Valuation in Welfare Markets

The Rule Books, Whiteboards and Swivel Chairs of Care Choice Reform

Linus Johansson Krafve



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Norrköping, April 2015 Linus Johansson Krafve

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Chapter 1

Introduction: Contestations of Value in Welfare Markets

Mr Gustav B, let's call him that, passed away in the spring of 2008. The diagnosis was cancer. But it was not the tumour that took his life. It was something completely different [...] Mr B died in the virtual reality, where the health care service plays Sudoku. Or maybe Monopoly. (Zaremba, 2013)

There is something deeply disturbing about the claim that games with numbers and money decide the outcome of people's lives. In the spring of 2013, Dagens Nyheter (DN) published a series of articles about Swedish health care, portraying horrific stories about unworthy treatment of patients, medical staff being involved in dubious activities and fraud, and public funds being wasted. The message was that money in general, and economic governance techniques in particular, have corrupted the way health care is performed, how it is valued, and how it plays its role in the Swedish welfare state. It told about an economic vulgarization, where health care is being trapped in the grips of a governance machine that only understands economic valuation, that is, price, while it is blind to other forms of worth.

Meanwhile, at the county council HQ, public officials work intensively to get the last paragraphs of the so-called rule book in place. The rule book codifies the criteria for running a care centre in the county. As primary care is organized to be a 'competitively neutral' care choice system, or a voucher market (cf. Le Grand, 2007), the rule book must be formulated so that all providers that fulfil the criteria are eligible to open and run a care centre. The rules must be the same for all care centres, regardless of who owns and runs them. The rule book is revised each year so as to capture changing conditions. These could be, for example, new initiatives from politicians, new discoveries in medical treatments, changing practices of audit of medical quality, adjustments to grants from national government, or alterations in the reimbursement system. It entails intense work engaging a wide variety of professionals, bringing together highly diverse – occasionally very challenged – issues of worth.

The work to design the rule book resonates with the ambition to implement a welfare market. All the while, even though it is supposed to be some sort of primary care market, there are legitimate expectations on the makers of the rule book to pursue, protect, and promote highly different values, apart from economic ones. And given that there are many diverging yet legitimate expectations on primary care, it is interesting to look into what values are taken into account in such governance practice. It opens up a space for inquiry and new questions: How are economic and public values handled with different governance techniques? How do value-related conflicts appear in governance practice? Could governance techniques be designed differently so as to allow values to meet in new ways?

There are huge gains in studying values as an integral part of the practical considerations of governance practice, for example in how to model the rule book. In writing the rule book, officials are up to the eyes in how to formulate rules for providers' behaviour, so as to lay down very

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¹ I acknowledge that the claim that there is something like a 'primary care market' will probably not pass unchallenged. In any case, rather than paying great interest to whether it is a market or not, the thesis takes interest in the processes whereby primary care undergoes a process of 'marketization'. To gerundive 'market' into 'marketization' implies a process where something is displaced to a setting where it has not usually been considered as belonging, rather than assigning essence to what a market is or should be. Marketization implies an incremental development in which market-like aspects are introduced to, in this case, the primary care sector.

specifically what counts as proper conduct in primary care. This means that they explicitly handle the values of the welfare society. They handle issues such as staffing and opening hours, how to condition reimbursement for different patients, and how to make ends meet from the allotted budgetary requirements. In such practices, values are not abstract entities, but come very solidly to the fore.

This detailed focus furthermore resonates sensibly with a fundamental question for a welfare society: What values to promote, and how? The question contains the idea that there are values 'in' health care as well as values 'of' health care. By values 'in' I refer to the statement that health care encompasses diverse values in a very composite way. Such ideas stress that health care is thoroughly saturated with a diversity of important values, be they improved health, medical quality, cost containment, patient empowerment, and more. As all of these are considered to be more or less legitimate values, the expectations on health care are multifaceted and complex. By values 'of' I refer to ideas of how health care is perceived to be valuable. It could be said to be valuable because it is says something about how people are willing to look after each other. It could also be valuable because of its key role at the heart of the welfare state.

More fundamentally, I take the question 'What values to promote, and how?' to rest on the premise that there are alternative routes for health care governance. The choices of how to organize the handling of values at the HQ have a profound effect on the prospect for values to be realized in healthcare practice. Therefore, I use the making of the care choice system in a Swedish county council to illustrate how the making of a care choice system entails the handling of tensions between contending principles of evaluation. It is a site where there are a variety of legitimate expectations on relations, actions, and proper behaviour. It could be viewed as a site where a diversity of accounts of worth (Boltanski & Thévenot, 2006; Stark, 2009) is advanced as proper and just.

The case of care choice reform is furthermore illustrative of how the contemporary Swedish welfare state is undergoing profound changes, and demonstrates the critical dimensions of this development in terms of worth. Values are highly visible entities in such reform, even in the

government bill that enforced the introduction of care choice in primary care:²

All citizens should feel confident that health care is readily available when they need it. Security, availability, and a holistic approach to patients' needs should be prioritized in all care, and should be based on the individual's right to the highest attainable standard of health.

To ensure that patients are capable of free and individual choice in health care, it is essential that health care is characterized by openness and diversity in content, form, and provider. A plurality of health care providers in publicly funded health care can stimulate the development of innovative and cost effective solutions and contribute to improved availability. Through 'the-reimbursement-follows-the-patient' principle, freedom of choice will encourage quality development, as large groups of patients will seek out the caregiver with the best quality. Consequently, competition is created that spurs health care actors to improve quality and availability. (Prop 2008/09:74, p. 23, my translation)³

The reform text aligns values of free choice, individual rights, and competition, and assumes that they will promote such values as openness, diversity, quality development, and availability. It hence creates couplings between values usually associated as 'market values' on one hand, with values usually seen as 'public values' on the other. The different values brought forth by the bill are seemingly comfortable together. This represents a very particular topography of values, advanced by so-called quasi-market theory, which has been very influential for the welfare reform of several western liberal democracies (Le Grand, 2007; Le Grand & Bartlett, 1993).

I term such a market situation a 'concerned market', where 'the economic and the social writ large are intricately entwined' (Geiger et al., 2014, p. 2).⁴ A care choice system furthermore challenges prevailing ideas

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² The legislation forced county councils to introduce care choice in primary care by 2010. By then, some county councils had already put into effect care choice reforms. The difference with the legislation was that care choice became mandatory for all county councils.

³ The key data and some of the literature are in Swedish. I have made all translations from Swedish to English.

⁴ Importantly, a market becomes 'concerned' because there are challenges to the prevailing ordering principles, agency configurations, and principles of justice: 'Concerned markets are thus no longer bound by the particular order of worth associated with markets, in which competition occupies the central role for resolving

about what are public and market aspects of the welfare state. In the precise modelling of the care choice system, county councils must reach local settlements, in which contending orders of worth are handled practically, for example as writings in a rule book. The regulatory practices involved in putting a care choice system in place brings a particular formatting for how values – be they free choice and competition, or openness and quality – are made to matter in a welfare society. It is hence an indicative example of a political and moral ordering of welfare reform, in which the central concern is to engage in the common 'goods' of the welfare state (Thévenot, 2002).

The making of a care choice system as study site

The efforts of county councils to put their care choice systems in place activate interesting questions about market and public values, and represent a particularly interesting window through which to study in detail how moral and political ordering takes place at the level of health care governance. First, this section briefly outlines some of the characteristics of this site. Second, it provides a glimpse of the stakes at play in order to illustrate the manner by which values are practical matters for governance.

The care choice reform as a process of primary care marketization

According to the Swedish constitutional model, county councils play a key role in the welfare state, as they are obliged to finance and supply health care. The Health Care Act (SFS 1982: 763) codifies the basic rules for all health care in Sweden. It sets the overarching goals for Swedish health care and establishes requirements on all health care, stating the aim of 'good health and care on equal terms for the entire population', and that those

conflicts. Instead, multiple methods of reaching agreement or encompassing disagreement come into play, such as scientific inquiry, political negotiations, legal proceedings, or civic ideas. Rather than the orderly exchange of well-defined products and services within an established infrastructure, these multiple arrangements result in struggles where actors tap into different principles of justice or explanations of what is good (Geiger et al., 2014, p. 6).

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'who are most in need of care shall be given priority to care'. The Health Care Act thus enacts a modicum of governance in which county councils must take great responsibility for realizing the universal welfare state.

Market reforms are however not new to Swedish county councils. One of the most prevalent marketization techniques has been Swedish public procurement legislation, LOU (*lagen om offentlig upphandling*) building on the so-called 'purchaser–provider split' (Siverbo, 2004). The purchaser–provider split imitates an idealized image of the procurement procedure in business. It calls for clear-cut roles and contractual management, in which the purchaser concentrates on specifying requirements, and the providers sell the service demanded. The aim is to increase competition between providers *for* the market (or competition between providers at the level of tendering). It means that suppliers, that is, public as well as private contractors, offer to perform a service for the procuring public organization, and the public organization chooses one among those candidates.

LOU could be used for many types of procurement. But what is interesting here is procurement of welfare services to be provided directly to citizens. For example, during the last decades, it has become increasingly common with public procurement of care centres. However, since 2010 the Swedish Government has taken one step further and decided that all county councils must organize their primary health care as a 'care choice system'. The ambition with a care choice system is that free choice of primary care provider will create 'competition that spurs the actors in health care to improve quality and availability' (Prop 2008/09:74, p. 23). The values of free choice, competition, quality, and availability are thus put centre stage as central values for care choice reform.

According to the government bill, the background to the care choice system reform is that the Swedish Government was not satisfied with the extent to which welfare recipients' choice at the market (competition between providers at the level of citizens) has spurred competition in welfare. Care choice brings a new relationship between the chooser (the citizen), the provider (public and private contractors), and the payer (the county council). County councils no longer make the choice of which provider the citizen will use, but are responsible for making sure that citizens could choose any among all providers living up to the standard.

The county council pays for the service, but the choice of which care provider to actually use is up to patients.⁵

Choice reform *per se* is not entirely new to the Swedish welfare state, but has been around since the 1990s in a few other welfare sectors, for example regarding choice of schools. The difference now is that generic legislation has been put down, LOV, (*lagen om valfrihetssystem*) meaning that local governments are invited to draw on the legislation in implementing choice reforms in several different welfare sectors. The new legislation presupposes other conditions than the traditional procurement legislation; this is where the idea of a voucher-based choice system as known from quasi-market theory comes in handy.

In the new legislation, all tenderers that fulfil the contract specifications are eligible to set up their service to compete for and attract welfare recipients on equal footing with all other providers. All providers are thus under the same agreement and must adhere to the same contract; that is, if a contractor lives up to the requirements of the invitation specification it has the right to a contract with the authority. The authority has the responsibility to provide information on the choice between contractors to its clients. This is to ensure that measures are taken to make sure that clients are able to exercise choice; after all, it is the choice of individuals that establishes the function and goals of the system, by choosing the 'best' contractors. If no choice is made, a non-choice alternative is supplied to the client according to pre-set principles, which nevertheless must adhere to the same quality standards.

The care choice system in primary care is to be achieved according to the proposed legislation on care choice, that is, LOV. When the legislation on care choice (Regeringskansliet, 2008d) was put into effect, there were however some important differences between the care choice system in primary care and LOV legislation; foremost was that the care choice system in primary care is to be mandatory for all county councils. The overall argumentation nevertheless largely remains the same; the competitive

⁵ There is thus a distinction between procurement and care choice reform when it comes to the meaning of 'free choice' and 'competition'. Procurement (I call it competition *for* the market) rests on one contract per care provider, which the county council elects; care choice (I call it competition *at* the market) builds on having one contract for all care providers and the patients choosing their own provider.

principle rests on competition taking place at citizen level. The system is to be designed so that the choices of patients are guiding the functioning of the system. It is postulated that there is a need for carefully prepared invitations to tender and contracts. All contractors must be reimbursed according to the same scheme.⁶

For a county council, this means that purchaser officials have to work out procedures and tools to define very specifically the primary care 'good' that is to be provided. To arrange the contracts, there is thus a need for county councils to mobilize a strong and active purchaser function. This is noteworthy, as the need for a fundamental division between purchasers and providers has provoked extensive interest from scholarly work in relation to previous market reform in Sweden (see for example Berlin, 2006; Forsell & Kostrzewa, 2009; Forssell & Norén, 2004, 2006; Kastberg & Siverbo, 2008; Norén, 2003; Siverbo, 2004; Sundin, 2006) and elsewhere, for example in GB (see Flynn & Williams, 1997; Robinson & Le Grand, 1995; Walsh, 1995). These studies indicate that in practice, there are many difficulties associated with living up to the purchaser ideal. For example, it has been shown that purchasers act as 'buffer zones' between policymakers and line organizations, where they are struggling to find a good mix between trust and control. This puts them in a central position in market reform (Berlin, 2006).

Research has thus treated purchaser practices as a vital bifurcation point for welfare market reform. It has furthermore showed that the practice of designing vouchers is full of challenges. Therefore, regulation of quasi-markets in welfare tends to be very unstable over time (Forssell & Norén, 2006; Kastberg, 2005; Norén, 2001, 2003). Besides, some of the challenges of traditional procurement are equally present in the making of voucher markets, such as difficulties in defining what counts as 'quality'

⁶ 'Free choice' is part of a larger welfare reform agenda. Apart from legislation on care choice in primary care, legislation on choice in municipal welfare has also been put into effect. The white paper and government bill behind this reform (Regeringskansliet, 2008a, 2008c) states that there should be an 'easier' alternative to public procurement in competition for welfare service; 'easier' meaning that there should be legislation for municipalities to rely on in choice reform. There is an outspoken ambition that users of welfare services are to be 'empowered' and gain a 'stronger position' vis-à-vis the authorities. The invitation specification must be 'clearly formulated' and designed to fit the aim and purpose of the procured service. The idea is that competition is to take place with regard to 'quality' and pre-set standards in the contract, and not on price.

