursue possibilities for negotiation in the A-segment, is highly consequential and de facto turns this segment into an 'almost-nonmarket'. 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 market arrangements that were being developed, 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). Within this program, hospitals were supported to improve their patient safety and logistics through a series of national breakthrough collaboratives and other quality improvement programs. Hospitals started to analyze 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. As a result, 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 in which they compared present with desired trajectories and could calculate the financial implications of their quality improvement efforts.

However, these business cases assumed that financial departments of hospitals 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 the costing data and they tended to prioritize calculating costs for interventions in the B-segment over costs that were only relevant in the A-segment. However, once available and integrated in these business cases, they sparked interesting discussions between hospital management, doctors and quality managers. In many cases quality improvement and cost reduction seemed quite probable 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 day-case surgery, but this would lead to a reduction in income compared to admitting a patient for one night, for which another DBC could be used. In such cases there suddenly seemed to be very good medical reasons to not take any risk and admit patients for one night anyway.

Improving care processes and assessing financial consequences were not the only tasks hospitals had to carry out. In addition to this work, 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 in which the hospital could face a financial loss. Overviews of for example the number of hospital visits between colonoscopy and surgery were readily available and were contrasted with the norm for such care set by the improvement team for this care trajectory (see figure 1).

Even if this was all achieved, a substantial challenge that the hospitals had to face was to interest care insurers for quality improvement. This turned out to be much and difficult work with insurers who did not always display the expected interest in quality during negotiations. As the quality manager of the hospital put it:

> We have to take the initiative to bring everything related to quality to the table, but during negotiations they are hardly interested. But at the end of the day they do return with indicators or with the Consumer Quality index, or with other monsters.

Datum klinische behandeling voltooid
Tussen 200904 en 201004

Definitie: Gemiddeld aantal **reguliere** ziekenhuisbezoeken tussen datum colonoscopie en datum opname

Figure 1: dashboards for steering quality.

Since insurers did not seem to have an a priori quality focus, the hospital went at length to position quality as a relevant issue, and tried to sell their quality achievements. This at times results in rather archetypical forms of commodification:

> We have to put it on the agenda. It is also not being asked: you have to offer it. On certain domains, these are increasing, where we realize: well, here we have a bit extra, a discerning product, we do put up an enormous show – always improvised; it is not very structured – but quite a show, just to make it visible for the insurer. Part of that show is the production of brochures about what that care looks like. We have those for obstetrics, gynaecology, paediatrics, in these departments we have nice brochures with graphs, protocols and other characteristics for the various target-groups within the insurance company. So we can show: here you are: this is what our care looks like. That is all part of our repertoire.
>
> *TZJ: And that is also clear to the insurer, that those brochures have been produced especially for them?*
>
> Yes, absolutely. You couldn't hand that out to anybody else. No patient would think 'this is about me'. So it's being explicitly offered and discussed [with the insurer]. Well, another string to our bow is of course that we always need to have the professional himself join the

> discussion. So we have gynaecologists talk till the last injection after delivery, about why that is required. At that moment we have two gynaecologists explaining the medical advisor [of the insurance company] why *that* injection at *that* moment *really* should be included in this DBC. Our experience is that specialists tend to convince medical advisers. But perhaps that model has already lost its strength, because we see the gynaecologists have to hand these things in again.

Despite the work by the hospital organization of producing sales brochures and by doctors sitting in on negotiations to personally specify quality, it remains hard to 'sell' quality in the terms that medical professionals would like to. In the debate on healthcare markets the fact that negotiations sometimes are more focused on financial aspects than on medical quality, is often explained through 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 as, 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 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:

> And what kind of quality-indicators we could agree upon. This is something we focused on immediately in 2005: we went for that quality. And we have invested a lot, especially during the first years, to uncover what care is actually being delivered. And that was the input, when we were having our price-negotiations, to put that next to those.

However, where the notion of information asymmetry would suppose that once these transportable performance-indicators *are* available, they would be taken into account when quality and price are being negotiated. The problem in our case however seems to be that *even* when such quality information *has been produced, and is readily available at the negotiation table, this only becomes part of the equation in very particular cases*. And those tend to be the cases where cost is an important factor again. As the purchaser put it:

> *One* indicator could be, if you want to be a preferred provider, than your price would have to be below average. But that doesn't mean that as soon as someone else is ten Euro's cheaper, they get moved to poll position. (...) We do assume that quality and affordable care could go together. Which means that as soon as you [as a hospital] do something right and it becomes more expensive, we are less interested than the other way around.

Though beyond the scope of this study, it would be interesting to do an analysis of the hospitals that are in fact assigned as preferred partners, but still this interpretation of quality explains partly why it is so hard for hospitals to bring quality into the equation of negotiations because, even when it is readily available, quality largely becomes relevant only when it also saves costs. If quality would always come at a lower cost, there would be no tension here but in that case healthcare could do with quite simple and technocratic – that is; purely calculative – arrangements for measuring best quality at lowest costs. As this was the initial assumption for many players in the market for hospital care, this market in this hospital ironically worked *better* in terms of negotiating for quality and price in the *early years* based on *rather 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 in 2010 and yet it proved harder to bring quality and cost together in some cases in annual negotiations. This on the one hand is an important finding that problematizes the notion of information asymmetry and brings to the fore the importance of *belief* to make policy instruments work. On the other hand it shows the importance of sustained analysis of how markets work over time as beliefs may change due to multifarious reasons, which may have dramatic consequences for how able market practices are to ensure public values. One of the reasons this belief may have changed over time is that it proves extremely hard for insurers to sell the quality they would purchase at a higher cost, at a higher price to their insured. We return to this issue below, but for now this situation puts centre stage the question what is to be done with better care that may come at a higher cost with an insurer who defines quality as implying cost reduction?

According to the respondents of the Dutch Healthcare Authority, there are three types of innovation, which will relate differently to the present regulatory arrangements:

> There are different forms of innovation; when it gets cheaper at the same quality, then of course all is fine. If it costs more and increases quality, then you have to pay for more quality, that has to be expressed in the price – or not, but then you have insufficient supply. And thirdly we have breakthrough technologies, which may need to be subsidized.

So for the actors involved especially the second form of innovation is problematic. There seem to be two possible strategies here, which the hospital both pursues: creative bookkeeping (in the not necessarily euphemistic 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 judgments aside, hospitals at present have more literal strategies of creative bookkeeping, in the sense of being creative to make sure that the costs they incur for delivering additional quality are actually born by insurance companies. Such creativity sometimes leads to adding up certain items to then be able to charge a different fee. As a division manager explained:

> Patients with oesophagus carcinoma get a PET-CT scan and after assessing that and in case it is required, also an endo-echo on the same day. Because of their illness they are quite frail and we admit them for day-case treatment so that they get enough rest in between these two large, heavy diagnostic tests and can recover. This is all the more important, given the relatively long distance many patients have to travel because of our regional specialization. This way we reduce the number of hospital visits and we create a way to somewhat cover our additional costs.

Where this creativity with booking DBCs was one strategy, this is not an approach that generally gains most societal acceptance and in health economists literature it is referred to as ‘upcoding’ (Steinbusch et al. 2007). Upcoding, being defined as “the practice of miscoding and misclassifying patient data to receive higher reimbursements for services provided” (Lorence and Richards 2002, pg. 423) may be a pragmatic solution and highly understandable given the presented complexity of financial streams, but by some health economists, this is rather seen as an “hospital acquired disease” (Simborg 1981). One of the main problems with the practice of upcoding is that there is no countervailing power that prevents that creative bookkeeping from turning into simple money grappling. It may be a way of making ends meet for a hospital that is inefficiently organized, and thereby not contribute to the public value of affordability of care.