(Norén, 2000) and what is the actual 'need' to be satisfied by procurement (Blomgren & Sahlin-Andersson, 2003; Fernler, 2004). Research also suggests that conflicts and discrepancy in political wills contribute to the instability of market regulation (Forssell & Norén, 2006; Kastberg, 2005; Kastberg & Siverbo, 2008; Needham, 2009; Norén, 2003). Kastberg (2008) sums up these research findings quite well when he states that the effect of these challenges is that purchasers are not broadminded enough to avoid 'blind spots' in their efforts to construct quasi-markets.

Taking an interest in how purchasers are struggling with a key challenge

There are ranges of difficulties associated with designing welfare markets in practice. As we just saw, the literature has identified 'blind spots' and contending notions of 'quality' and 'need' as prevalent challenges. Even the Swedish National Audit Office (Riksrevisionen, 2014) has expressed serious concerns over such challenges in care choice reform. The concern could be condensed into a particular challenge for primary care governance: to decide *who* gets *what* from *whom*. I take this particular challenge to be interesting in terms of how a variety of values have to be handled in the practice of welfare reform. The handling of such challenges could teach us about the ways in which the specific ordering of welfare state governance plays out in the face of contending criteria of evaluation.

The report from the Swedish National Audit Office highlights some of the central dimensions of the challenge. First, regarding the *who*, that is, the receiving end of welfare:

Customer demand means that the supply of primary care is guided to the solutions that most customers demand. When demand for care has been decisive, relatively healthy individuals from advantaged social groups have increased their share of healthcare consumption. The ethical principles should govern the provisions of primary care for those patients with the greatest suffering and needs. Such prioritization requires an actor with the mandate and ability to determine whose suffering and needs is to be addressed, i.e. the opposite of customer demand deciding the consumption of primary care (Riksrevisionen, 2014, p. 104).

Should health care be provided according to patient need or through patients' free choice? The legislation, suggests the report, is ambivalent; the preamble of the Health Care Act forces provision according to need, while in the LOV each patient has a unanimous right to choose a care centre. The right to choose is pivotal to the functioning of the care choice system and the intention to empower patients' 'free and individual choice'. The report concludes that there is a risk that care becomes 'demand-driven' rather than 'needs-driven'. They refer to the risk that more care is made available for patient groups perceived to be more profitable for care centres, and that more care is given to 'stronger' patients' groups that are able to formulate a more articulate demand of care. A significant cause of this problem, they conclude, is a perceived conflict between contending principles of prioritizing in primary care between 'need' and 'free choice' of patients.

Second, regarding the *what*, the report states about the actual 'service' to be performed:

The government's ambition for care choice reform was to create greater diversity. The design, with identical assignments for all healthcare providers, has however spurred uniformity within each county. In this way the care choice reform has come to counteract increased diversity [...] For the care choice system to function as a market and stimulate quality and diversity, patients must actively choose their provider. If few choices are made, and if few changes occur, no competition is created and the opportunity for new care providers to enter the market is hampered. (Riksrevisionen, 2014, pp. 106–107).

Should there be standardization of treatments, or should there be diversity? The contracts in a care choice system must look the same for all care providers. Besides, from a medical point of view, it is often emphasized that treatments should be standardized and 'evidence-based.' However, from a competitive point of view, there must be some difference between the services offered by care centres; otherwise, the function of free choice is only a chimera. Besides, what are the prospects for 'diversity in content, form and provider,' which is one of the intentions of care choice reform, when there is too much isomorphism?

Third, regarding the *whom*, the report states about the 'production' and 'control' of welfare service:

The county councils should design reimbursement systems that control the behaviours of care providers. Imposed requirements and conditions must be possible to control and monitor. It is difficult to operationalize requirements on medical quality. Control systems are therefore often constructed so that they control the behaviour of care centres against indicators that are relatively easy to measure, not the medical quality. [...] When anomalies are detected in the

reimbursement system, county councils make corrections that often lead to new detailed requirements. The price mechanisms also increase the risk that the care given and recorded is manipulated in order to increase reimbursement. As such practices are detected, county councils often try to introduce more control and corrective measures to rectify the behaviour. The more detailed requirements for care providers, the easier it becomes to manipulate reimbursement; and the more complex the system is, the more time is required for reporting. This results in increased administration for healthcare professionals at the expense of time with patients. (Riksrevisionen, 2014, pp. 107–108)

How should prioritization in the reimbursement system be made; via firm budget planning or via incentives to care providers? The purchasers have in their hands different measures – financial and other – for prioritizing care. On one hand, county councils collect their own taxes and regulate patient fees. There is only a certain amount of resources available for primary care, and as competition on price is not allowed, the regulating authority has much responsibility for budgeting the entire care choice system. On the other hand, county councils have no right to refuse care centres entry to the primary care market when they live up to the contract requirements. The number, location, and profile of care centres rely on them being competitors. There is an interest on behalf of care providers in being sharper and performing better than the competitors, and the purchasers are expecting them to do so. How are responsibilities for administration and efficient use of resources distributed in such a system? Or how are routines organized for preventing free riding?

Aim, research questions, and study design

The aim of the thesis is to contribute conceptually to the understanding of how market-making activities in the welfare state bureaucracy handle the values at play in welfare reform. The research questions are:

- 1. What are the important concerns in the making of the care choice system?
- 2. How are purchasers handling such concerns?
- 3. What can these findings contribute to the development of a conceptual understanding of how conflicting values are handled in welfare reform?

Theoretically, the thesis builds on a 'flank' approach to values in welfare reform. The flank approach claims that values are most productively studied in their practical manifestations rather than as universal and stable (Muniesa, 2012). The research task is hence to deflate the core values in and around care choice reform by treating them as practical accomplishments. It takes seriously that values are grappled with in concrete situations and uses the making of a care choice system at a county council HQ as a vantage point to zoom in on valuation in welfare markets. It studies how values are enacted governance in practice, rather than assuming that they are determined beforehand in policy.

The strategy is to study how articulations of value are made, and how techniques and devices are involved in performing the care choice system so as to determine the worth of the primary care 'good.' The strategy rests on a strand of theories that takes interest in practices whereby values are enacted, and not given (Helgesson & Muniesa, 2013; Kjellberg et al., 2013; Muniesa, 2012). By enactment I refer to the concrete activities that performs values, and which make them appear as states of the world. Enactment of value denotes the activities that are ongoing, contingent and socio-material, that is, about *valuation*. Valuation is here understood as the practices – involving the metrics, rules, and other practical measures – that enact particular values or versions of value (cf. Helgesson & Muniesa, 2013). From processes of valuation, values arise (Dewey, 1939).

The making of the care choice system is thus approached as a 'valuation practice', that is, a process that renders particular versions of value visible. Articulations of value are always practical, while seemingly 'neutral' rules and measures in the making of the care choice system are also value-laden in different ways. This practice orientation raises values and valuation as empirical objects of study, and sees that values are not entities for abstract conceptual space; they are just as much up for grabs in the typical course of market reform. The act of writing a rule book, for example, provides the empirical details from which to deconstruct the values at play in marketization reform.

To appreciate values in practice means to abandon analytical discrimination between values that are, for example, articulated discursively (Roscoe, 2013); configured through market devices (Muniesa et al., 2007); or performed materially as 'valuemeters' (Zuiderent-Jerak et al., 2015).

What these forms of invoked values are, and how they are interconnected, is precisely what is up for grabs in the analysis. It is a highly empirical domain. Following Dewey's plea for pragmatism, this thesis is cautious not to get stuck in approaching value only as a stable signifier, either as a noun or a verb, either abstract or concrete, but both. What rather makes values interesting is the way their different manifestations are connected in the practice of determining the worth of the primary care market good.

The case study foremost rests on observational data from 'shadowing' (Czarniawska, 2007) the makers of the rule book at the county council HQ. This tactic allows seeing how the worth of the primary care market good is negotiated via devices and in other practical situations. This I refer to as 'methodological situationalism' (Stark, 2009) as advanced by pragmatism, in that I target perplexing, highly practical situations in which actors grapple with problems of worth. This strategy devises something that could be labelled a 'valuography' (see Figure 1.1) (Dussauge et al., 2015); that is, an empirical investigation of a practice where values are concrete matters.

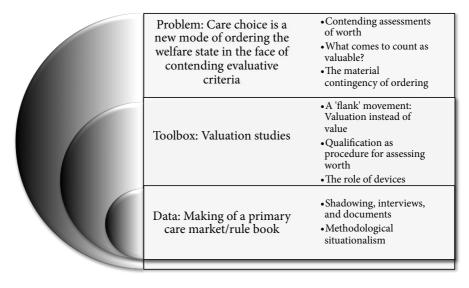


Figure 1.1: Valuography diagram.

Contribution

What will come out of an investigation of how situations are formatted so as to decide what is the worth of the primary care good in the making of the care choice system? The effect of the analytical approach is that market reform and involved values do not appear as clear or fixed, but are instead emergent in unforeseen ways through ongoing valuation practices. With the help of the pragmatic valuation practice orientation, the thesis has the potential to interrogate taken-for-granted assumptions of what markets can and cannot do, what values they will promote, and what values they will suppress (cf. Kjellberg & Helgesson, 2010; Zuiderent-Jerak et al., 2015). It takes a serious interest in questions such as: What values are promoted in the practice of getting the care choice reform in place with the help of a rule book? How is it achieved?

Could this interest recast more profound opinions on values in welfare reform, by stressing the contingency and situated foundation in the making of a care choice system? The thesis attempts to find a way forward, one which not only pays great interest to the details of market regulatory practice, but also has the potential to recast ideas and beliefs related to market reforms in general. It interrogates the grandiose concept of 'market reform' – and the forces, ideals, and effects associated with it – by treating it as an ongoing experimental practice. This could afford to contribute with both theoretical and political implications.

Theoretical implications

The valuation practice approach breaks down the idea of value as an inherent principle, and transforms it into a question of valuation as an activity. Consequently, this thesis starts with the assumption that there are gains in not becoming analytically stuck in evaluating and comparing the outcome of the care choice system under study to idealized textbook versions of how healthcare markets are supposed to work. Much more insight is potentially to be gained by moving beyond the pros and cons of markets only as theoretical constructs, and what they can and cannot do in conceptual terms. It could move beyond binary discussion of markets, in which proponents of marketization that favour market before rigid regulation are on one side, and on the other side are the sceptics that point

to the risks of marketization for other public values such as equity and justice. The binary divide is a vital component of democratic politics. But it is not a very fruitful premise for research looking into the precise workings and peculiarities of the healthcare markets of the real world.

The pragmatic outlook provides for collecting data of how values are conditioned by valuation practices at the county council HQ. This cannot be known beforehand, further stressing the importance of detailed empirical work. At the same time, the study takes an interest in how actors invoke worth by recourse to expressions of values from political philosophy (Boltanski & Thévenot, 2006), which is not given beforehand either. Yet the analysis proposes that the marketization process should not be overburdened with orders of worth as formulated as ideal types. Could the pragmatic interpretation of the way contestations of worth play out in practical situations lead to new insights about the relation between material and discursive expressions of justification? How do such insights feed back to our understanding of values in contested reform practices and contested markets?

The study uses the details of market reform to challenge some of the central assumptions in social science, as well as core ideas about what market and non-market values do in the welfare state. In this way, the approach deviates from a common-sense understanding of values, in which values are usually considered to exist prior to social action, or that action is said to be derived from values. This approach furthermore shakes the foundation of social science that treats values as exogenous to practice. Quite the contrary – the case study illustrates that values could productively be studied as enacted by practical actions. And when values are invoked in practice, values become what values are, precisely in the moment of interaction. This may *appear* as situations in which people follow values, which gives rise to disengaged summary reports of situations as driven by values. The thesis will search beneath the surface of precisely such takenfor-granted propositions.

Political implications

The Swedish welfare state is often described as a long-standing ideological project resting on social democratic values (Esping-Andersen, 1990), that is now subject to pressure from 'market forces'. This thesis proposes another

view: that it is a highly practical accomplishment amid contending principles of evaluation in political and moral modes of ordering (Thévenot, 2002). As the development of the welfare state is full of contestations of value, what if we started to accept, appreciate, and handle the indeterminate nature of values in welfare reform much more actively in empirical work?

The premise of the study challenges the ideology–practice and policy–implementation decoupling assumed in policymaking and social science. And it challenges the idea of the implementation of values in welfare reform, what welfare markets are, and what they can and cannot do. Instead of assuming that a care choice system in the form of a 'primary care market' in and of itself limits the scope for values to play out – for example in statements about health care being inevitably caught in the grips of economic valuation – the thesis is devoted to studying the conditions whereby the limits of the marketization effort are themselves subject to negotiation. Instead of closing debates between market and non-markets beforehand, the thesis opens up a space for action and understanding of pressing matters for welfare reform: What routes of action are possible in the governance practice of the welfare state? What affects the potential of devices in (dis)articulation of values in welfare markets (cf. Zuiderent-Jerak et al., 2015)?

The case study could provide detailed insight into how this is handled in a particular place in time, from which we could theorize and draw conclusions. Therefore, the thesis is written in the spirit of improvement, in that it proposes different questions to be asked, and different solutions to be sought. Strangely, the actual work done to regulate markets is often overlooked, and judgment in policy, media, and academia is soon cast on whether 'normal' effects followed or whether there was 'market failure' of a market reform. This thesis works with a more symmetrical interest in that it does not privilege market success over failure, and allows for taking into account both intended and unintended consequences of the market reform (cf. Zuiderent-Jerak et al., 2015). It is cautious not to project what either failed or successful market practice entails beforehand. Rather, projections

and judgment on the success of the reform make up interesting empirical data that is analysed within the ambit of the thesis.⁷

It is still an open question as to what this approach to the case study affords in terms of action and intervention in welfare markets, which makes it an exiting and indeterminate endeavour in political terms. A vital question is therefore how the study could be used to develop concepts that put handles on the practical problems of welfare markets. The study does, nonetheless, also pertain to the importance of being critical towards market reform; not by debunking, but by asking different questions and searching for alternative answers. I could state with sincerity that the pragmatic stance is for me not a political theory, but rather an epistemic strategy that helps to achieve new knowledge about things that we may already think we know about the values in (and of) the welfare state – but continually fail to solve in practice. I am by no means an advocate of marketization of public service; I am not even particularly fond of it. But I think we can learn from unpacking how values are struggled with and handled in the making of a healthcare market, and not assume that we already know. Believing that you already know is potentially a misguided and dangerous attitude among both opponents and proponents of marketization of welfare.

The intention of the thesis is therefore to provide input to an ongoing discussion. I want to widen the scope of the discussion above technical detail, as well as to make it more focused on improvement. The thesis has the potential to generate new scope for political action, as the endeavour comprises a reintegration of the philosophy and justification of the welfare state, with pragmatic analysis of attempts at solving practical problems in contemporary, everyday affairs of the welfare state. Could such an outlook move beyond ideological debates, while adhering to the inescapably political and moral substance inherent in all welfare reform? It might shed new light on the relation between theoretical and practical knowledge in policy, and hence for rearranging the balance and authority between them. Ultimately, it aims to understand why value conflicts in welfare will never

⁷ It means I take interest in the processes whereby care choice reform is qualified as success or failure, good or bad. This stance could also be explained as downplay of *a priori* normative judgment, for the benefit of a symmetrical interest in practical valuations of market reform. This attitude relates to how Latour (1987) dealt with scientific truth claims.

be reformed away, which is an insight that will provide a space for doing welfare politics differently.

Outline of thesis

Chapter 2 takes on the questions: What is the political context for contemporary Swedish welfare reform? What are the central value dimensions and key (normative) positions regarding the aforementioned central tensions? The chapter illustrates how proponents of market reform, exemplified foremost by 'quasi-market theory' (Le Grand, 2007; Le Grand & Bartlett, 1993), have proposed a well-formulated alternative to welfare provision by the social democratic welfare state, which brings new meaning to old disputes in welfare, and makes salient new value positions.

Chapter 3 outlines the theoretical approach. The theory chapter builds the vocabulary to describe marketization reform and qualification of the primary care 'good' in terms of valuation practices. The valuation practice perspective allows analysing competing claims over what to take into account in qualifying the good, while it puts focus on the performativity of devices in enacting values. Three concepts – qualification, device, and test – are chosen for analysis. The chapter ends with refined and theoretically ingrained research questions.

What methods are most appropriate to the research enquiries of this thesis? Chapter 4 presents the methodology of the thesis, while providing an exploration into the fieldwork and outline of how I went about data collection. The case study builds on investigating the practices whereby the primary care 'good' is qualified *in situ*. Collecting data on such practices calls for sensitive instruments that capture the techniques, material contingency, and normative framing of practical situations. The methods chapter outlines the 'shadowing' methodology, and how observational data is supplemented by interviews and documents. The chapter furthermore presents how I went from data to analysis and provides examples of how data is viewed from the analytical concepts.

There are four chapters presenting the case data. Chapter 5 introduces the reader to the governance setting: the county council HQ. The chapter shows how the county council employs certain managerial techniques and procedures, and discusses how these enact particular evaluative techniques.

It also provides part of market reform history and outlines the movement towards the care choice system. In particular, it highlights the systems and procedures for how valuations are to be performed, priorities made, responsibilities distributed, and how conflicts are to be resolved in the making of the care choice system.

In Chapter 6, the so-called rule book is introduced. I take the rule book to be one of the key devices in performing the care choice system as a primary care market, and the prime tool for qualifying the primary care 'good'. The rule book embodies the central challenges for welfare delivery in a very concrete sense, and is a site where compromises between values are struck. As it is supposed to be the same rule book for all providers, while capturing the complexities of primary care delivery, it is a very composite construction.

Chapter 7 takes a look at the work of constructing of the rule book. The rule book may appear as a solid market device, but it is subject to continual revision. The chapter shows the diversity of actions involved, and highlights the situations where values become a very practical concern for rule book designers. It provides a window into how rule book designers are managing contrasting demands and a diverse set of evaluative criteria. More dynamic than Chapter 6, it shows that things are difficult, that some things might not work as intended. It answers the question 'how is it done?' with 'work', and outlines how this work is performed.

Chapter 8 takes a closer look at the work to design the so-called targetand-measure scheme. The chapter outlines what procedures and beliefs it entails, and what it means for the overall market-making efforts. It takes the reader to sites located at work meetings for modelling financial incentives, meetings with statisticians, and to other places where the scheme is produced. It shows how practitioners perform different measures and ideas of value in concrete activities, by working to fit just right the representational and incentivizing ideals of the scheme.

Chapter 9 takes on the case data and puts the theoretical tools to work. The case chapters illustrate the organizational features, procedures, and techniques involved in getting the care choice system in place; that is, where values are specifically handled. The qualification of the primary care 'good' negotiates several different principles of evaluation at the same time. Care choice reform has not resolved ambiguities usually associated with non-

market solutions, but rather brought them more acutely to the fore. Hence, the detailed practices whereby purchaser officials handle values via the rule book is a form of politics by other means. It is in such practical matters that values are given specific meanings and significance.

Chapter 10 discusses the implications of the study and concludes the thesis. The questions addressed by the chapter are: How could analysis of qualification of the primary care 'good' lead to an increased understanding of the handling of competing evaluative frameworks in moral and political ordering of the welfare state? The chapter puts up a number of requirements of such conceptual development, and furthermore suggests that the notion of 'ecology of values' could answer to those demands. The thesis is concluded with suggestions for new directions for studies of valuation in welfare markets.

Chapter 2

Background: The Rejoicing of Quasi-Markets in Welfare Reform

This chapter acquaints the reader with the normative foundation of care choice reform and outlines how the case study resonates with the political philosophy of welfare. The aim is to provide a brief 'crash course' with the kinds of interpretative repertoires of value that are at play in the making of care choice reform. The chapter works with the questions: What are the central value dimensions in contemporary choice reform? What is the (conceptual and normative) background to contemporary reform attempts in scholarly work and policy discourse?⁸

My informants may never have heard of books and theories I quote in this chapter; but they reside in the background to legitimize the public imagination that builds up and motivates these kinds of reforms. I should make clear that the case studied is not overdetermined by the particular ideas put forth in these chapter; rather the opposite. But a look at the normative positions provides insight into the imaginary that may (or may not) impact the leeway for (certain

⁸ Why discuss a 'normative' background rather than outlining more substantial claims about the 'reality' of quasi-markets? The answer is because the relation between politically ingrained claims about reality (i.e a normative metaphysics) and positive laws in social science is very intricate. The critical dimensions in welfare reform are normatively laden and have been subject to extensive theorizing and scholarly attention. It is thus politically and intellectually nested territory. The interest of this thesis stands in relation to a large body of literature that has a simultaneously heuristic, descriptive, explanatory, and prescriptive tone. Normative statements about the 'ought' of welfare reform goes hand in hand with positive laws about what 'is'. They are essentially two sides of the same coin. Therefore, it is important to deal with and understand the philosophical foundations of theory about the welfare state in the background chapter.

kinds of) valuation to take place in making the care choice system in the county council that is subject of this study.

As a way to handle the nested territory of this topic, the chapter works through an exploration of the vital aspects of quasi-market theory (Le Grand, 2007; Le Grand & Bartlett, 1993). This look at quasi-market theory helps to tease out and deepen our understanding of the critical tensions embedded in the transition from the universal welfare state to a choice based welfare system, a transition which Sweden is currently undergoing.

A brief recap of choice reform in Sweden

It is often proposed that the height of the Swedish welfare state is a unique chapter in political history, in that it was a social democratic project aimed at creating a society around the values of social equality and universal rights to social welfare (Esping-Andersen, 1990). In light of such strong statements, it might be surprising that according to *The Economist* (2013), Sweden has become best in class of western liberal democracies when it comes to the values of free choice and competition in welfare provision. For commentators like Esping-Andersen, free choice or competition were definitely not virtues of the welfare paradigm of the Nordic countries; on the contrary, free choice and competition are qualities usually associated with the 'market' as ordering principle. Some authors therefore propose that choice and competition have 'revolutionized' Swedish welfare policy, as it 'represents a significant break with previous policies and their value basis' (Blomqvist, 2004, p. 140). 10

⁹ Yet, after the election in September 2014, the new Swedish Social Democratic government launched their road map for 'limiting profits in the welfare state'. The exact consequences of the political road map are not yet spelled out, but its intention is to curtail the power of private enterprise and increase the influence of county councils and municipalities in welfare delivery. One of the propositions is to remove the obligation for county councils to set up care choice systems in primary care. As of November 2014, the government has decided to keep the right to choose care centres, but not the right of care providers to establish their business wherever they want. However, the opposing parties are fighting against the suggestion. It is still a political process with unclear outcomes.

¹⁰ Other authors (e.g. Nordgren, 2010) suggest that there are many 'false promises' in choice discourse. The choice rhetoric promises to take welfare recipients on a journey towards empowerment. It promises freedom to choose and take responsibility for one's own care. But such demands on patient choice, he claims, are inconceivable in practice.

The idea that there are distinctly 'public' values commonly feeds into normative arguments and theorizing about the values in (and of) the Swedish welfare state. For example, Rothstein (1998) claims that the welfare state is under attack from competing 'logics', foremost from the challenge of marketization reforms. However, Rothstein and Blomqvist (2000) make the claim that marketization reforms, particularly in the name of free choice, could be democratic, and hence, public in nature. Free choice is a way of increasing citizens' room for manoeuvre, and hence their autonomy. It could even enhance democracy on an 'aggregate' level, since welfare providers may become more responsive to the needs and wishes of citizens.

However, positions in public and political debates over welfare provision are often framed as either being for or against markets. In political rhetoric, the question often comes down to a distinction between the values of equality on one side, and choice and competition on the other. Moreover, due to increased public interest and media-portrayed scandals with private contractors in welfare provision in Sweden in recent years, the political discussion has been taken up a notch. The topic is highly ideologically laden in contemporary Swedish politics, and a clear divide is found between the left and the right bloc. The political right are embracing choice as a basic human right, and they highlight the benefits of competition in increasing quality. The political left is raging against profit seeking and the risk of uneven distribution of welfare (Fredriksson & Winblad, 2009).

Welfare provision is a hot topic at the heart of political life in contemporary Sweden. And politically, positions seem to be locked. At the same time, there is a countertendency in that public debate has also become more fragmented. Nowadays, much more is written in the media about the details of markets in welfare services, how they are constituted, and their effects. Technical terms such as 'capitation' surface in media reports, and journalists make ambitious attempts at disseminating the core of New Public Management (NPM) (e.g. Zaremba, 2013). To some degree, this has enabled new discursive, political, and analytical positions in relation to market reform. Such debates have increasingly shifted attention from hypothetical promises of market rhetoric to the practical importance of carefully prepared quality standards and reimbursement principles to safeguard and advance certain values; within government

(Riksrevisionen, 2014), 'mainstream' academia (Anell, 2010), and think tanks (Winberg et al., 2009) alike.¹¹

Quasi-market resembling reforms have come to pervade the reform agenda of the contemporary Swedish welfare state and suggestions have been made with regard to increased choice and competition in more welfare services, including social services. The care choice system in primary care is the latest reform where the 'voucher' is invoked as a prominent governance technique. What is this mysterious 'quasi-market theory' that contemporary reforms of the Swedish welfare state purportedly draw heavily on?

Quasi-market theory: The essentials

The term 'quasi-markets' for welfare (eg Le Grand, 2007; Le Grand & Bartlett, 1993) aims to stress the something-else-ness from ideal-type markets, and it takes stock of two market values in particular. These are 'free choice' of welfare clients, and of 'competition' between care providers. By each client having an imaginary voucher, the client is allowed to choose any one among the competing providers. In the case of Swedish primary care, it means that the county council pays the providers for their service according to the vouchers' set prices. Public as well as private actors compete with each other for the right to produce the service, but the public sector pays for the service and has overall responsibility for the service being produced. Competition is thus to be based on patient preferences and the quality of the service (Le Grand & Bartlett, 1993).

In the broadest sense, 'choice' could be made in numerous dimensions: where, who, what, when, and how. In these types of markets, choice is not 'free' in the definitive sense, but always conditioned. Choices are 'bundled' rather than

¹¹ Furthermore, interest in the details and practices of welfare markets has caught the attention of other types of research, formed outside and/or in opposition to economics. The merit of such research is to cut through the normative opposition between market and non-markets, often via recourse to a pragmatist research approach. Healthcare markets are no longer exclusively a concern and academic interest for health economics, but regain more and more interest from sociology, organizational studies, anthropology, science and technology studies, etc. (Dussauge et al., 2015; Mol, 2002; Moreira, 2013; Roscoe, 2013; Sjögren & Helgesson, 2007b; Zuiderent-Jerak, 2009; Zuiderent-Jerak et al., 2010). The effect is however that 'the' debate is highly heterogeneous, and it would be hasty to proclaim a conflation of the interests of academic analysts, media, and other commentators. What is clear though, is that the thesis is written in the midst of heated, and to a large extent, frustrated debate. It denotes an interest founded outside the domains of economics, formed by engagement in the sites where healthcare markets have been allowed to play out in practice.

free. The prefix 'free' rather speaks of the statutory right of the individual to choose service provider, as opposed to public authorities choosing a provider (Le Grand, 2007).

On 'competition' in welfare Le Grand (2007) writes: [Competition] is simply the presence in the public service of a number of providers, each of which, for one reason or another, are motivated to attract users of the particular service' (Le Grand, 2007: 41). 'Competitive neutrality' means that public providers of welfare service should not gain unduly competitive advantages over their private competitors in public markets. The aim is a 'level playing field', where each provider plays by the same rules: 'We argue that models that rely significantly upon user choice coupled with provider competition generally offer a better structure of incentives to providers' than other systems (Le Grand, 2007: 38).¹²

I take the key features of quasi-market theory and care choice reform – free choice and competition – to resonate with two classical matters in political philosophy of the welfare state: the relation between 'need' and 'free choice' on one hand, and 'implementation' and 'competition' on the other. This makes care choice reform a challenge to the universal welfare state, at the same time as it renegotiates the role, function, and meaning of central values in welfare.