One possible alternative route that does not involve upcoding would therefore be to play the patient card. Within 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 they are not satisfied with the way the insurance company, as a third party, is ensuring their interests (Schut 2009, p. 70). This would encourage the hospital to target patients and their representatives more directly in order to ensure that insurance companies may be willing to broaden up their definition of quality. This is exactly what this hospital does. Besides the extra work that the hospital and care professionals have to carry out to articulate quality at this negotiating table, this hospital does not focus 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 via other routes by signing a ‘contract with society’, including highly specific care agreements per diagnosis that are announced in local newspapers and the quality journal of the hospital.

> That started with our anniversary in 2004. That was our first contract with society: that's where it started. Because we used the anniversary year of 100 years Atrium to spent many Saturday mornings in our auditorium with many patient groups, talking about: what do we want from each other, and the care guarantees [that were introduced at a later stage] are actually a specification of what commenced there. And by now it is an annual adjustment of the contract with society and it got this specific: What do we deliver to our patients with Parkinson? What can he count on? When is it not good enough? And what penalty card will you hand in where? With a management-system behind it on our side: do we still deliver what we agreed to?

However, there are two problems with this strategy: first, as we will see below, this strategy assumes that insurers are able to sell better quality at a higher cost to individual clients, which requires a trust in insurers that is presently absent, and second, the individual patient *nor* the insurance company at the end of the day really seem to define where patients go. Referral of patients is organized in the Netherlands by the gate-keeping position of general practitioners (GPs). These may refer to specific hospitals or even doctors and thereby to a large extent define where patients go. They can do so on the basis of long-term relationships with hospitals and, given the fact that they at present are among the few actors that see patients go to the hospitals they refer them to *and* return with their stories of what happened, while also to some extent having insight into the medical outcomes produced, this may well make them crucial actors for qualifying public values in their referrals (Dixon et al. 2010). However, their central role also at times produces problems for the hospital, insurers *and* patients and became painfully clear during an incident between the hospital and GPs. The hospital at one point in time was quite surprised that the stream of patients for their well-organized oncological trajectories, all of a sudden seemed to vanish almost entirely into thin air. They soon found out that this had everything to do with a problem that was not even closely related to these care trajectories but had to do with a conflict that had emerged between the hospital and the local GPs. The hospital had developed a diagnostic centre that GPs had to refer to from now on. This centre was separated from the hospital and placed at some organizational and geographic distance. However, the president of the local GP association had been involved in the set up of the previous diagnostic centre that used to be based inside the hospital and he was not amused, as he found the previous situation much more suitable and workable. And to show his dismay with the situation that emerged between these two organizations he urged his colleagues to not merely take legal action and sue the hospital, but also to follow some guerrilla tactics: he proposed that they would not refer patients to the hospital any more until the issue was resolved. As the quality manager of the hospital explained:

> The relationship got tense all of a sudden and well, this has been played in all kinds of understandable and incomprehensible ways, which resulted in an increasing number of referral-streams that passed us by. Also to put the pressure on us and show that we no longer were friends and how powerful they are. And sometimes Sittard could have an access time for endoscopies that just beat ours and that then became the only target [for GPs]. The fact that the whole trajectory after that was not organized and that after being diagnosed – your worst nightmare – you're put on hold for several months because they didn't have our care program over there, that all of a sudden didn't matter [to the GPs]. (…) They didn't give access to patients to the things we had organized really well here.

The quality manager admitted that the hospital possibly made mistakes but that is beside the point here. More importantly, this event shows how fragile the notion of the individual patient as a countervailing power is and how this may at once be a highly coercive force and a force that is not necessarily linked to the expected role of standing up for quality (Silverman 1987; Zuiderent-Jerak, Bal, and Berg forthcoming). At present the hospital is distributing their attention even more for of course they cannot shift it away from insurers and society, as these are not *un*important, but they, as well as insurers, do need to include GPs in their communication about delivered care but especially maintain good relations with them as patient streams may become the plaything in other political struggles.

3.2.2 Insurers at work

When analyzing the work that hospitals need to do to make the market work and try to overcome what they perceive as its problems, we already met the insurance companies, and they turned out to at times pose difficulties to hospitals. But the dynamics are a bit more reciprocal than just that. Insurance companies have since the introduction of the Healthcare Insurance Act in 2006 been positioned in such a way that they are the main negotiating party for hospitals and, with the Healthcare Inspectorate mainly ensuring minimum quality, that they have a core role to play in ensuring public values in hospital care. This is no small task, given that they – in principle – could negotiate on a large number of DBCs. This would require enormous capacity of staff and detailed knowledge on every bit of care delivered within hospitals – a daunting task that obviously is unfeasible for insurers. So one of their core activities in making sure they can at least negotiate on *some* trajectories rather than get lost in the entire bulk is to minimize the DBCs they are negotiating. As a purchaser of a large insurance company put it:

> We cannot review all DBCs till behind the comma. So we made a list with spearheads that have mainly been based on revenue and volume, so let's say a top 20 or a top 15. And we also looked at what we find important topics, 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.

So the idea that insurance companies negotiate in the name of their patients needs to be substantially nuanced to understand how insurance companies reduce their tasks to a doable scale. If insurance companies were delegated the task to ensure public values the question thereby of course becomes: what about the other DBCs? For those in the B-segment Zorgverzekeraars Nederland (ZN), the sector organization representing the providers of care insurance in the Netherlands publishes an annual DBC purchasing guide (figure 2) with the subtitle *Quality as a compass when purchasing care*.

Figure 2: DBC purchasing guide 2009

They do so together with a number of actors. In the process of constructing this commercially available "guideline for the negotiations between healthcare insurers and providers of secondary care" (http://www.bsl.nl/shop/dbcinkoopgids-2009-segment-2-9789031360925.html), the sector organization cooperates with scientific medical associations, structuring their cooperation around the use of clinical practice guidelines. Furthermore, performance-indicators that are developed on a national level are directly integrated and the opinion of patient associations is included for a number of diseases. This guide was developed as an immediate response to the new role insurers had to play when they were to negotiate 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, that when the [previous minister of Health] Bomhof said: "you go and negotiate about this now", so insurers had to negotiate about say cataract. But what is that actually? Because what is good care? And do we have an indicator for that? That has been the trigger to start discussing this, so that is why the first purchasing guide was developed for the B-segment, because then you have to negotiate for a product that doesn't come with a price. So you have to know: what is that product actually? What does it look like?

This purchasing guide frames to a large extent what the negotiations that are taking place should be about and what would be a good standard for care that is not being negotiated. As the purchaser explained:

> Initially we produce an aid for the purchasers, based on ZN care profiles, that have been developed in the knowledge centre of ZN with their medical advisors and professional associations. You shouldn't quite call it a norm-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 that we ask, we call that 'clever questions' but perhaps they are stupid questions, but we hope for clever answers. We ask those to hospitals. We do so in writing and then we initially have a quality meeting, as we call that, and there we discuss the care profiles. And then we also request the care profiles [of the hospital], at least of our spearheads. And based on those profiles they give us, together with our medical advisor, we combine their profiles with the ZN profiles or with our own CZ profiles and based on that we start to ask questions or we have a meeting. Then we see if based on those profiles they deliver the care we would actually want and if not, why not.

This DBC purchasing guide is a rather interesting market device for a number of reasons. First, it seems indispensable in reducing the enormous work for healthcare insurance companies to doable proportions. Second, though this framing is crucial for a pragmatically working hospital care market, the idea that public values were delegated to insurance companies, who act on behalf of their insured customer/citizen-hybrids, seems in need of respecification. The hot potato largely seems to have ended up on the plate of ZN with its hybrid forum of doctors, patients and guidelines. This raises questions about the form and place where public values are in fact being shaped and what is brought into this de facto national framing of the quality of care.

For those DBCs that do fall within the negotiation scope of the insurance companies, they need not rely solely on the profile in the DBC purchasing guide or the sweet-talk of medical specialists. They also have their own DBC profiles and are supported in their negotiations by medical advisors that they employ. And though these advisors have to deal with a selection of DBCs, the range of topics is still quite broad.

> We have medical advisors and these are linked to a hospital and we tend to bring those to the meeting. They are more general advisors, so not really specialized in cardiology or another specialism. Within our medical advisory group there are of course some specialists, people who specialized or have a specific interest in certain disciplines. So in this way we build up expertise in this matter.

So though the insurers try to develop specific expertise on the main care trajectories, it is of course hard to match the detailed expertise of care professionals who are sitting at the same negotiation table to discuss the kinds of details outlined above. As for them, in their definition of quality, the devil is in the details, this is bound to lead to a substantial discrepancy in how care can be discussed at the negotiation table. As one of the medical specialists phrased it:

> It is not surprising if you look at the medical advisor, what their background is and what an incredibly wide range she has to cover, that it is simply not doable to cover the entire range of specialized medical care. They don't get further than the map with profiles of ZN: the purchasing guide and that's it. And of course that's pretty marginal, because it's not hard to exceed that. Especially since the purchasing guide is not necessarily attuned with the most recent guidelines and developments in medical research.

This may indicate even further the importance of the purchasing guide, as it already may be hardly doable for insurance companies to bring the expertise to the table to really be able to ascertain public values in care negotiations. But before drawing this conclusion the framing of this guide would need some further scrutiny.

One of the ways in which the purchasing guide deals with the rather overwhelming number of DBCs that could in principle be negotiated, is to cluster them. As the respondent of ZN explained:

> Let's take a simple example: cataract. There are now 3 DBCs: one in outpatient clinics, one as day-case surgery 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: we turn this into one basket: we make a combined profile. So we reduce these three to one. There are three different codes, but as far as we're concerned, you can put one price to this and that will

> be a mix of these three. From outpatient, day-case and admission. That is one way in which we made it doable.

Besides clustering, another way of creating doability of negotiations on large numbers of DBCs is to specify which one can be excluded from negotiations. As the ZN respondent again explains:

> Everywhere where it reads 'no' we said: we don't make a profile for that. This actually means two things. *Either* it is nonsense: this DBC should actually not even be listed. So this means: price zero. *Or* it is so rare: we're not going to negotiate about that, you give your price and I'll see if I think: 'ouch, let go of my arm'. (…) So in that way we've approached it. So we looked at: how many DBCs are there in the B-segment – something like 10.000 or so, and we have been able to reduce these to let's say 200. And then our focus has always been on high-volume DBCs.

In an interesting quest for doability, DBCs thereby are increasingly combined and selected. What this of course introduces is a notion of representativeness of certain DBCs for the quality of care in more general terms. A relatively small number of 'baskets' covers a large percentage of care delivered, especially in certain types of care like eye-care. The assumption of the purchasing guide thereby becomes that a small number of DBCs can be used to negotiate, while still pursuing quality on a larger scale:

> At some point I can start to discuss eye-care. Because someone who's very good in cataract procedures, why would that person not also be very good in glaucoma procedures? (…) So then we're talking about eye-care, if I know that these are some core points, of which I can say, well, if that is well organized, then the rest will follow along.

This assumption is highly understandable in the light of the creation of a doable healthcare market, but raises questions based on the observation of quality improvement researchers that improvement of one stream of care often is 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 'streets' that are completely decoupled from other forms of eye-care. Yet, even negotiating on all 200 DBCs would simply not be doable for insurance companies, given the capacity this would require, or would at least come at a huge burden and potential cost.

A further specificity of the negotiations taking place is that where the insurer is expected to have a certain 'buying power' this is not always the case. Where sometimes the hospitals voice their concerns about the force with which insurers push them to the lowest price for a DBC, there are other occasions where the insurer has to settle for whatever price it is offered because it simply is uninteresting for the hospital to negotiate with an insurer that only has a few patients a year in that care trajectory.

> We have hospitals where we are market-leader, we have hospitals where we have a substantial market-share in the B-segment and we have remaining hospitals where we have a minor market-share. That is divided in about 35 in the first category, so where we are market-leader. In the second category there are about 11 and that leaves about 55 in the last category. And that last category, there we discuss quality to a much lesser extent. There we basically ask for a quote. An then we do it the other way around; we look at the prices and where we see strange prices, and in principle there where we have spearheads, we ask for a clarification: "how come you are so much more expensive?" So then we reverse it.
>
> But what we also face; these [hospitals] are more of a nuisance. Last year during the negotiations we told one hospital "listen, your price is way too high". Then they say "yea, so what?!". "Well, then we don't contract you", and then they say "well, how do you see that", they say, "because then we'll put a notice-board in the corridor that says: caution; if you are insured with CZ, you will probably have to pay yourself. Around the corner here you find an Achmea boot where you can change insurer to Achmea." That is the kind of threat we then face. Not that we are sensitive to that.

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

> We act as care intermediary and that also is an important aspect, but you shouldn't overestimate that in terms of volume.
>
> *TZJ: How big a percentage of your patient population are we talking about here?*
>
> I think that at most 5% [turns to us]. So... And often that is because they have to wait too long, but also quite often just because they want to receive good care. We have quite a good network for that and a feeling for what hospitals deliver. Of course there are signals, like: this hospital over here is really better than the other one. But to be able to objectify this reliably, we are working on that to map that more clearly.

So though this insurer is trying to develop expertise and become a more central player in referring patients, they do realize that they are still far from becoming 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 quite some work to do to improve our image. We are still not perceived as an insurer who is knowledgeable when it comes to quality, that knows where to find the best care. We are also suspicious, because if we recommend something it will probably be something cheap rather than something good.

This image is the problem that insurers want to work on and selectively contracting certain hospitals may produce exactly the opposite result. As a respondent of the Dutch Healthcare Authority explained:

> I think there is a not that credible threat that insurers will not give hospitals a contract. That has to do with the fact that, in case an insurers plays hardball during negotiations, then they risk not having a contract. They then need to explain this to their insured, meaning: you will no longer go to that hospital, or you have to contribute a substantial amount. This leads to reputational damage, and that contradicts the purchase profit.

Ironically, the infrastructures for negotiating may at times be more consequential and less problem-ridden than the actual negotiations themselves. This became clear when the respondent of ZN 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 of the [one of the large hospitals in the West of the country], they took this guide and went to their doctors, saying: "well, look here?!" Within one week the length of stay was down by two days. (…) They have something on paper that isn't theirs but has a certain degree of objectivity, because 'we [as hospital directors] also didn't make this up'. The professional organizations have indicated: this is how we think it should look on average. This is what they took to the specialists, saying: "well, you seem to deviate from this norm. You *can*, but than I'd also like to know why that is the case." Apparently there was no valid reason, so in that sense it has produced results: wonderful!

In this sense the purchasing guide is setting a de facto norm, without being designed to formally function as a national norm. But apparently, the threat of a future negotiation combined with a standard set partly by doctors themselves, can produce quality gains without needing the actual negotiation.

As we have shown in this paragraph, where the hospital already had to do much work to shape public values in the market for hospital care, the challenge for insurers to make the market work through all kinds of visible and invisible work seems no less daunting and the results for themselves and for 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, we now return to the question what the values are that are produced.