Matter I: 'Need' and 'free choice'

One of the big disjunctions in welfare theory is the difference between: (1) liberal rights related to individual exchange at the market (meaning the right to choose for oneself)¹³; and (2) the social democratic idea that the 'social' is a collective

¹² Quasi-market theory and the values of choice and competition have been subject to substantial critique from a conceptual perspective in relation to welfare in general and health care in particular. Some literature (Greener, 2003; Mol, 2008) proposes that citizens' activities in (good) welfare involve much more than making 'informed choices' in particular situations, for example in choices of care centre. The 'logic of care' needed in good care makes it unsuitable to be subject to marketization in the form of patients acting as consumers. Consumers are expected to dis-embed their rational choices from their bodies, while patients are trapped in their bodies. In the 'logic of choice' patients are targeted for marketing and grouped in market segments, while in the 'logic of care' patients are active members of care situations. The two different logics enact different versions of a higher good; although they both share the vision of empowering patients (Mol, 2008).

¹³ The 'utilitarian' ontology gives privilege to welfare as an issue of *wellbeing*, which only individuals are capable of experiencing. Above all, utilitarianism is a theory that purportedly moves beyond morals in organization for welfare provision. The challenge for a utilitarian is

feature and ethical category distinctly different from the utility of individuals (meaning the right to have one's needs satisfied). In welfare policy, this distinction is often not solved at a principal level, but becomes embedded in policy and legislation: on one hand, according to the Swedish Health Care Act, care is to be provided according to 'need'; on the other hand, care choice reform makes the claim that all patients should be allowed to choose their primary care provider. This seemingly tricky tension raises a range of different questions for policy and governance: What goes into 'need' and 'free choice' respectively? What could be the roles of welfare recipients and the government respectively in formulating the content of welfare service?

One solution is the recourse to 'social rights'. In welfare history written very succinctly, social rights is a distinctly liberal idea that marries need and free choice:

[W]hat matters [with social rights] is that there is a general enrichment of the concrete substance of civilized life, a general reduction of risk and insecurity, an equalization between the more and the less fortunate at all levels – between the healthy and the sick, the employed and the unemployed, the old and the active, the bachelor and the father of a large family. (Marshall, 1950, p. 107)

The social rights model of citizenship stipulates *provision* of service from a welfare state, rather than *purchase* of service in a free market system.¹⁴ The

to model welfare institutions that render the utility function to achieve as high a score in welfare as possible. This builds an oxymoron theory; on one hand it is *laissez-faire* and advocates every-man-knows-best-for-himself, on the other it is interventionist and has strong commitments to state welfare policy (Barry, 1999). Although, most of the liberal ideas of the nineteenth century were less harsh towards welfare than were the utilitarian ones. For example, John Stuart Mill (1859) was a proclaimed defender of liberty and market principles, but there are egalitarian overtones to his liberal thought. Of course, liberty could also be a very tough concept. Modern advocates of neoclassical economics (Friedman, 2009 [1962]; Friedman & Friedman, 1980) take it to extremes: 'Government measures that promote personal equality or equalities of opportunity enhance liberty; government measures to achieve "fair shares for all" reduce liberty' (Friedman & Friedman, 1980, p. 134). Although, most influential liberal theorists and all but the sturdiest advocates of *laissez-faire* think there is good reason to entitle people to some kind of relief in capitalist society, especially when they could not be held responsible for the predicaments they find themselves in (Rawls, 2005).

¹⁴ The legacy of contemporary western liberal democracies for the state taking responsibility for welfare largely rests on the idea of 'citizenship', or being 'a full member of society' (Marshall, 1950, p. 72). It is a very fundamental liberal thought that citizenship is bestowed upon those who are full members of a community, while historically there have been very different meanings to the rights and duties attached to it. According to Marshall, there are

minimum service is set very high (or abandoned for universal welfare) so that all citizens should receive the same output. Welfare thus develops into a distinct logic and value system by its own virtue:¹⁵

In contrast to the economic process, it is a fundamental principle of the Welfare State that the market value of an individual cannot be the measure of his right to welfare. The central function of welfare, in fact, is to supersede the market by taking goods and services out of it, or in some way to control and modify its operations so as to produce a result which it would not have produced of itself. [...] Welfare decisions, then, are essentially altruistic, and they must draw on standards of value embodied in an autonomous ethical system which, though an intrinsic part of the contemporary civilization, is not the product either of the summation of individual preferences (as in a market) or of a hypothetical majority vote. [...] [W]elfare policy would be of little use if it did not actively help to create standards of value in its field and promote consensus on them. (Marshall, 1972, pp. 18–20)

Welfare cannot be based on individualistic virtues; it is by necessity altruistic. It designs its own logic, outside of both economic and democratic affairs. ¹⁶ The

three ideal types of citizenship, namely civil, political, and social citizenship. Social citizenship is most advanced, and entails a 'whole range from the right to a modicum of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilized being according to the standards prevailing in the society' (Marshall, 1950, p. 74). This form of citizenship requires a range of public institutions that will see to the general welfare of citizens. Social citizenship is thus the hallmark of a welfare society.

¹⁵ The twentieth century was a time of development of liberal thought – but foremost, it was a time of fierce attack on it. The normative basis of this attack was the rise of ideas that individuals are not the only relevant category to welfare affairs. The category of the 'social' emerged as explanatory notion, and social causation figured prominently in the welfare theory of the time. The normative foundation for welfare notions was formed outside from the utility of individuals. If contractual bonds are not all that bind people together, new forms of social entitlements appear to be viable, such as citizenship and social rights within the confinements of a welfare state (Barry, 1999). At the height of the welfare society, the different components that make up modern states – democracy, welfare, and capitalism – are inseparable: '[The mix] refers to the elements we may assume to be present when a country with a *capitalist* market economy develops *democratic* political and civil institutions and practices out of which emerge a mixed economy including both private and public capitalism similarly organized and using the same calculus, together with that complex of public social services, insurances and assistances which is the eponymous element in what all the world knows as the Welfare State' (Marshall, 1972, p. 18).

¹⁶ It is a practical problem. Marshall again: 'Obviously there are values at stake here, the values of freedom and independence, both of which have a crucial role to play in the democratic and the 'capitalist' components of the composite society. So there is bound to be conflict, but at what level? It is not, as I see it, in the nature of a head-on clash between irreconcilable beliefs

rationality of welfare policy is that it determines its own appropriate levels. The effect is that promoted values come to be treated as some sort of 'social facts' in the shape of 'needs', which could be the basis of the universal welfare state, built on social solidarity rather that market individualism. This marks the move to a social democratic value system, in which welfare ought to rest on moral attitudes of altruism and of giving, rather than on (contractual) obligations or entitlements of behalf of citizens (Titmuss, 1958). Therefore, welfare systems must not be too rigid, and legality should not override the trust that fosters reciprocity based on altruism in society. Welfare must be based on 'needs'. Writes Titmuss:

All collectively provided services are deliberately designed to meet certain socially recognized 'needs'; there are manifestations, first, of societies' will to survive as an organic whole and, secondly, of the expressed wish of all people to assist survival of some people. 'Needs' may therefore be thought of as social and individual; as interdependent, mutually related essentials for the continued existence of the parts and the whole. No complete division between the two is conceptually possible; the shading of one into the other changes with time over the life of all societies; it changes with time over the cycle of needs of the individual and the family; and it depends on prevailing notions of what constitutes a 'need' and in what circumstances; and to what extent, if at all, such needs, when recognized, should be met in the interest of the individual and/or of society. (Titmuss, 1958, p. 39)

'Needs' are both individual and social entities, and they could never be one *or* the other, but always both.¹⁸ Welfare policy in western liberal democracies thus

or of a contest seen by each side as a battle between good and evil. Welfare recognizes the values of freedom and independence, not only in the abstract but in its daily work, and the champions of these values know that without some curtailment of them welfare could not meet its responsibilities. [...] So the issue is one of balance and proportion, of deciding how much freedom of choice can be provided for' (Marshall, 1972, p. 25).

¹⁷ Historically, up until the welfare state was built on universalistic principles after WW2, most social benefit was means-tested; a true liberal idea. Titmuss is very suspicious of such rights-based welfare systems. It undermines social cohesion, and causes individual stigma: 'The corollary for any society which invests more of its values and virtues in the promotion of the individual is individual failure and individual consciousness of failure' (Titmuss, 1958, p. 55).

¹⁸ For Myrdal (1972), such 'social facts' could be interpreted in relation to 'valuation', rather than the theory-laden term 'values'. To him, the term 'values' comes with certain value-premises, often hidden, and underlying the economic assumption that value is objective. Valuation is subjective – but a social fact. He writes: '[V]aluations are regularly contradictory, even in the mind of a single individual, and also unstable, particularly in modern society. Human behavior is typically the result of compromises between valuations on different levels

comprises ideas about citizens both as subjects in need and as capable choosers. Welfare governance plays a role in formulating and assessing what such needs entail, and how the balance between need and free choice should be struck in practice.

Matter II: 'Implementation' and 'competition'

The core idea with formulating policy, for liberalism and social democracy alike, is that it is to be 'implemented' by the public administration. On top of that, in a welfare state the formulation of policy is perceived to be legitimate, as it follows the due processes of democracy and the rule of law (Hill & Hupe, 2009), not to forget that it is supposed to be independent of market forces. ¹⁹ There has been a tendency to rely on expertise from different domains, for example medicine, when formulating the content of welfare service, not least in the Swedish version of the universal welfare state. The highly contested Myrdalian heritage of 'social engineering' rested on the promises of policy analysis to model a welfare state in which the matter of welfare provision could be established scientifically (Rothstein, 1998).

There has been a wide variety of developments in the face of efforts to 'engineer' the welfare state. For example, welfare state governance makes investments to model a coherent knowledge basis for health care. Currently, in the face of the 'evidence-based medicine' (EBM) movement, good care has come to equal standardized care. The EBM movement does not claim to rest on a specific political regime. It does, however, rest on specific assumptions about the nature of epistemic virtues, and with a specific idea of the place of scientific knowledge in welfare society. Knowledge is supposed to be put together 'at the top' and translated into rules of 'best practice'. The authority, and legitimacy, of the movement rests on ready-made protocols of assessing research, which come from the scientific community itself. Evidence-based procedures that could be

of generality' (Myrdal, 1972, p. 1). My suspicion is also that his usage of the term valuation will better correspond to the Swedish term *värderingar*, which means shared beliefs.

¹⁹ The political economy of the Swedish welfare state was built on certain relations between key notions of citizenship and class, efficiency and equality, capitalism and socialism. For Esping-Andersen's (1990) influential analysis the main theme is 'de-commodification'. Decommodification is a key criterion for realizing social rights in a polity, and denotes the degree to which people are enabled to make their lives independent of market forces. The prefix 'de' denotes the capacity to diminish people's status as commodities in markets.

codified into policy protocols become high quality material for policymakers. The intention of spreading and employing evidence-based practices coincides with the tendency in policymaking to (1) make sure that practices in the public sector are possible to assess according to quality criteria (Bouckaert & Halligan, 2008); and (2) to target perceived problems with dubious local care practices and arbitrary exercise of public authority (Bohlin & Sager, 2011).

However, the role of (social democratic) government in expressing what people need, and want, has become subject to substantial critique, not least from economics. The intention to improve welfare in general and health care in particular through 'marketization' is a long-standing tradition. It has occupied health economists, policy analysts, and others for decades. Health economists (at least since Arrow, 1963; see also Enthoven, 1993) have been working on models to provide infrastructures for welfare reform.²⁰

The effect is that the normative framing of healthcare governance has increasingly become moulded in economic terms. For example, ideas of empowerment and promotion of the capacity of patients to choose – as in the care choice system – are not new in health policy rhetoric, but they have been increasingly associated with competition and the working of healthcare markets. Whereas, in the past, public organizing and provision of health care was seen as an answer to market failures, market elements have been more recently presented as a solution to public sector failures of aligning health care to the needs and wishes of individual patients (Zuiderent-Jerak et al., 2010).

As with the relation between need and free choice in welfare policy, the tension between competition and implementation is a complex construct. Scrutinized up close, the major argument for a market rationale in policy is that there is a need for competition between contractors and for an 'invisible hand' to be more decisive as to what is the best output. There is furthermore a perceived need for diversity in output. This is where the notion of 'market' offers an

become more economic in kind (Moreira, 2013; Sjögren & Helgesson, 2007).

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²⁰ A pertinent example of such a model is the QALY. The QALY is an economic valuation technique for measuring how different intervention benefits different health states. It makes up a form of 'currency' by which matters and entities that are usually perceived to be different becomes transported by a single metric. When introduced in policymaking, it performs new couplings between social and public values, and reconfigures the organizational framing to

ordering solution. ²¹ However, not market *per se*, but markets specifically constructed for welfare service such as healthcare markets.

Along such interventionist lines, the notion of 'market failure' is a construct that counterbalances the sturdiest promises of market advocacy and *laissez-faire*. In modern debates on market failure, health care as a 'public good' has taken a central locus – just as it did for Adam Smith.²² Health care specifically has been portrayed as a sector burdened with too much uncertainty and lack of information for supply and demand, price and quality to be coordinated spontaneously. Health care is therefore said to force the deployment and intervention of social institutions other than markets to reach 'optimal states' (Arrow, 1963).