3.3 Values in this market

One aspect of public values in this healthcare market that has come to the fore quite explicitly is that public values tend to get framed in particular ways in the light of financial market devices. Quality is being improved through these devices, but mainly 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 that are not part of the DBC B-segment a purchasing guide is absent, insurers indicate that quality is only quality if it includes efficiency gains and hospitals point out that quality does not come with a financial advantage cannot be sold – neither in the A, nor in the B-segment. In the case studied here, attempts to improve quality of care that does not fit the insurers' definition leads to strong debates between hospital management and care professionals, with professionals at times pursuing quality improvement and regional specialization that proves a management puzzle in a hospital that is committed to quality improvement but 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 have a selected number of surgeons carry out the operations. Clinical evidence has shown that the mortality of patients has a direct inverse relation to the number of operations carried out by surgeons (Birkmeyer et al. 2003). The Dutch Healthcare Inspectorate has 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 had taken up this challenge and had informed their colleagues in the region that they were specializing in this type of surgery, would organize a smooth running care trajectory for them, as they had done for other trajectories, and agreed that their colleagues would refer these patients to them. These surgeons thereby did exactly what any quality-committed healthcare inspector could have hoped for and they could literally be expected to be saving lives through this improvement. However, their strategy seemed to be perfectly opposed to the emerging management strategy to deal with the present market arrangements. As the quality manager explained:

> There is one promising strategy: reducing the products you loose money on. And this is what just about everyone on the market is doing. So we all do that, perhaps we are the last ones to find out, because it so much goes against our nature: we see surgeons cheerfully bringing in their next spearhead, 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, which indicates careful diagnostics. Well, if *that* is the measure, then they're doing a fantastic job over there: in fact this makes all of us in the Atrium really happy. There now however is a dominant development, in which the [managerial] divisions certainly play a role. Bleeders and feeders: what is draining us and how do we stop the bleeding. Besides zip codes there is a range of different options. Already now the next bleeder will not get in. So the next issue like oesophagus will be obstructed by many people here in the hospital, before some enthused professional says: "I can do this! I can do that! So we have a good ICU and at the ward I also will get it together, we can do this together! Can I do it?" "No way!", that is what we'll say. We're already saying that.

On the one hand this is a typical problem of the budget-driven system where prices are set at a national level, without differentiating for quality. However, *because* of the looming expansion of the B-segment, there is some reluctance to make any changes in the specification of the A-segment DBCs. So within the present arrangement where the maintenance of DBCs is no longer carried out for the A-segment, quality that comes at a higher cost can simply not 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 would only apply to the A-segment, this could easily be read as a plea for extending the B-segment, in which the price-mechanism *does* operate and could be used to get a better price for a product of a better quality. However, hospitals are not quite that positive about the developments in the B-segment either. As the division manager put it:

> If you now look at the price for the first batch of B-segment DBCs, that is quite interesting, because what is happening to the price? You see that over the last 4 to 5 years these prices are 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 can have a marvellous care program with all kinds of care- and service activities, but it's very unsure if this leads to a higher price. So especially for the B-segment we end up with a nationally fixed price. We are not allowed to discuss [price] with other hospitals, because then we immediately have the NMA [the Netherlands Competition Authority] breathing down our neck as care providers developing

> provider power. But those insurers have so many hospitals that they exactly know what the average price is.

What this respondent points out here is that, according to him, the value that is built into the present market is one of cost-reduction through a price-mechanism that frames quality in a particular way. As a consequence of this situation – that is remarkably similar in the A and B-segment – of it being harder to sell good quality than to get rid of expensive care, the policy of bleeders and feeders has an ironic consequence that, where the policy aim was that healthcare organizations are increasingly competing with each other for the favor of the insurance companies based on relevant quality differences, they in fact become *more alike* at a not necessarily optimal level. None of the respondents concluded from this that the market devices in relation to public values were not working at all, though numerous difficulties were discussed. When asking the purchaser of the insurance company, who already works for 28 years for this insurance company, how his work has changed over those years, he replied:

> Well, what really has changed is that we're getting a bit more of a view on quality. Hospitals also focus much more on that. It is not even that long ago, but if we were negotiating about 6, 7, 8 years ago, it was really about the price and about the extra money they wanted. And to show that they did see more patients. And we would ask: "why do you see more patients?" or "why do you have waiting lists?", and based on that we would assess if they needed extra money to deal with these bottlenecks, because nobody looked at: should we solve it here or should we solve it elsewhere? So that discussion is much less present now. And what we also faced, in the beginning, we would say: "we'd like to talk to you about quality", and then they said: "that's none of your business! Who are you? Just pay the bills and don't interfere with other things." And now you see, especially with medical specialists, they increasingly enjoy talking to insurers about what they do and what the quality [of their work] is. And then there are those who are very enthused, who want to make it known that they actually are really good or better, or special. There is a much stronger willingness to do that, but also to openly indicate what they do and why they do it. It has become much more transparent than about 6 years ago.

So though the negotiations on quality seem to have started, which most certainly is a major gain for hospitals, patients, insurers and policy makers, through the central position of price mechanisms, these very negotiations may according to the respondents in this study be shaping the definition of quality as one that is 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 ideal-typical form. Given such an analysis of the market for hospital care we notice some of the difficulties of a market for public values in hospital care, and will return to this in the conclusions. We will however first 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 tuned to the individual needs of each client (TK 26631, nr 1, 1999; TK 26631, nr. 14, 2001). This implies that delivered ‘products’ by providers will get a ‘price tag’, as in a normal market. Modernization of the AWBZ (General Exceptional Medical Expenses Act) was needed to enlarge choice options of clients. The supply-oriented long term care system was no longer equipped to serve emancipated citizens:

> Citizens adopt an emancipated attitude and express explicitly that they want to give meaning to life themselves and be responsible for that. Anticipating this societal development constitutes the most important problem of the modernization of the AWBZ. It requires such a redesign of the system that it meets the wishes of citizens for more freedom of choice, more choice options and more voice and participation. (TK 26631, nr. 14, 2001: 1)

The Ministry of Health wanted to develop new financial rules for the AWBZ with the intention to improve customer choice and voice. According to the Ministry of Health, flexible entitlements, and hence individual-linked payments, are necessary for the realization of tailor-made care. However, the description of entitlements should not be made so abstract that clients could not determine if the receive ‘value for money’ (TK 26631, nr 1, 1999: 24).

In 2007, after a long period of preparation, the Ministry of Health has introduced care packages (zorgzwaartepakketten - ZZP), which are a kind of 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 budgets has had consequences for providers who are now paid on the basis of output and are thus actively stimulated to attract and hold clients, since clients have more exit-options. The idea is that if clients are better informed about their rights or their budget, because of their better position in relation to their provider, they will have a better chance of satisfying their own particular needs and wishes. For instance, clients can choose being given either 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). On 1 January 2009 care level packages were introduced in the AWBZ.

In the new scheme, the indication becomes tailor-made, which is translated into a ZZP. For 2010, there are 52 care packages (ZZPs) defined for the three sectors of intramural care, 10 for nursing homes, 13 for people with a psychiatric problem and 29 for people with a mental disability. Entitlements are broadly defined within ZZPs. A ZZP describes which functions, including a global indication of hours per week, will be delivered, like support (BG), personal care (PV), nursing (VP), behavior regulation, daytime activities and treatment. In a former design version of the ZZP, entitlements were more strictly defined with exact hours per function. Another important aspect of the new system is the allowance of substitution of activities. In the example of figure 3 the client can, for instance, substitute between support and personal care.

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						

Figure 3. Example of a care package: ZZP3 VG (VG = mental disability).

With 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 could more easily switch to another provider or make use of different providers (more choice). According to the Ministry of Health, a system of output finance will trigger 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 individual-trailing 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 explicitly explains that individual-trailing 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)

Even though ZZPs are partly developed to empower the user of care, the ministry wants to prevent that this would lead to claiming and calculating clients. Nevertheless, the basic idea is that tailor-made finance could more easily lead to tailor-made care than the old system of finance.

4.2 What makes markets work?

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

> Now there is some limited market functioning. If you just look at the intramural compartment, then you must be honest to say that there is really no market functioning. There is still a matter of scarcity. Actually, a client still cannot choose by which provider he wants to obtain care. Moreover, we have to deal with tariffs which can just actually vary between a very confined basis, between 98 and 100 percent. (Interview senior adviser, organization for disabled people)

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

We will analyze how the new market-oriented financial regime already triggers healthcare providers to change their behavior and impacts on the position of clients. Even though the provider has hardly any room to negotiate prices and volumes with care offices, the introduction of price tags affects the internal organization of the provider and the relationship between the provider and client.[ii] In the next sections, we will describe how providers have dealt with the new market device of ZZPs.

4.2.1 More registrations in ambulatory care

Care packages are split up in parts so that clients can make use of different providers, which increases customer freedom. In that case the provider has to register the activities of the client in various administration systems, each with its own registration rules. According to one of the respondents, administration has become more complex and intensive because the organization has sometimes to show accountability to various care offices for one client. He tells that the new policy rules for production contracts with the purchasing care offices are needlessly complicated:

> Now, there are care offices that say 'we don't purchase ZZPs with day activities for clients', whereas they are entitled to day activities. That means thus that you have to account for this client a ZZP without day activities, but furthermore, because the client is indicated for day activities, you have to score and account for day activities in a different way. And, that is again per half a day. That implies therefore that for one client you have to show accountability at least two times, while you can actually do it in one way. Next, you probably have to justify capital expenses and transport costs, too. If you have bad luck and you have to face with region exceeded traffic – for instance, if the client lives in the region of DWO and falls into the care office DWO, but receives day activities in the region DWO as well as Haaglanden; we have that kind of clients – then you have to account for a ZZP without day activities, you have to account for day activities by DWO, and you have to account for day activities by Haaglanden, plus connected transport and capital expenses. Well, in what way more simple? But then you have of course to deal with the fact that every care office has its own accountability template. (Interview senior financial adviser, organization for disabled people).

The provider chooses to make agreements with these special clients for a ZZP inclusive of daytime activities, even if clients make use of a different organization for these activities. The provider contracts then daytime activities to a sub-contractor. The reason to choose for this solution is to prevent the loss of money in case the client doesn't go fulltime to the day centre and stays in the residential home – some substitution between residence and daytime activities is allowed for ZZPs with daytime activities, but not for ZZPs without daytime activities. Output finance has especially 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 difference with the old system of administration.

4.2.2 More attention for business processes at location level

Individual trailing funding has increased insight in business processes. The provider is better equipped to benchmark locations internally. Next to issues of quality and absence due to sickness, the management can now compare locations in terms of economic performance. With the aid of ZZPs, it becomes more transparent if locations have issues of overproduction or underproduction. With this tool the provider can show how the location has performed compared to other locations in the same cluster:

> Look, if there is underproduction and next to that overspending, then you have to deal with a reinforcing effect. Then you shall call such a location to account one day, depending on the degree of underproduction and overspending. On the other hand, you can have of course locations that are doing extremely well: overproduction and underspending. That's perfect you would say. All right, then you should be very strong, then you have, as a figure of speech, to check if the quality is still of the sort that… (Interview senior financial adviser, organization for disabled people).

The improved transparency of results at location level triggers a development to adjust supply better to the indication. We see that the responsibility for budgetary control has partly shifted from the organizational level to lower levels. To balance their books, organizations used to shuffle funds between their various budgets (substitution). Departments that had not needed to spend their entire allocation were able to compensate for those departments that had overspent their own budgets. The organization for people with a mental disability in our case study does not rule out every form of substitution, however locations are nowadays more aware of their business results and realize that substitutions is less accepted than in the past.[iii]

4.2.3 Making ZZPs fit to location level

In the new financial scheme, every client brings along its own budget based on the entitled ZZP. To create a workable situation, the provider doesn't strive for a complete transparency of the spending of the ZZP (in euros) for the client, except for some information about the hours, including collective hours. Moreover, it creates some latitude for professionals and caregivers to anticipate fluctuations in daily need. When professionals draw up the care plan that defines the care that the client will receive, they don't normally look after the ZZP directly. In that sense, caregivers are kept at a distance from the ZZPs. That doesn't mean that caregivers don't notice anything of the introduction of ZZPs.

The organization for people with a mental disability expects, for instance, that the personal counselor and/or location manager checks during the yearly evaluation of the care plan if the (new) care plan still fits with the current indication or if a re-indication is necessary. Re-indication should also be considered by staff when the circumstances of the client decrease. Employees have increasingly started to realize that a good indication is important for the budget and with that for the workforce of their location.

Another consequence of the new financial structure is the clustering of the same type of clients. In the past, there were different levels of mental disability within one group. The provider wants to stop mixtures of ZZP 1-2 clients and ZZP 5-7, as the level of the caregiver/professional should be tuned to the heaviest type of client. 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.[iv] One of the cluster managers explained that no longer the client can choose every location. He said that they developed the same policy as in hospitals, where patients leave the IC as soon as they have recovered enough to go to another, cheaper ward:

> Now, that actually happens here. Here stands a large, professional team to deal with complex clients. Thus, they can deal with less heavy clients very well, however, and then you just get too less money for that place. That is pure the incentive. Only in the past, we took things easier, because it was paid out of the margins. Anyway, parents have of course problems with that. That's where the area of tension is. If parents think this is the ideal location, but we say 'sorry, the indication is not enough'. Yes, that is of course difficult. (cluster manager, organization for disabled people).

In the same way, location managers also better check if the new client fits with the staff of the location. Locations with high qualified staff look more critically at the intake if the client has received a high ZZP. On the other hand, location managers sometimes experience some pressure from above to accept a client with a high indication which they are not inclined to accept:

> That they sometimes have something like 'this client with ZZP7, which brings in money, we place it thus to you'. And then I say: 'Yes, stop a while! I first want to know'. 'Yes, but it is

> possible, it fits well.' And then I say: 'No, I first just want to know if this really is possible.' And that sometimes implies fierce discussions. (location manager, organization for disabled people)

Another development is that low scale locations are not possible anymore, because of management costs. In the new policy of the provider, locations should have at least 24 residents, unless the location head is no longer connected to only one location. The idea is to build smaller units of six persons within one location. The new financial structure triggers the provider to cluster the same type of clients in order to save overhead and staff costs. Clustering of clients is also done for marketing reasons. The provider has started to develop product groups or service-market combinations, which the provider can use to attract new clients.

Individual-trailing funding has been developed with the idea that clients could better determine if they get "value for money". However, providers search for a doable form of accountability. Complete transparency of the spending of the individual ZZP would require an extensive form of registration of hours or fixed hours for activities. Collective ways of accountability at the level of the location are 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 prevent that the accountability for how the organization spends individual ZZPs becomes very complicated. The cluster manager of the organization for people which are mentally disabled said: "The pressure on accountability increases; so we take a look how to make things more clear."