²¹ Markets, in abstract form, function through the mechanism whereby a supplier sells a product to a buyer. Price and quality of the product are determined in the interaction between the buyer and seller (so-called exchange value). Markets promise to solve the distribution of goods and services in an efficient manner. In the line of thought following Adam Smith (2010 [1759]), unhampered markets most efficiently realize the welfare of individuals, expressed as self-interest. As such, market is an organizational form that could be enrolled to do the work of efficient distribution in a polity. In doing this, markets uphold a legitimate, and hence, moral order. Smith is thus sketching a political metaphysics based on ideal-type individual-hood and market exchange. Price is the moral expression on which social order rests, and the rules of the game are codified in contracts. At the marketplace, where self-interest is expressed, exchange processes makes up a greater good to the public, even though it happens to be more accidental than rational. The more radical liberal standpoint is therefore that it is most rational, from a welfare perspective, to refrain from intervention in markets; hence the adjective *laissez-faire*.

 $^{^{22}}$ In the eyes of orthodox utilitarianism, there is an obligation to correct 'market failures' and problems of 'public goods' (that is, goods that are not priced accurately: health care is one classic example). As public goods are not accurately priced in the marketplace, there is room for some sort of institutional machinery in its place. Even Smith argued that public goods should not to be supplied in the marketplace, at least not without severe difficulties. In such circumstances, utilitarian doctrine expresses a pressing need of a legislator to 'provide surrogate incentive structures' (Barry, 1999, p. 21). A classic example of a policy designed according to utilitarian principles, and one of the first welfare institutions, is the English Poor Law of 1834. The idea was simple: to take control over giving and taking pleasure and pain, caused by externalities and unsmooth transitions in the marketplace. The law was harsh by design, with the social utility function as overarching target. According to Barry (1999), although Smith could be seen as utilitarian in the individualist sense, he would disagree with orthodox utilitarianism (Bentham foremost) as to the possibility of identifying and normatively modelling the outcome of exchange activities in such a way. For Smith, markets do not produce knowable outcomes, but they coordinate mechanisms for people to pursue their wellbeing, and thus welfare for individuals and for society as whole.

Market regulators often perceive the best way to design this 'market intervention' to be 'incentives'. Incentive management mushrooms in the world of healthcare markets, not least in Swedish primary care. The use of incentives as governance technique is thus a consequence of how an economic rationale has come to be prevalent in management of welfare service. Academic discussions of incentives as managerial tools are often centred on the difficulties of getting service delivery to work as intended, and are framed as a question of designing and pricing incentives exactly right.²³

Applied to Swedish primary care, incentive management means that the principal (the county council) possesses means to have a service performed, but it cannot count on the agents (the care centres) to perform as the principal wishes. The principal thus sets out to implement a planning scheme (for example the rule book) and other techniques to better align the incentive of agents to perform as intended. The agents take cognizance of the incentives and act to maximize their own expected utility. This is supposed to guide market behaviour to create a valuable exchange (see for example Rees, 1985a, 1985b).

Incentives are used to build complex policy instrument designs. Le Grand (2003) specifically presents the idea that incentives in welfare services ought to be meticulously organized and designed in relation to governance of quasimarkets. If such an endeavour is successful, governance of incentives will take up and align the motivation of the principal, those who will perform the services, and of the recipients of welfare. The structure of Le Grand's governance model is based on building 'robust incentive structures', with the right mix of knightly and knavish motivations. Le Grand advances the idea of a voucher system for

²³ To recap a brief historical account of how the incentive became such an important governance technique: the theoretical landscape of incentives belongs to economic discourse of how to put pressure on care providers to deliver better output. Just like other techniques and devices employed in the marketization effort in welfare, incentives are set to bridge the divide between 'market' and 'non-market' by stimulating the forces that are supposed to play out in the former. Healthcare markets, due to their perceived problems of information asymmetry, are considered to be in need of contractual solutions that enable compliance without full control of behaviour. Schemes of incentives are implemented to align interests, thus downplaying the advantage of the agent possessing information that the principal lacks. This is familiar terrain for economists, and thus enables both problem (information asymmetry) and solution (the incentive) to be framed as economic ones (Dix, 2012).

welfare that treats recipients like queens, not pawns, and providers (at least to a great extent) as knaves.²⁴

There is an historical aspect to this idea. Le Grand's (2003) argument is that the advent of NPM led to a shift in assumptions about motivations and agency, from knight to knaves, and from pawns to queens. Before, the social democratic society assumed policymakers, managers, and taxpayers to be altruistic, while the recipients of welfare services were seen as pawns. When Thatcher came there were two changes in belief. One was empirical, when it was believed that the ideal of chivalry no longer worked satisfactorily in providing welfare. The second was normative; it is not moral that recipients of welfare are treated as pawns; they should be treated as queens. Consequently, this led to the belief that the market is a better organization and distribution mechanism for welfare than other modes of ordering.

The challenge for managing quasi-markets in health care is thus to predict the motives of the professionals. These insights must be used to construct incentives in every aspect of professionals' work that the principal intends to control. Hence, the major problem becomes solving the incentive puzzle. There is a pragmatic element to this as well, in that refinement of methods makes management better at solving incentive puzzles over time. Le Grand puts great effort into identifying patterns of motives, especially for GPs. Even though he does not believe the task to be easy, he clearly favours a mindset to strive for the perfect incentive scheme (Le Grand, 2003).

One of the central concerns for policymakers is how to construct incentives in the form of financial reimbursement. This is a topic receiving much attention

²⁴ The subtitle 'Of Knights & Knaves, Pawns & Queens' of Le Grand (2003), draws on some ideal-typical and normative metaphors built on the idea that public servants could be either knaves, that is, self-serving egoists, or knights, that is, altruistic; and the recipients could be either pawns, that is, passive servants, or queens, that is, strong and capable customers. Le Grand assumes that the service performed in the public sector is altruistic by default, and the altruism of the public sector builds on the altruism of the professionals. For this to work in the long run there is a need for officials and others to feel that they make a personal sacrifice; for otherwise they would not sustain the feeling that they are doing it for altruistic reasons. Hence, the balance between intrinsic and external motivation must be just right. Professionals cannot be paid too much money to perform their duties, because knavish motivation (that is, money) will 'crowd out' the knightly motivation each professional feels within. It calls for balance. If one is paid 'just right', the effect of payment is 'crowding-in' of altruistic motivation; and monetary compensation enhances intrinsic motivation and increases performance.

in economics; again, an economic solution to an economic problem.²⁵ However, one complicating factor is that the voucher enacts non-price competition. Policymakers deliberately exclude the price mechanism from the voucher, as it has a very particular aim: to improve quality of care. Yet, even in the quasimarket policy constructs to which Le Grand refers, price reappears in different forms. It is included in the payment schemes, and in the total healthcare spending. It is included in the arsenal of carrots and sticks employed to get the 'right' incentives in place.

Le Grand (2003) favours mixed forms of financial policy instruments; for example the right mix of capitation and pay-per-performance. In the theoretical literature that grapples with such notions, the big issue is whether reimbursement will be based on salary, capitation, fee-for-service, or performance, or a combination of them. In Robinson's (2001) account, pay-per-performance is promoted as a superior incentive for reimbursement in primary care markets compared to other models, such as capitation or fee-for-service.²⁶ Drawing on economic theories of agency, there are (again) very strong ideas of motivations of addresses of policy instruments and what they bring with them. He writes:

Fee-for-service rewards the provision of inappropriate services, the fraudulent up coding of visits and procedures, and the churning of 'ping-pong' referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem. (Robinson, 2001, p. 149)

Robinson mobilizes the lingo of the principal-agent thesis; ideas and terms such as 'incomplete information', 'risk aversion', and the willingness of agents to pursue their self-interests are used to frame the issue. He argues that an incentive that uses pay-per-performance and carefully prepared performance

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²⁵ One manifestation of this is previous research in Sweden on the organization of the voucher system in primary care. The discussion has so far revolved mostly around how the 'reimbursement systems' of different county councils is, and should be, designed (e.g. Anell, 2009, 2010; Anell & Paulsson, 2010; Janlov & Rehnberg, 2011; Paulsson, 2009). The literature is much engaged in how to make the voucher as 'efficient' as possible, using economic theories based on the principal–agent thesis.

²⁶ See more about different versions of reimbursement in Chapter 6.

indicators is a strong instrument of government and allows compliance at a distance. The major rationale behind performance payments is that they should facilitate transparency to make service delivery more accountable; hence the connection to the information deficiency problem of principal–agent theory (Robinson, 2001). But there are yet other justifications with such a model, which relate to facilitation of learning and breaking of unjust reputations, and above all, to make the market situation work efficiently (Freeman, 2002).

Conclusion

The chapter portrayed the ideas and principles behind choice and competition in welfare service. It showed how proponents of quasi-market theory, exemplified foremost by Le Grand, have proposed a coherently formulated alternative of welfare provision to the social democratic welfare state. The aim of quasi-market theory is to mobilize market techniques so as to realize public values, such as quality in health care. In doing so, it replays old debates within welfare theory, while also problematizing the relations between market and public values, between ends and means in welfare policy.²⁷

The point of this chapter is to provide a background to the normative framing and to understand the political, theoretical, moral, and epistemological milieu in which the care choice system is performed. To a large degree, as will be shown in the case study chapters, many of the old concepts and perspectives from liberal political economy are replayed and revitalized in the reform practice. New and old value concerns are brought to the fore again. At the same time, for the sake of the case study, it is vital not to get analytically stuck in the theoretical tracks worn by centuries of welfare theory. The point of the case study is to unpack many of the taken-for-granted positions and beliefs related to quasi-market reform. For this, a new more pragmatically ingrained valuation practice vocabulary is needed, which is provided in Chapter 3.

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²⁷ Importantly, I have deliberately chosen not to go for ideal type standardizations of a proposed 'quasi-market world' (cf Boltanski & Thévenot, 2006), but instead painted an ambiguous picture of an emerging quasi-market polity. Instead, by referencing classical and contemporary commentators on the topic of welfare market reform, I show how influential authors (e.g. Le Grand) have strived to combine elements from liberal and social democratic welfare theory in new ways. A pragmatist analysis should not shy away from political economy of the welfare state, simply because it is normative, but instead embrace it precisely because it is!

Chapter 3

Theory: A (New) Pragmatics of Valuation

In the practical governance activities putting the care choice reform in place, there are highly different activities mobilized – such as the rule book – and there are different notions of what counts as valuable – such as free choice and competition. The making of a care choice system is thus a case of a complex and emergent governance situation in which new value concerns are raised and new techniques employed to secure them. I take it that the handling of values is integral to such practices.

This theory chapter builds the vocabulary to conceptualize the practical work of handling values in such practices. It outlines the conceptual framework with which these situations can be studied empirically to learn more about the handling of values in the practices of market reform. This so-called 'valuation practice' perspective puts focus on the performativity of devices in enacting values. It means to treat the care choice system as an emergent object that becomes alive through the practical and value-laden measures that treat it as real. At the same time, it takes seriously how actors assess the desirability of this process with reference to political ideas about worthiness. This entails analysis of the justifications and moral standards evoked in such events.

I take such valuation practices to entail competing claims over what to take into account in the reform – as activities rest on competing evaluative criteria and are oriented towards different ideas of worthiness – while they employ different devices for such assessments. The analysis hence looks into the equipped valuation practices and justificatory repertoires involved in making the care choice system. This pragmatic stance is founded on a belief that market

reform and involved values are not clear or fixed, but could instead be fruitfully studied as emergent in unforeseen ways through ongoing enactment of valuation in governance practices.

Valuation as practice

The presupposition of this thesis is that values can be studied in processes of valuation. From processes of valuation, which could appear in many different ways, values are enacted. What these forms of enacted values are, and how they are interconnected, is precisely what is up for grabs in the empirical analysis. In modelling such an analysis, Dewey (1939) sought to integrate several of the terms on values commonly separated in everyday language, such as the separation between *to estimate* (relates to value in the singular) and *to esteem* (relates to values in the plural), while the terms:

[P]raise, prize and price are all derived from the same Latin word; that appreciate and appraise were once used interchangeably; and that 'dear' is still used as equivalent both to 'precious' and 'costly' in monetary price. (Dewey, 1939, pp. 5–6)

This stance eventually led Stark (2000, 2009) to break the distinction between *value* (in the singular, that is, monetary value (e.g. economics)) and *values* (in the plural, that is, 'cultural values' (e.g. sociology)), something he refers to as a termination of 'Parson's pact'. It does not distinguish between 'public', 'market', 'civil' or any other *a priori* essence of values beforehand. It flattens the landscape of values that are said to belong to different domains and treats value as something that goes on, takes place, or is enacted in practice. It treats values as something 'grappled with, articulated and made in concrete practices' (Dussauge et al., 2015, p. 6), not as something universal and stable.²⁸

This precise meaning of valuation thus shatters many of the conventional ways of treating value in social theory. It reintegrates all values to practices of

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²⁸ However, this entails more than mere value pluralism. In this respect, Beckert & Aspers (2013) somewhat miss the point with this argument. For them, 'value' is always calculable and rateable, and calculation transfers into the realm of 'values'. They write: 'In social life, different forms of value are present simultaneously, such as moral value, aesthetic value, and economic value. Each form of value has a scale used for evaluating the things that value covers. An activity may be judged as more or less ethical, and an object may be more or less beautiful, more or less appropriate, or more or less expensive. These different scales of value exist concurrently, leading to different ways of evaluating social events, people, organizations, or objects' (2011).

valuation; which is furthermore a highly empirical domain. Dewey treats expressions of value as observable social facts: 'Valuations are empirically observable patterns of behaviour and may be studied as such' (Dewey, 1939, p. 51), and 'Valuations exist in fact and are capable of empirical observation so that propositions about them are empirically verifiable' (ibid., p. 58). Grappling with such matters calls for an analytical strategy that takes interest in situations and valuations in relation to the objects to which such activities are targeted, without resorting to essentialist resolutions of value. Values must be regarded in context.²⁹

Valuation à la Dewey furthermore dismantles the distinction between means and ends, that is, it treats both means and ends as matters of valuation. As values are enacted in practices, what is a mean might easily become an end, and vice versa. Still, claims Dewey, there must be a certain analytical acknowledgment of the 'ends-in-view' of valuation practices. Valuation as activity is forward-looking, towards desired states of the world. Valuation has purpose, as it targets the promise of the future; therein lays the connection between valuation and intentionality. Hence, to assess the empirical validity of valuation claims, the analyst must have a conception of ends-in-view. It allows for seeing how valuation develops over time, with priorities and definitions of value changing: 'Improved valuation must grow out of existing valuations, subjected to critical methods of investigation that bring them into systematic relations with one another' (Dewey, 1939, p. 60).

Valuation is thus pragmatic, but not haphazard or disentangled from normative sensitivities. Dewey pertains strongly to the idea of intersubjectivity in the shaping of value propositions, in which the meaning of values is carried by a shared language. In Joas's³⁰ description, Dewey is a realist, as he refutes the

²⁹ It furthermore recasts mainstream ideas of how to analyse social 'interests' and 'desires': 'The undertaking can be carried out only by regulated guidance of the formation of interests and purposes in the concrete. The prime condition of this undertaking ... is recognition that desire and interest are not given ready-made at the outset, and a fortiori are not, as they may at first appear, starting-points, original data, or premises of any theory of valuation, for desire always emerges within a prior system of activities or interrelated energies ... The test of the existence of a valuation and the nature of the latter is actual behaviour as that is subject to observation' (Dewey, 1939, pp. 53–54).

³⁰ In Joas's opinion, which he arguable shares with Stark, Muniesa, and others, no writer handles the tension between value objectivism and value relativism in a more insightful and original manner than Dewey. Apart from the cliché images of pragmatism, e.g. that the only

mysticism embedded in accounts of purely individualistic feelings and sentiments of value. At the same time, he refuses to view value propositions as something imposed on people and situations, as something external to action. Instead, values are intimately linked to the reciprocal social relations, and as such, they can rise to generalizable value propositions:

[It entails a] process of interaction through which subjectivity and objectivity first constitute themselves and where, as part of this process, valuations simultaneously arise. (Joas, 2000, p. 106)

For pragmatic analyses of value, valuations are considered to be intrinsic to all social action. Again, there is a rationalistic undertone to this reasoning. For valuation to become researchable, it has to become accessible for the researcher by communicative means.³¹

Valuation, as advanced by Dewey, brings two analytically useful aspects of valuation to the fore. First, studies should entail a practical, interactive, and communicative component, which is the process whereby a value materializes and becomes what it is (appears to be). It means to engage in detailed analysis of the rules, devices, routines, and more that makes up such practices. This stance has been developed as a hallmark of Actor Network Theory (ANT) studies of devices (Callon et al., 2007). Second, studied should be able to assess the process whereby values become desirable and shape the direction of future action. Studies ought to take interest in the stabilization and development of desirability in the observable form of justifications. This has been the interest of 'sociology

thing there are, are experiences of practical action, Dewey could be read very productively in a much broader and intriguing manner via his claims regarding value, which could be read as some sort of 'practical idealism'.

³¹ According to Joas, valuation for Dewey originates in certain 'creative movement of the imagination'. This movement gives rise to solidified form of ideals, which pervade our conception of world, moral orientation, and ourselves. This idea allows Dewey to recognize the importance of ideals for social life without writing into them having a separate, prior existence. Ideals are effects, not starting points. Thus, in Joas's interpretation, Dewey would buy into something like: 'defining values or ideals as the product of creative processes in which contingent possibilities are idealized' (Joas, 2000, p. 114). The genesis of values according to Dewey would thus be a product of our creative imagination of each other and ourselves as we grapple with the world. Even though it is an incomplete process in practice – we have in view a wholeness that never existed – it seems to us to be very real, as it gives us a sense of meaning and coherence; it promises possibilities to improve. Faith in values and moral orientation is not a cognitive fact, but rather the conviction of ideals that govern us.

of critique' (Boltanski & Thévenot, 2006). Now, let us turn to the former of these developments of Dewey's valuation theory.

Devising our understanding of valuation

This thesis borrows the notions of 'qualification' and 'device' from ANT. Within ANT, the pragmatist stance on valuation rests on a particular flare of materiality. The notion of 'devices' highlights the importance of things in configuring behaviour, visions of reality, ways of knowing, and accountability in markets and economic affairs.³² In their simplest form, devices are treated as having 'built' into them (cf Winner, 1980) ideas, knowledge, and theories about power relations and ontological status between the governing and the governed. Such devices are treated as political instruments, having the capacity to steer action, alter identities, and distribute agency at a distance in the affairs of the welfare state (Lascoumes & Le Gales, 2007).

The device notion hence provides a particular way to conceptualize practices of valuation. The notion orients analysis towards material and process aspects of markets and the enactment of value therein; for example the making of the care choice system (cf Johansson Krafve, 2011, 2014, and the current thesis). By taking an interest in the material methods of acting involved in the market designing process, it becomes possible to see what role these devices have in market-making, that is in qualifying market objects and subjects; render things and services commensurable; while configuring exchange, prices, and monitoring (Muniesa et al., 2007).³³

³² The plea for detailed analysis of market design is not new, especially not in the light of the 'pragmatic turn' in the studies of markets (see Muniesa et al., 2007, p. 1 for a declaration of the programme). In a doctrine history painted in very broad strokes, the market devices literature picked up analytical ideas from Science and Technology Studies (STS) and economic sociology, and brought them to the realm of markets. For some STS scholars, the 'economy' and the 'market' were seen to represent another bastion of rationality that needed unpacking – perhaps even more so than science. Authors such as Michel Callon started to engage in studies of markets by bringing, among other things, perspectives from the ANT framework.

³³ Briefly, ANT treats the basic dynamic in market design as a matter of framing and overflowing (Callon, 1998a). Framing is a process in which there are attempts to establish well-defined actors and relations so that a market transaction can take place. If there is an overwhelming uncertainty over relations, it might not be possible to conduct transaction. Not only buyers and sellers are involved in the negotiation process, but a range of actors and devices. Framing as such is a way of relieving uncertainty and creating an arena for

The notion of 'qualification' (Callon et al., 2002) captures the process whereby a good acquires its qualities; that is, the process where the good being bought and sold in a market is negotiated and specified. For example, qualification could lead to a good being specified in a contract so that a market relation could be enacted. In the current thesis, it means that a specification of the service of 'primary care' has to be established for the market to function; hence the term 'primary care good'. I take it that the qualification term concerns all activities employed to make the primary care service appear manageable, packable, and marketable.

Some studies pursued along these lines of inquiry in Sweden suggest that welfare markets are highly complex activities in terms of qualification (Fernler, 2004; Forssell & Norén, 2004; Johansson Krafve, 2011, 2014; Norén, 2001), and claim that welfare markets are often characterized by instability and a constant dynamic between framing and overflow. The device notion is furthermore to be used to illustrate qualification procedures, as devices stabilize the evaluative criteria for assessing value; they are performative (see for example Greener, 2003; Grit & de Bont, 2010; Roscoe, 2011; Sjögren & Helgesson, 2007; Zuiderent-Jerak, 2009; Zuiderent-Jerak et al., 2010, 2015). For example, Sjögren and Helgesson (2007) studied how metrics were established for assessing products to be reimbursed at a market for pharmaceuticals. They used the notion of qualification to illustrate how goods for a market of subsidized pharmaceuticals could be achieved via classification schemes. They also showed that performativity is a complex matter that could run in different directions, as classification schemes that draw on economic theory are forged by other values that enact the market good in a multitude of ways.

The device notion has also been used in attempts to stabilize market action 'in the wild'. Zuiderent-Jerak (2009; see also Zuiderent-Jerak et al., 2015), made enthusiastic by the performativity thesis, set out to configure a market for hip and knee replacement to be more 'value-driven' than 'cost-saving'-driven. The market in question was hence rigged with instruments to measure and numerically assess quality, which should enable competition not based on price

transaction to take place (Norén, 2003). However, most studies claim that there could never be an absolute stabilization of framing in the market. This leads to the framing efforts being constantly subject to overflowing. Overflowing is the challenging imperative in the market that leads to changes in its framing, regulation, and management. An overflow could be defined as the 'unhandled complexity' calling the market's function into question (Kastberg, 2008).

to increase value for patients. Zuiderent-Jerak shows that markets could work without very clear-cut market materiality; devices do not determine outcome in terms of evaluative criteria, but serve as a negotiation point (Zuiderent-Jerak, 2009).

How can such openness and indeterminacy in terms of devices and the performativity thesis, as suggested by previous studies, be used productively in analysis of case data? One way to strengthen the apparatus is to take in the rhetorical force of economic reasoning and linguistic aspects of performativity in the making of markets (Roscoe, 2013). Such analysis shows how economic 'facts' come to function together with devices in contested moral valuations at markets. They have the ability to recast morality in terms of values belonging to the economic realm: 'economic facts are constructed, claim moral force, and come to dominate a discussion previously had in philosophical terms' (Roscoe, 2013, p. 2). There is thus a moral performativity of economics, which has the power to transfer 'might be' into 'ought'. This is captured neither by materiality nor discourse, but by both.

Roscoe's approach illustrates the gains in highlighting the performativity of both linguistic acts and devices. Economic facts, once produced, are often decoupled from their origin, which makes them useful in debates over, for example, the use of markets in general. It provides for universal claims which structure discourse and recasts moral and political debates in terms of economic calculativeness. From the claim that markets will function in principle follows the political 'ought' that markets should be enacted in practice. And from the promise that markets will function, experimentation with devices could commence. These devices produce economic facts that are in due turn invoked in public debate, policymaking, and governance. The effect is that devices appear to possess technical and moral superiority over competing claims to worthiness in the market setting in which they are employed. In due turn, economic facts become justification for implementing markets. There is a small step from technical argument and moral virtues in producing the facts to normative judgment on what ought to be done (Roscoe, 2013).

The market devices literature as a whole is a bit hesitant on the role of devices and values. On one hand, it has convincingly shown the importance of taking very seriously the performativity of devices. On the other hand, it leaves room for openness and counter-performativity (MacKenzie et al., 2007) in terms of value enactment. The term 'writing device' (Callon, 2002) has been suggested

to better account for the complexity of contemporary economic affairs. The notion writing device illustrates the scripted tools managers use to organize action, for example in markets. In such settings, such as health care markets, it is often suggested that it is becoming ever more important to stabilize and formalize economic engagements, as they tend to become increasingly complex and difficult to anticipate, as the realization of the activities is dependent upon complex and knowledge-intense cooperation between different actors (Moreira, 2013).

At the same time, healthcare management is a good example that there is a need both to cherish complexity, and also to find ways to reduce and simplify it. The writing device notion describes such processes, where there are activities to make complex systems manageable without entirely eliminating complexity from the scene. A writing device partakes in qualification of goods, while also putting into words the objects, subjects and relation of importance to the market situation and organization at hand. Emphasis is on (re)writing, and the performativity of writing devices rests on successive adjustments of the script. The changes made to writing devices could be 'technical', but could also be more profoundly about tone and 'character', for example from legal to moral writing in style. Usually, several hands do the making of writing devices and it could entail tough negotiations between different actors. This allows for actors being active in shaping their own role and others' agency, rather than opposing them altogether (Callon, 2002).³⁴

To conclude, the literature gives a multifaceted picture of devices and their role in qualification. On one hand, devices are performative and seem to be vital in establishing and configuring calculative capacities and in allowing action to be ordered in markets, even when markets are complex. The calculating capacity is entangled in the specific rules of the market, and framing is the process whereby these rules are established. Devices play a crucial role in the framing of markets, and thus in assigning, enacting, and establishing the assessment rules. Taken to extreme, this literature works with the idea that value is nothing but a product of the materialized network. On the other hand, when reviewed in the light of a

³⁴ What is more, in the light of writing devices, organizations often appear functional and possible to manage. Writing is often distributed according to certain principles, mostly organized by management. It also allows for management to evaluate results and interrogate the performance of agents in relation to the prescribed order in the writing device. Having overseen the flora of documents in an organization allows management to plan its work, and make it look intentional, rational, and guided by objectives (Callon, 2002).

'flank movement', the device notion provides a useful heuristic for analysing enactment of valuation in the complex moral and political ordering of the welfare state.

Reenacting a flank movement

Contemporary valuation studies enact a 'flank movement' (Muniesa, 2012) to values in search of the original spirit of valuation in pragmatism. The flank movement takes as its starting point that values are always practically rendered to appear as values. This allows an analytical stance where it is not interesting to establish *a priori* the question of whether values are objective or subjective. Instead, the interesting question is whether, and how, valuation processes render values as objective or subjective. Values could be both objective and subjective, but only in connection to the situations and practices that render them as such. They are socially constructed inasmuch as they are the result of (equipped) social practices. At the same time, values that undergo processes of objectification will appear to be objective. 'Value' does not reside in objects themselves, but in how objects are referred to (Muniesa, 2012).

Valuation as social activity is treated as a matter of complex ordering and construction of agency and desirability in relation to certain situations and objects (Helgesson & Muniesa, 2013). There are different methods for analytically unfolding such practices. It is a topical empirical terrain for a multitude of different disciplines that has something to say about social practice. It calls however for an agnostic, empirical curiosity towards these processes. For something to occur and be established as a situation in which judgment of value could be cast, it needs other processes to establish it as such a situation. And this is a never-ending movement. According to Muniesa (2012), this is why analysis must be cautious not to make distinctions between 'means' and 'ends', because a pragmatically established value (in a process of valuation) is always a condition for establishing new valuation practices. It is an ontological and a methodological standpoint, as well as a reversal of causation: since value enactments are the outcome of valuation practices, these values could not explain how and why the valuation practice produced these particular values.