We have to be aware that not all these consequences are directly caused by individual-trailing funding (ZZPs). According to the financial adviser of the provider, 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 helps 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 limits instead of possibilities

The quality of an indication is very important in an individual-trailing system. According to the location manager, personal counselors have to describe stronger the disabilities in order to realize what the client needs. To receive a 'good' indication, employees need to look again in an outmoded way to clients. Employees have to make a paradigm shift when they prepare an application for a care package; it becomes a transformation from ‘possibilities’ back to ‘limits’. This is a difficult, uncomfortable shift for some of the employees:

> There are personal counselors who made very easily the turn to look more critically. However, there are personal counselors who became entangled with the idea that you have to start from the good things of the client, and not from what the client cannot do. Those had described very well what the client can do, but they didn’t realize that the client was able to do that all as a result of the presence of support. Therefore, those personal counselors have struggled very much: ‘I don’t get the indication away; this he can and that he can still do.’ Than you have to say: ‘Yes, you have to think away the support too. Can he then still do that?’ (location manager A, organization for disabled people)

Interestingly, these solutions are not interpreted as a form of ‘upcoding’ or fraud, but as a way to guarantee that clients receive the care they need. In the same way, making a paradigm shift during the request for an indication can be interpreted as part of the professional responsibility for organizing enough care for the client.

Some clients have problems with this new way of thought too. For instance, people with a non-congenital brain injury (NAH) receive a ‘better’ indication if they would have used the label 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 receive now LG ZZPs, but in practice they also experience cognitive problems. However, they have problems with the qualification VG, which they interpret as a stigma.[v] These examples show that the individual-trailing 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. We have to be aware that this is only a minimal form of standardization, since the provider doesn’t search for standardization in terms of concrete activities, hours or Euros. ZZPs are only used to describe in general terms what the client could and could not 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 can realize what you advocate”. According to the financial adviser of one of the organizations, the provider can now better substantiate what is possible:

> Okay, that was of course not possible in the old system. It was just an indication for residence and for care. Okay, then you have emancipated clients who think that everything is normally possible. And now you can make clear that, that ... much is possible, however within the limits of. If you have chosen for something at a given moment, yes, that applies for me and that applies for you too. Look, if I buy a new car, which means that on a given moment I can't buy, let us say, a new bike or new audio equipment or place a new dormer. I mean, I can spend my euro only one time. In that sense you can make things more transparent. (Financial adviser, organization for disabled people)

However, according to our respondents, clients' advocates almost never start a dialogue about the amount and quality of care with the aid of a ZZP. They are mostly interested if the care is all right or if everything goes well with the client. In that sense, the ZZP is not or scarcely used by clients as an instrument for demand-driven care. At this moment, there are also not many clients or advocates that deliberately select providers, even though one of the providers notices internally that some partly outdated locations are not so popular anymore. Moreover, there are a few choices like the ability to choose between two showers of fifteen minutes or one bath for half an hour. Most respondents expect that this will increase in the future. However, there are client groups for whom the ideal of more choice and options will not apply, for instance people with autistic disorder in the highest ZZPs. They need a clear structure in their life. Or, part of the clientele of nursing homes has reached a life stage where people have no longer a large demand for luxury lifestyles. The demand for extras or luxury, such as a large apartment, happens before this life stage.

Interestingly enough, individual-trailing 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 a client's demands are not 'reasonable' and when to say 'no' to clients. Under the guise of demand orientation, clients are disciplined to fit their demand with the ZZP they receive.

ZZPs thus act as a countervailing power 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 and calculating behaviour of clients. However if, providers gain more power than the patient, 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 advocates expect that everything will be delivered by the provider. However, that is not always the case. For instance, providers don't have enough personnel to cope with clients who want to walk outside as soon as the weather is fine. There are two options for providers to increase the amount of care: (1) informal care and volunteers or (2) private paid services. We will discuss in this section to what extend providers make use of these two forms of private initiative and how ZZPs are related to these private options.

The increasing role of informal carers and volunteers

At this moment, the provider solves special requests as walking outside with the aid of volunteers. Informal carers and volunteers are very important for improving the well-being and offering special services. The provider has, for instance, several buses which are financed by fund raising and are run by 40 volunteers. These buses bring people to day activities, are used for collective pleasure trips and can be demanded by individual clients (e.g. for visiting family members). In the last case clients have to pay only petrol costs. Another special project is the own boat financed by the Foundation of Friends of the provider and run by pensioned skippers. The provider is very proud on this specially built boat with a lift, which can transport 10 persons with a wheelchair. This creates a lot of well-being, according to one of the respondents. People have only to pay petrol costs. Respondents admit that the role of volunteers and informal carers has become more important:

> I think that it is very important for the client, because volunteers and informal carers can offer something, which we can't manage due to lack of time and finance deficits. A part of the ZZPs is removed in order to get to the core of care. And all extras are hardly possible. Thus it is very important for the client, for clients who have a need for this, since not everyone has a need for this. And, it is also important for us, because if the client is satisfied, it is nice for us too and it works easier and finer if he had a nice day (interview care adviser, organization for elderly care).

The care adviser explains that employees value informal carers highly. Nevertheless, they still hesitate to ask explicitly for more help from informal carers, because most people expect that everything will be done by the institution. The executive of the provider also mentions that professionals find it difficult to transfer the responsibility for the client to somebody else.

> I find that we utilize and apply insufficiently the possibilities of informal care. Especially in the intramural part there is a little bit the attitude of 'this is our patient and we do everything'. There is some change really necessary in my view; that our personnel on the shop floor learns much more to deal with informal care (interview 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 about the separation of care and residential services, could also lead to a re-framing of what 'basic care' is. Some activities will then be reframed from 'care' into 'well-being', which could imply that they are no longer part of the publicly financed health care system.

Hesitant development of private paid extras

Private finance creates another option to offer more than is possible within the budget that is financed by the AWBZ. We researched an organization for elderly care, which had already a few years ago the ambition to develop plus packages. 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 wants to develop products that could make life more pleasant for his organizations' residents:

> If people say, "I'd like to..." then we could say, yes that's possible, but it will mean extra effort for the staff. We can arrange it for you but will cost you a specific amount. If they say "We want our Mum or Dad to have a one-hour walk outdoors every day" then we'd have to say sorry, that's not included in the standard care package, although we can do something about it. We will arrange that for you, but that means we will have to send you a 'plus package' bill. (Executive, interview 2007)

In contrast to the former ambitions of this provider, the supply of plus-packages or commercial activities develops very slowly. According to our respondents, there is still a limited range of products and services, like food and beverage for people, washing cloths, TV at bedside and the rent of a room for birthday parties. Services with out-of-pocket payments are mostly offered for other people and not so much for the own clients. Until now, there is not much demand of clients for more services (interview care adviser).

The offering of paid extras in the publicly funded part of the market is a complicated matter, because clients and their advocates still have the expectation that everything will be delivered by the provider (interview care adviser). That people from the neighbourhood have to pay for services is clear. Organizations who want to introduce plus packages must make the difference clear between what falls under standard care and what is regarded as extra care. If you offer clients the option to buy extra services, then you cannot deliver these extras as part of your regular care. ZZPs can be used to make clear what the limits of publicly funded institutional care are.

However, the Dutch public financed system of long term care does not have a tradition of paying for services, except for income-related contributions for residential care. Clients and employees expect that everything what is needed to improve quality of life should be delivered within the possibilities of the budget of the provider. Caregivers use a broad definition of activities that could be part of 'normal care' depending on the individual situation of the client, such as visiting a supermarket to buy something for the client or doing the clients' account for them. A system of plus-packages requires a clear dichotomy between basic care and other services; however vague demarcations 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 outside part of the basic care or is this the responsibility of the family, volunteers or other private initiatives. The manager cure explains that these kinds of activities also improve the well-being and health of clients – clients, for instance, sleep better if they go outside for some movement.

Employees say they find it difficult being able 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 that employees would find it difficult to start with payments for people who want to walk outside with the aid of professionals two times per week.

> I estimate that employees find this pitiful, because the other has no money and thus doesn't go outside. Anyway, that will also give a change of thought. Employees are inclined to treat everyone at the same level. I think that they find it pitiful and annoying that some do, some don't (interview care adviser, organization for elderly care).

This does not mean that no differences are accepted within the institution. It is already normal that people from outside have to pay for the services. In the same way, if residents call for a taxi, nobody would protest in terms of inequity. Or if family members make a difference, employees will react positively on active family members: 'because that is then a nice daughter or nice son who comes to do that and then it's a habit' (interview care adviser). Problems arise if employees themselves have to make differences in, for instance, opportunities to go outside:

> That feeling is different when one of the employees is paid to come to do that. That is different from someone calling a taxi to go outside. (..) They in principle have no problems with volunteers, however, according to me, if we make the difference through the payment factor ourselves, that will be very difficult for employees. I don't have much problems with that, but for most employees this is really difficult, because they also see that some people remain sitting at the table (interview care adviser, organization for elderly care).

Even though making differences by the provider is very complicated, respondents see some opportunities if the provider can make clear that it is more than basic care. Asking contributions for a concert is more accepted than for assistance to walk outside. The first example can be presented as an activity that is not care, but something where people normally have to pay for. If extra paid services come close to professional care, ethical objections will start to arise. According to respondents, caregivers do not want to make different classes of care. Interestingly, individual-trailing funding could be used to make more clear what is basic care and what people have to pay for.

> I think that if you explain that well, that it is thus something extra on top of the normal package, and those discussions we are in any case to make with the transformation to ZZPs, in the sense of what is your need and what would you like more, and what to do if that goes beyond the package. We have therefore now a good reason to explain this; you can make this visible now with the aid of those ZZPs. Then people themselves have the choice. As you also hear, this is not fair and if someone has no money, how do deal with that? These are the more ethical issues that play a role. Some people say then 'I have a smaller car than my neighbour. Is that then also not fair?' That is a tricky issue, that is still really complicated. (interview care adviser, organization for elderly care)

This implies that before offering extra paid services, the provider needs more insight in business processes. The executive explains that she wants to know first what the provider is supposed to do from the AWBZ, because the provider should not deliver privately financed extra services if this could also be part of basic care. This is a complex matter, since professionals and caregivers are traditionally not very concerned about the role of money and are inclined to do as much as possible for their clients. The new financial system of ZZPs is used for making more transparent what should be part of the publicly financed compartment and hence what could be offered by plus packages.

> Well, that's an enormous turn to make that transparent; what all our people are actually doing. Only if we know that, we can search for what fits into the publicly financed part and

> what would we like to do extra and what we will ask for this. We had to make that turn this year. However the complexity is of such a nature that we have said: lets shift this to 2011. Let us use 2010 to analyse further what we deliver actually, how our care arrangement is organized from the ZZPs and where we have some latitude. (Executive, organization elderly care)

Notwithstanding that the market device of ZZPs is developed for the publicly funded part of long term care, providers use these devices to stimulate or initiate private initiatives.

4.3 Values in this market

4.3.1 Two forms of internal solidarity

Traditionally, providers employed a kind of internal solidarity through financial substitution where departments with an overflow of money compensated departments that had overspent their own budgets. This solidarity was needed since the provider received an average budget for every client. With the introduction of individual-trailing funding internal solidarity isn't abolished; however providers give other interpretations of solidarity.

The provider for people with a mental disability in our research has chosen to maintain this solidarity both at the level of the location as well as the provider. There is room for substitution between locations in specific situations, even though this mechanism is or will be used less frequently than in the past. In our former research, the provider was more concerned that substitution would not be possible anymore in the future. They expected that underspending would no longer be accepted in a system of individual-trailing funding. If the right to care has become defined by patient budgets, any shifting of funds between budgets could increasingly being interpreted as in conflict with the rights of individuals and thus gets 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 that something will be deducted from the care package in order to give to specific groups the care they need. He stated that this is part of their societal responsibility: “We find it so important that you can give extra care when someone needs extra help. (..) You can explain that story.”

This organization tempers the problem of a ‘wrong’ indication by loosening the requirement that the indications of every ZZP group should fit with the budget of the location or by a long, smooth and careful transition to a way of working that is more in accordance with the height of individual-trailing funding. This prevents problems of accessibility or a lowering of the quality of care for some specific groups, like NAH-clients and people with an extreme care need.

Another provider, the Gemiva-SVG Groep, has explicitly chosen for only solidarity at the level of the location. The organization realizes that the new financing system of ZZPs implicate that some locations will receive more money, whereas others have to sacrifice some of their budget.

> If it might turn out that a location needs to tighten their belt, then it could not be explained why we should not cooperate with that, for the government finds that these clients have to make do with less care than what they receive till now. If this results in a deficit of care for the client, we have to check if we, together with the client, can get a higher indication. But if that is not possible, then is democratically decided – with the approval of the parliament – that we have to allocate the scarce AWBZ money this way and no other. The opposite is of course true too. If clients have a right to more and more intensive care in a location and there also arises budget for this, we will and should deliver that too! (De Gemiva-SVG Groep, News letter October 2008)

In this example, solidarity is partly placed outside the organization: the degree of solidarity is the responsibility of society or its representatives, that is: parliament. In that sense, individual-trailing 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, if people with this indication (ZZP) go to the provider, the care package is transformed partly from ‘need’ into ‘economic demand’. This happens not so much at the individual level, but at the collective level of the location. Within the collectivity of the location, equity of ‘demand’ will then become an important consideration, besides equity 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 serious, shuffling budgets between locations is considered inappropriate. As we already showed, this idea is not completely 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. Within 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 expects that in the future supply would be fitted more closely to the indication. This already happens in a moderate, indirect way, because people with the same care packages are more clustered together in one group and these care packages become more relevant for the supply of care.

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

4.3.3 Collaboration of market mechanisms and new initiatives of civil society

Interestingly, the tendency of more market mechanisms seems to go hand in hand with the stimulation of new initiatives from civil society or the social network. Care packages could also be used to make clearer what is part of institutional care and what should be done by the family or volunteers. The care giver can now 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 better show that the staff could not do everything that is needed for the welfare of the client. ZZPs can be used as a kind of expectation management, which could trigger family members to become more active. In the last decade, providers have developed a more active volunteer policy.[vi]

Moreover, some respondents acknowledge that an active pool of volunteers could be a positive message in the marketing strategy of the provider. Next to 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 competition element:

> In the past, we didn’t do that, because we didn’t have the new boat for that long. We had an old boat and we had those buses for years too. However, you didn’t make known that, you just did that. People talked about that and people in the region did really know that, but you didn’t present such an image. Nowadays, we are doing that more. Also, in all our public relations (interview executive, organization for elderly care).

In the same way, selling services (meals, drinks, leisure activities) to people in the neighborhood is increasingly becoming part of a marketing strategy to attract potential clients. Respondents say that locations did not open up their doors in order to generate huge direct revenues (sales). This was done for the ideological reason to bring in society within the institution: “we are more than a building in the neighborhood”. Nevertheless, there are indirect effects in terms of the market, because it is a good marketing strategy.

Both trends of an increasing role of the market and civil society fit with a more moderate role of government, which allows more space for private elements. We have to acknowledge that the stimulation of civil society is not only the consequence of the retreat of the state, which dumps some problems over the fence. The positive effects are also caused by the introduction of 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, fixed or static. Rather, these domains are emergent and co-construct each other. Our approach of studying the process of the composition of market practices and public values, not explaining positive effects as ‘natural’ effects of well-functioning markets and problems as ‘market failures’, has allowed us to analyze the *work* that is needed by many actors to produce such effects. It also opens up the study of “markets as political issues” (Barry and Slater 2002, pg. 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 such pre-defined values, the composition of market practices is an empirical domain that is directly relevant for the state. Government agents will want to understand how this shaping takes place, with what consequences and alternative possibilities to try to remedy undesired shapings.