Approaching values in this way highlights that values at play in marketization do not stay the same over an implementation process; instead, values are actively shaped by the methods to secure them. Therefore, Zuiderent-

Jerak et al. (2015) contend, it is a good idea to start seeing values as 'composed' (Latour, 2010) instead of as implemented. Again, there is a prospect for political action, in that increased usage and sophistication of diverse sets of 'valuemeters' (Latour & Lépinay, 2009) will help more values to be taken into account in a marketization process. A value-meter can thus be a device that makes numerical and calculable a (public) value, so as to make it account-able in economic practices. This stance puts the question of whether value could/should be analytically defined beforehand in a new light. Dussauge et al. (2015) explains:

When it comes to values, two inevitable and recurring questions are 'what are values?' or 'how do we define values?' Many discussions involve a struggle to define, delineate, or even to reconcile different notions of value. What is a value? How do you know when something is a value? How are economic values different from cultural values? How do you know if you are studying values? We believe that these questions are posed in the wrong manner. Here, and throughout this volume we explore what would happen if we stopped asking 'What is a value?' and started asking 'How are values made?'.That is, what happens if we shift from an etic register, attempting a priori to delineate and define what proper values are, to posing the emic question: 'How does something come to count as a value?' (Dussauge et al., 2015, p. 7)

Dussauge et al. dodge the question 'what are values?', with a suggestion to ask instead about the process. At the same time, they suggest a move from 'etic' to 'emic' definitions of value. Briefly, this means to take seriously value definitions made by actors themselves. However, abandoning definitions, or the quest for them, is not easy to do in the practice of analysis, therefore:

[W]e deploy a few clumsy and provisional placeholder-terms to give an indication of the sets of values which recur across the empirical fields of interest to us. We use words like 'economic', 'medical', and 'cultural' to point to the diverging registers of value that this volume explores. These placeholder-terms stem from empirical work, and are not an appeal to analyse values using these words as the only categories. (Dussauge et al., 2015)

The authors propose that we (analysts) need some idea of what values are (for studied actors) to be able to conduct analysis at all. Such 'placeholders' are to be deduced emically. Are there ways to use the openness of the notion of valuation,

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³⁵ The composition argument thus builds on bringing the discussion of public values in healthcare markets to the economists' end of the table, using arguments and figures that they understand. This perspective puts the public vs market values distinction on its head; the problem is not that quantified values are crowding out unquantified values (as is common in much critique of market reform and healthcare markets) but that the (public) values one wishes to include are not quantified enough. Therefore, more work should be put in designing value-meters that proxy (i.e. shape) public values in practice.

while at the same time working with placeholders to make our analysis more stable?³⁶

From valuation to worth and justification

The term 'worth' is usable for capturing a diversity of values and ways to enact value, while it takes studies of valuation closer to the issue of morality. Stark (2000, 2009) proposes to use the term 'worth' instead of values, as it encompasses all meaning of value, having a 'double connotation of an economic good and a moral good', and 'signals concern with fundamental problems of value while recognizing that all economies have a moral component' (Stark, 2009, p. 7).³⁷ This approach relates to the analytical question of 'How does something come to count as a value?' (just as in valuation studies) in a very direct way. As we will see, it however broadens the scope of valuation practice to

³⁶ Bénatouïl (1999) gives us a hand here. On one hand, pragmatic sociology is built around the idea that action is the root and source of social life: 'Practically all personal verbs indicate an action' and could be studied in those forms (Bénatouïl, 1999, p. 382). Everything that people do is action. The methodology on which this approach rests must take into account a pluralism of highly diverging actions. On the other hand, we can study how people are categorizing and casting judgment. We see the materials and objects people attach to their actions to construct orders, principles, or metaphysical entities: '[Materials] to which persons make reference in their actions so as to justify them, to judge others, to criticize, or to qualify a situation, and the objects on which persons rely to stabilize certain interpretations of a situation, are pragmatically indispensable for persons' (Bénatouïl, 1999, p. 386). Hence, we must also treat justification symmetrically; meaning it needs to take into account the accounts made by the informants and cannot establish *a priori* which are the pertinent straits of moral and political engagements for the informants.

³⁷ This 'sociology of worth' takes a distinct interest in 'accounts': 'Etymologically rich, the term [accounts] simultaneously connotes bookkeeping and narration. Both dimensions entail evaluative judgments, and each implies the other: Accountants prepare story lines according to established formulae, and in the accountings of a good storyteller we know what counts. In everyday life, we are all bookkeepers and storytellers. We keep accounts and we give accounts, and most importantly, we can be called to account for our actions. It is always within accounts that we "size up the situation", for not every form of worth can be made to apply and not every asset is in a form mobilizable for a given situation. We evaluate the situation by manoeuvring to use scales that measure some types of worth and not others, thereby acting to validate some accounts and discredit others. How am I accountable? What counts? Who counts? Can you be counted on? Will you credit my account? By which accounting?' (Stark, 2000, p. 5). Accounts thus encompass economic and moral aspects of social life. However it loses some of the momentum of the verb character inherent in the term 'valuation.'

situations whereby the 'drawing' of values from philosophy are brought forward to shape the direction of future action.

The concern with worth is thoroughly oriented towards morality, but opens up very concrete, plural, and multi-vocal studies of government affairs in terms of values. West & Davis (2011) suggest that such research should rest on three pillars: (1) 'A re-engagement with questions of the right and the good, but in ways that collapse the established division between epistemology and philosophy'; (2) 'A realism that understands action as meaningful within networks of both human and non-human actors in practical situations'; (3) 'The search for an approach to valuing that respects a plurality of values, but avoids the relativism of critical sociological approaches.' (West & Davis, 2011, p. 228)³⁸

The basis for this move originates from the 'sociology of critique' as outlined by Boltanski and Thévenot (2006), in which the central object is actors' critical engagements with practical situations. Events of dispute offer windows into how people build arguments, in which values are justified and negotiated in reference to a (collectively acknowledged) 'common good'. The analysis takes interest in the processes whereby the common good is used as a basis for agreement in social affairs. The perspective integrates political philosophy with pragmatic analysis of judgment, which makes it a bi-level construction, in that it incorporates both the level of people and everyday phenomena and a level of higher generality founded in political philosophy.³⁹

³⁸ Write West & Davis: 'Values can only ever be defined when they are wedded to facts and as they come to light in situations' (West & Davis, 2011, p. 229). The relation between values and facts, or what separates them, could never be fully settled. Rather, facts take form in processes of objectification, while values do not. But there are many shifts; values could become facts and vice versa.

³⁹ This approach represents an interesting fusion of political philosophy and the study of organizing action: 'Concepts of worth become particularly salient in disputes, and can be observed in many everyday situations. Characterized by uncertainty about the evaluation of persons, such situations are propitious for discerning modes of qualification. [...] [D]emands for systematization and exposure of underlying principles are precisely the ones that must be met by political philosophies, which are expected, if they are to be convincing, to show that the definitions of the common good associated with these concepts of worth are well founded. [...] Our detour by way of political philosophy allowed us to advance, then, in our understanding of the capacities that actors bring into play when they have to justify their actions or their criticisms. [...] To be sure, most members of our society have not read the original works that inspired us to construct models of the competence that is brought to bear in disputes. But the ordering principles that are formalized in these political philosophies are also inscribed in the arrangements of objects that make up the situations of daily life. [...] By

The starting point is that all meaningful social action and argumentation draw – consciously or unconsciously – on different orders of worth founded in philosophy. These orders are pragmatically evoked, challenged, and sustained as actors draw upon them in concrete situations. Over time, situations form polities, that is, political associations working in practice according to certain principles. Basically, the argument is thus ANT-oriented. Qualification according to Boltanski and Thévenot (2006) entails engaging with objects in situations and making reference to something that is already known. It is a fundamental form of comparison between the particular and the general. While this is an ordering activity, it is also laden with judgment and critique of both truthfulness and righteousness, of logic and justice. It is highly based on pragmatism; meaning situations are forged via equipped associations of local order.

This perspective assumes that in a process of generalization, participants in situations act to invoke a higher common principle founded in political philosophy. But it is done pragmatically; there are no transcendental rules to govern particular behaviour: 'Political philosophies remain at the level of principles; they tell us nothing about the conditions under which an actual agreement is reached' (Boltanski & Thévenot, 2006, p. 127). Justification is thus a double movement in which people rise above the contingencies of the situation while also taking into account the circumstances at hand. Worthiness is determined in situations, not in abstract space. In each situation, procedures, materials, arguments, and other resources have to be set up so that links are made between the local and the universal. The presence of particular objects helps to stabilize processes of generalization over time, and reduces uncertainty about the capabilities of a situation to determine worth.

'Test' as concept for valuation practices

The notion of 'test' highlights that in the practice of ordinary life, actors are continually 'testing' different objects and people in different situations against a higher, more general order of value. The higher orders are codified in political

moving back and forth between classical constructions of political philosophy and justifications produced by actors in disputes, we were able to construct a solid link between political philosophy and sociology' (Boltanski & Thévenot, 2006, pp. 12–14).

philosophies.⁴⁰ Tests are accomplished so as to determine the 'nature' of a situation, situations that 'hold together'; that is, they are firmly anchored in one order of worth and are not subject to questioning from other regimes or by foreign objects:

A test leads the persons involved to agree on the relative importance of the beings that turn out to be implicated in the situation, whatever the issue is... [...] Very diverse beings-persons, institutions, tools, machines, rule-governed arrangements, methods for payment, acronyms and names, and so forth – turn out to be connected and arranged in relation to one another in groupings that are sufficiently coherent for their involvement to be judged effective, for the expected processes to be carried out, and for the situation to unfold correctly (as opposed to disrupted situations that are qualified, depending on the applicable discipline, as pathological, dysfunctional, or conflictual, for example). In order for the system to be open to judgment with reference to a higher common principle, each being (person or thing) has to be adjusted to it. When these conditions are fulfilled, we can say that the situation 'holds together'. A situation of this type, which holds together in a coherent way and which includes no questionable objects, is a natural situation. (Boltanski & Thévenot, 2006, pp. 40–41)

A test is performed to determine the proper evaluative criteria for assessing worth. In such tests, it is important to align the objects present. Importantly, the distinction between what is accurate and what is just is no longer as important; what matters is how they are aligned:

Thus we are led to short-circuit the distinction between the two definitions of what is *adjusted*, oriented respectively towards *justness* and *fitness*, and to use a single set of conceptual instruments to deal with situations in which maladjustment will be qualified either in the register of injustice or else, for example, in that of dysfunctionality. (Boltanski & Thévenot, 2006, p. 41)

This is why the question of agreement is about both justice and fit. The adjustment process includes both people and things, and 'objects' act as stabilizers of tests:

Persons and things offer one another mutual support. When they hold together, they prove that agreements concluded among persons entail a type of justice that is in conformity with a type of justness or fitness characterizing harmony or 'agreement' among things. With the help of *objects*, which we shall define by their belonging to a specific world, people can succeed in establishing states of worth. A test of worth cannot

⁴⁰ Although Boltanski & Thévenot claim full coverage of all possible orders in 'contemporary France', they make no mentioning of quasi-market theory as higher order. However, as we will see, it is not useful to get stuck on whether they have identified all possible orders or not; the analytical point remains the same.

be reduced to a theoretical debate. It engages persons, in their bodily existence, in a world of things that serve as evidence, and in the absence of which the dispute does not have the material means for resolution by testing. (Boltanski & Thévenot, 2006, p. 131)

The test notion allows for looking into challenges to well-ordered situations, to resolve the worth of the situation, and assess the configuration of the beings involved in situations. For actors, a test is 'purer' than the situation in terms of worthiness, in that it is allowed to determine worth by removing uncertainties through appeal to the higher common principle. Analysis is targeted at the pragmatic conditions in which people cast judgment and attribute worth. The connection to metaphysics is stabilized via the mobilization of relevant 'objects'. Objects are drawn upon for supporting arguments and qualifying situations.

Situations that hold together, 'natural situations', give the actors a feeling of righteousness and justice, and vice versa; situations that do not hold together cause discomfort and distress. Sustained justification to stabilize natural situations requires investments and durable commitment. Continuous testing establishes and makes clearer the common principles and common good of an order. This leads to new elements that could help to stabilize the order, or to make it appear more stable. It is however rather the rule than the exception that clashes and incompatibility rise from such processes. Multiple forms of generality are always conceivable.

This perspective on testing brings forward how compromise is essential to ordinary life. Persons have the will to settle troubling situations, to arrange the objects at hand in a comprehensive manner, and to remove disturbances. In a compromise, people come to agree and resolve a clash without resorting to test in only one world. The result is, indeed, composite, but it is not considered monstrous. Participants could still favour different common goods, without actively seeking to change the situation.⁴¹

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⁴¹ Moreover, the test notion assumes that people, unlike objects, can manifest themselves in and handle different worlds. Natural situations are therefore often utopian. Still, what makes life practical is that people have learned to master different worlds. They therefore have to be construed as having the capacity to shift between registries of worth, that is, with moral capacity. They must be able to distance themselves from the peculiarity of a certain situation in order to reach agreement on principles. People must know how to act 'naturally', meaning that they know how to deal with a certain situation. It is furthermore assumed that they must master metaphysis, in that they can lead an argument in abstract terms with a particular world view in mind. It calls for prudence and practical wisdom; essentially a feel for what is right and just to do.

The test notion furthermore assumes that as different objects are mobilized in compromises, new worlds could emerge. Tests in such situations could resemble tests that draw only on one world. Certain objects are highly plastic; even though they may originate in one world they could be mobilized for determining justice in other worlds as well. The same goes for certain terms and notions, and there are ways of adjusting them to different worlds so as to establish a compromise in which there is consensus over certain key terms.