In our analysis, the market practices for hospital care and long term care shape specific public values through the development of the market devices of DBCs and ZZPs. In both cases the aim seems to be to increase choice for either an individual client (ZZPs) or for both clients and insurance companies (DBCs) that then should result in an incentive for quality improvement and diversification of hospitals or institutions for care for the disabled. Ironically, our case studies show that rather than facilitating diversification, they both may produce the opposite result of organizational isomorphism (Powell and DiMaggio 1991). Also, they may lead to a specific operationalization of the public value of quality that is shaped in terms of the financial instrument. In the hospital market quality that was hardly on the agenda in discussions among hospital representatives and insurance companies, this public value has now become an issue of considerable focus during their negotiations. However, what quality *is*, has shifted substantially through the market arrangements in which actors privilege price-mechanisms and assume those to be easily quantifiable proxies for other public values. At present, quality easily comes to be defined in terms of cost-savings, which has lead to substantial gains in the affordability of care and reduction of length of stay in most hospitals, which, given that each unnecessary day in a hospital is both a societal cost and a risk for patients, is a substantial improvement. Yet, this specific definition of quality sits uncomfortably with notions of quality that do *not* involve cost-savings. In our cases, these 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 shows 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 rather dominantly shape what *counts* – in that very literal, calculative sense – as quality. Information may be available but still not be consequential if finance 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 defining in times of fixed budgets that tended to be consumed towards the end of the year and 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 of quality being defined by financial aspects.

The point we want to make therefore is not that with these new market devices, price or money has become an issue. 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 were supposed to ensure. We therefore consider this a fact of life. But if this is the case, this crucially points to the importance of the composition rather than implementation of public values through markets or other policy arrangements. The composition of markets for public values can neither 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 quite positively shaped the relation between public values like affordability, quality and access. Long waiting lists that were so common under the budget-driven system have virtually vanished and 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 importance of the composition rather than the implementation of healthcare markets.

Based on this approach, one of the findings that we encountered in our research is that in practice market devices at times also seem to *undo* the very aspects that they were supposed to *strengthen* according to the policy aims. Where market devices have often been studied as shaping the setting in line with the assumptions under which they were expected to operate according to policy aims – generally captured under the heading of market mechanisms being ‘performative’ (MacKenzie 2004; MacKenzie, Muniesa, and Siu 2007) – 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 ‘counterperformative’ (MacKenzie 2007). In the case of DBCs one of the policy aims of the market was that it would lead to diversity through the specialization of hospitals that would aim at outperforming their competitors. Ironically, the practice of keeping in feeders and getting rid of bleeders, in combination with the definition of quality as cost-saving and national semi-standards of the DBC purchasing guide make hospitals more similar rather than more diverse. This shows that the current isomorphism is not merely institutional or a failure of the market as intended by policy-makers, but is actually 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 that were supposed to lead to increased choice for disabled clients, resulted in practice to a 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 advantageous in terms of cost assessments, as this centralizes more qualified and expensive personnel. However, the policy aim that client choice would be the driver for competition and quality is less likely to materialize if clients have fewer institutions to choose from. Even if these reduced 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, one of the core aspects of quality that disabled clients have persistently shown to be crucial to them, being the geographical proximity to their dear ones, has been reduced. A definition of quality that excludes distance at the benefit of costs may be a convenient outcome on the level of affordability of care, but is at present a somewhat unintended outcome of the instrument of the ZZP that may require further scrutiny and a more explicit policy decision on whether this is the kind of trade-off that is to 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 provide clients greater choice and control over their support arrangements, however these budgets could also be used by providers to say “No” to the demanding client; it becomes a mechanism of managing demand. Care is being 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 the role is for the state in the composition of public values and healthcare markets. Realizing that public values are shaped in practices should, according to us, not lead to the re-politicization of such policy domains. Direct involvement by politicians in the shaping of healthcare markets tends to lead to the problems associated with incident-politics and calls for democratization through participatory instruments are practically cumbersome and theoretically problematic (Berg 1998). Also, they presume that ultimately, the composition of markets that are to ensure public values can be completely regulated and controlled, which empirically 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 policy *consequences* can never be fully captured through a logic of implementation. For this the process is too unpredictable and the consequences too unforeseen. Such unpredictability and dynamics is better captured in an experimental role of the state. A state would thereby not see market devices as an operationalization of policy aims, but would 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 the experiment and the experimental set-up, but the consequences will need a kind of ‘formative evaluation’ (Øvretveit 1998), in which the production of evaluation results is not postponed till the end of an experiment, but is fed back into the experiment in terms of adjustments of the experimental setting and the devices that are being deployed.

If we were to re-conceptualize the Dutch policy initiatives of making markets for public values as a real-time experiment, this would perhaps turn the present study into a part of the formative evaluation and would 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 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 point to the limitations of price-based market devices: they are calculatively convenient but at times counter-productive 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 in which affordability is ensured in different ways, while 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, while the composition of the market and its competition could focus on other public values like quality and maintaining accessibility. The experiment of developing markets for this care sector would hereby be allowed to move away from extending the B-segment and would provide an interesting new natural experiment of constructing a market in which other public values are put more centre stage. Of course there are substantial basic requirements for this experiment to stand any chance. DBCs would have to be set at a high enough level to cover minimal costs and of course 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, this would in principle not be a harder task for government than it is for insurance companies, though it would of course require a more dynamic maintenance of A-segment DBCs then presently found. This new twist to the experiment of 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. 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 this would in principle not be more complicated than for B-segment DBCs. Also, collective negotiations between insurers would be problematic and would probably need to be prohibited, just as it is 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 in such a way 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 crucial role in steering patient streams, GPs have largely been overlooked by all players in the construction of a market for hospital care. We propose that this is largely due to the fact that they are part of a separate financing structure, which makes them invisible when privileging financial instruments in the construction of markets for policy domains such 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 like the GP can also be included in the long term care market such as MEE, 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 the user of care than financial devices like individual-trailing budgets.

Such suggestions about the shaping of markets for public values are not to be taken as design suggestions that aim to 'fix' markets for public values. They rather point to tentative ways of exploring experimental ground 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 produce substantial limitations to the experiment. Moving the quantification of public values away from this close-to-perfect financial measuring device will require developing many different and not always equally neat 'valuemeters' that would "make visible and readable the value judgments" (Latour and Lépinay 2009, p. 16) actors make. Such valuemeters may prove to be crucial cognitive equipment of the thinking state (Latour 2007) and for the shift to an experimental state that is actively involved in the composition of public values.

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Notes:

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[i] Such as in 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 proof for such claims tends to be anecdotal.

[ii] The new financial regime has serious consequences for one of our case studies, the organization for people with mental disability. In contrast to many providers, the total budget has decreased for this provider. Besides that the new method was a correction for a regional difference in finance, the lower budget was also the consequence of some specific characteristics in the supply of the provider, such as relatively much low scale locations and the target group non-congenital brain injury (we will discuss these problems later).

[iii] A location manager said that she is alerter if all potential benefits are secured. A PB client appeared to pay only for short-stay accommodation and not for showering assistance, after which the tariff is adjusted.

[iv] We have to acknowledge that in the past clients were also moved for ideological reasons (participation in society) by providers.

[v] The provider has raised this matter at the VGN, the national association of organizations for disabled people.

[vi] However for some groups, it is difficult to attract volunteers.

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