Conclusion: Assembling the theoretical tools for the inquiry

I have argued that the pragmatic valuation practice perspective provides a fruitful platform for conceptualizing the handling of values in welfare market reform. It is fruitful because it equips the study with a vocabulary to describe healthcare markets as highly malleable rather than ideal-typical; thus a space is

⁴² And yet, the polity prototype is a bottom-line argument so that the politics restrain the political grammar and rules for justification. One on hand, it is ambitious of Boltanski & Thévenot to claim full coverage. On the other hand, there is nothing in their proposed model that prevents new common goods from recurring. However, this is only possible to the extent that there is a systematic construction of the polity in the political tradition, which makes up 'the basic political equipment needed to fabricate a social bond' (Boltanski & Thévenot, 2006, p. 71) at the same time as 'our list of *principles* is not exhaustive; we can discern the shape of other *polities* that might be constructed in conformity with our proposed model (Boltanski & Thévenot, 2006, p. 71).

⁴³ For example, the 'quasi-market' construction becomes interesting to review in this light; not least because it is by default a composite idea in terms of market and public values. However, the making of a new world is usually no easy task. It requires activity to employ, secure, and generalize the new principles of justice, both for 'lay' people and philosophers: 'The philosophic undertaking thus constitutes a fundamental moment in the process of generalization that achieves universalization of values by devoting to the common good qualities that had been previously attached to particular aims. The process ensures the reproduction of the polity model in new forms of worth, without necessarily requiring a complete theoretical mastery of the structure of the model: the qualities revealed by the highlighting of new compromise objects are subjected to the control of logic and are systematically confronted with the requirements of justice, which derive from common sense. The rigor of this work of shaping helps explain how ordinary persons can have the necessary competence to recognize the validity of an argument intuitively, even though they may not be able to generate new principles of justification - principles that would belong in any event to the realm of utopias, in the absence of a world in which they could be deployed' (Boltanski & Thévenot, 2006, p. 284).

opened up for understanding market practices that takes into account versatility in terms of values. By directing analytical interest to practices of valuation rather than to values, more insight is gained into the pragmatics of value composition. There is also good reason to be agnostic about how different values coexist, and that they are conditioned by materiality and practices, and always contingent on the situation at hand. At the same time, there are gains in acknowledging that actors are aware of and reflexively relate to commonly held ideas of what counts as valuable, and what are deemed 'market' and 'public' values respectively.

Healthcare markets make up a topical domain for the study of such value enactments. I take it that the work done at the county council HQ to put the care choice system in place entails the handling of a variety of values. I treat this work as valuation practices, which are highly pragmatic modes of dealing with values, while it entails competing accounts of worth. The actors involved seek justification in different orders of worth, and employ devices and objects to stabilize the situation and format it in a particular manner. I assume that the main source for justification of the care choice reform is quasi-market theory as codified in legislation and policy. However, several ways of bringing other accounts of value into play are conceivable, so I should be prepared to investigate how studied situations might enact values in diversified ways. Importantly, it calls for studying valuation practices *in situ*.

The key concepts are: *Qualification*, which entails development of the quantifiable and normative qualities of a good, while also establishing the assessment criteria. It has a pragmatic component, as it enables certain action repertoires. At the same time, it anchors valuation practices in philosophical orders of worth; *Device*, which is a material entity that carries, establishes, and stabilizes the qualities of a good. A device functions as a 'proxy' or 'signifier' of value. I treat device as an analogue to 'objects' in the order of worth sense; *Test* is the process whereby the qualities of the good are assessed according to normative standards. It is the decisive moment when justification becomes pivotal in reference to a political order. A test both entails qualification of worth via devices, and a conception about the legitimacy of articulated claims.

I take interest in the worth of the primary care 'good' as it appears in the practical efforts to make a care choice system in a Swedish county council. In such a setting – a 'concerned market' – there are competing claims as to what the worth of the good is, as its valuation rests on competing evaluative criteria. With this perspective, the research questions can now be sharpened:

- 1. What values are considered to be at play by the informants in qualifying the primary care 'good'?
- 2. How are these different values enacted and ordered in the practices being examined?
- 3. How does analysis of the qualification of the primary care good shed light on conceptual development regarding the handling of competing evaluative frameworks in the ordering of the welfare state?

The empirical examination entails analysis of: (1) the justificatory repertoires for assessing the good as evoked in practical situations; and (2) the equipped valuation practices, which enacts particular values or versions of value of the good. The terminology is thereby directed towards practices of valuation rather than ideal type analysis of values. Agnosticism allows analysis of the coexistence of different values, how they are conditioned by practices, and how they are contingent in the situation at hand. Exactly how this is done in relation to data is the topic of Chapter 4.

Chapter 4

Method: Studying Primary Care Marketization *In Situ*

What methods are the most appropriate to engage with the research enquiries of this thesis? There are several methodological challenges in an investigation of the current kind, having to do with both collection of data and analytical handling of data. As for data collection, the study thrives on a 'valuographic' outlook (Dussauge et al., 2015) from which valuation is seen to be multiple, indeterminate, and contested, as expressed in data. It is nested territory; for actors the stakes are high, and for people living in the studied county, the outcome from the valuation processes result in real-life effects. This means that trust between the researcher and informants have been a key ingredient for data collection. What is more, the analytical challenges revolve around questions such as: How are values operationalized in empirical enquiry? Can I use placeholders to recognize a 'value' in the case data, without making rigid a priori definitions of what a (political, economic, social, medical, etc.) value is?

This methods chapter describes and justifies the techniques for data collection. It furthermore outlines how data is viewed in the light of the analytical concepts. The main data collection strategy was to 'shadow' (Czarniawska, 2007) the purchaser officials responsible for primary care at the county council HQ in their daily work; I term these officials the 'rule book designers'. 'Shadowing' means I have followed the rule book designers around in their everyday work. I have also carried out interviews with them regarding the work to get the rule book in place. Three interviews with other professionals were also pursued. Supplementing these methods is a close reading of different

versions of the rule book and of other documents constituting the care choice system setting.

The case study builds on investigating the practices whereby the primary care 'good' is qualified *in situ*. The shadowing methodology put me in places from where to study such valuation practices. Collecting data on such practices calls for sensitive instruments that capture the techniques, utterances, material contingency, and normative framing of practical situations in which primary care marketization plays out. I term this strategy 'methodological situationalism' (Stark, 2009). I hence approach the work of the rule book designers as a 'field of practice' (Czarniawska, 2007) in which human and non-human actors work together to enact the values of the care choice system. The interest is targeted at the technologies and machines involved in rule book designers' work practices, actors' strivings for betterment in their tasks, and of their moral capacities. It targets the accounts produced in the field, with me as a researcher entangled in the making of data.

Studies of valuation and methodological situationalism

The case study method is methodological situationalism (Stark, 2009), meaning data consists of practical situations in which actors grapple with matters of worth. It furthermore zooms in on the equipment involved in enacting value. Methodological situationalism thus allows studying in detail the 'nuts and bolts' of the practices where the care choice system is made to seem what it is and how situations come to be rigged for casting judgment. It is a study of the activities pursued to get the reform in place and to work as a market. It hence deflates the grandiosity of 'the market' and related concepts like 'choice' and 'competition' by deconstructing the messy process where they are performed as values.⁴⁴

⁴⁴ I borrow a few methodological 'sensitivities' from STS. Foremost, there is the sensibility to show that 'it could have been otherwise' (Woolgar et al., 2009). STS has taught us not to take authoritative claims at face value. As for the current case, there are a whole range of problems and questions with *a priori* theorizing of market values enacted by policymakers and quasimarket theorists (STS has been productively employed outside its original realms before, not least in health care marketization reform (Moreira, 2013; Sjögren & Helgesson, 2007; Zuiderent-Jerak, 2009)). With the idea that 'it could be otherwise', STS vaunts itself with a profound analytical scepticism, that is, to take on weighty issues, like 'market', and disarm it and bring it down to earth. However, one complicating factor is that actors in health care

Stark (2009) suggests that methodological situationalism puts the searchlight on what is commonly understood to be disorderly events and perplexing situations. It allows for seeing that disorder and dissonance is part of everyday life, just like there are orderly events. At the most basic level, a situation is perplexing if there is disagreement over what counts, what is valuable, and what is worthy. This is what makes such situations usable for valuation studies:

[U]nsettling situations are special moments in which the researcher discovers what is at stake because it is in such situations that the actors themselves become cognizant of what had previously been taken for granted. (Stark, 2009, p. 32)

Just as dissonance is a normative statement for Stark, it is also a methodological statement: researchers are not to avoid perplexing situations, but to embrace them (I would suggest a more symmetrical treatment of orderly and disorderly respectively; what unifies them is that contending values are always handled practically). Importantly, this stance is interested in the ideas and cognizance of the actors involved; a sort of 'reflexive cognition' in sites where actors partake in situations. It also means that order is sustained, altered, disputed, or changed by the actors themselves. It relates to the importance of taking 'emic' registries of worth seriously in discussing value (Dussauge et al., 2015). However, the researcher does not sit around and wait for somebody to throw in a provocative statement. Instead, to study perplexing situations means to study enactments of

governance themselves have already completed a lot of the unpacking so characteristic of STS studies. This is where another sensitivity comes in: the researcher moves close to a practice, finding that there is already much reflexivity going on in it. To produce knowledge in such a setting calls for a mindset of learning rather than of teaching. Instead of debunking and looking for extreme positions for the sake of it, showing that 'it could have been otherwise' and engaging with informants that are already reflexive about their objects and themselves allows the researcher to develop insights with mutual benefit for involved actors (cf Helgesson, 2014; Winberg et al., 2009; Zuiderent-Jerak et al., 2010).

⁴⁵ There is one fundamental difference in the treatment of perplexity between Boltanski & Thévenot and Stark. The former sees the determination of an evaluative principle as pivotal for action, as a way of moving out of evaluative deadlocks and stalemates. The latter, on the other hand, sees indeterminacy as an opening for creative action. Anyway, I treat this foremost as an empirical question.

valuation and assess the conditions that determine how tests of worth are performed by the actors themselves. 46

I take the role for the researcher to be twofold in relation to such events. First is to analyse how the situation is rigged to enact valuation. This entails close scrutiny of the features of the situation, that is, the function and role of devices, the role of actors involved, and how involved features are organized. Important questions are which actors are involved in the situation, and what do they do? How are materials employed? What subjects, object, actions, and relations are claimed to be important in realizing the values at play? What rules, tools, and devices are employed in such endeavours?

Second is to understand how orders of worth are called upon, to investigate how disputes are settled, and to describe how the higher orders are invoked in practice. It entails being especially attentive to explanations, descriptive and normative accounts as formulated by the informants in talk and documents. It is a way of studying how actors engage in problematizing, and what happens when they engage in testing. Pertinent questions are: What are the criteria and methods for casting judgments of morality, desirability, success and failure, good and bad with regard to the care choice reform? How are disputes and clashes between valuations settled?

⁴⁶ According to Moreira (2013), this demands symmetry and the researcher to maintaining his/her cool and distance to the claims advanced by actors: '[I]t is necessary to withhold our own "moral sensitivity" about such processes. What I am advocating here is related to STS' policy of symmetry in relation to knowledge claims explained earlier, but it extends it to the moral and political significance of processes of healthcare reorganization. Only a political indifference to the origins, processes, and outcomes of healthcare change can support us in this particular task. This is not to say that I do not have any views on the benevolence or otherwise of healthcare policies, but I am pursuing this indifference as a methodological procedure that aims to open up exactly why healthcare reform is such a controversial issue in our for societies. This is possible only by attending to the claims and counterclaims used by reformers, policymakers, practitioners, and patients in these controversies as knowledgeable and morally competent actions' (Moreira, 2013, p. 31). I think, with Moreira, that we could productively pursue symmetrical analysis of justification in conversation with the complex situations where actions are formatted. But I also believe it is a challenge beyond human capacity to withhold a moral sensitivity completely, which is why it needs to be handled reflexively by everyone. Here, I take it that the particular symmetry of methodological situationalism - which assumes that every person is a theorist - to be one way to handle it. This double symmetry serves to break the division between the researcher and researched, and between the language use of research and practice. Research is not to be conducted devoid of informants' own interpretations in favour of my own, but because of informants' interpretations (cf. Boltanski & Thévenot, 2006).

Data collection

Data collection for the study is exhaustively qualitative. The data consists of field notes, transcribed interviews, and documents. The prevailing method for data collection was observations, mainly in the form of shadowing, and to a smaller extent with me as active participant. The observational data collection and interviews took place from February 2011 to March 2012. It was mainly concentrated on the spring of 2011 and over a period in the winter 2011/2012. In total, I have data for 31 occasions of observation and five transcribed interviews; two interviews where I took only notes, amounting to approximately 145 hours of observation; and ten hours of interviewing respectively (see Table 4.1 for a full compilation of observation and interview data). Collection of documents was started during this period, and was continued until early 2014.

Meeting with rule book designers

My entry to the county council HQ was granted via the designers of the rule book, working as purchaser officials in the studied county council. By chance, I met with two of them at a local conference about prioritization in health care organized in 2010 by Linköping University. We got to talk to each other about diverse matters of management in health care when we started talking about the subject of my coming dissertation. I told them that I was interested in studying the practice of getting a care choice system in place and that I wanted to study it *in situ*. The timing was key here. They were eager to invite me to study their work practice, as the care choice reform was a novelty to them too, and it seemed a good idea to have a researcher taking a look at the process.

Therefore, the rule book designers invited me to study their working practice at the county council HQ. At the time, I was not aware of them being rule book designers, but only that they worked with a job description of 'purchaser governance in primary care'. As purchaser officials, they manage contracts with care providers and formulate 'needs analyses' for the political leadership of the county. This way into the county council organization seemed promising, given the significant role assigned to purchaser officials in previous research of Swedish marketization reform of health care (Berlin, 2006; Fernler, 2004; Forsell & Kostrzewa, 2009).

When data collection started in early 2011, it was initially guided by an open approach, aiming – in a very broad sense – to take into account practices

that mattered to the making of a care choice system at a Swedish county council HQ. The strategy was ethnographical in spirit and anthropological in mindset, in that I started with an open-ended orientation to the field of interest and made use of a range of data sources (cf. Hammersley & Atkinson, 2007). From the initial round of data collection (post 1–15 in Table 4.1) I constructed a pilot study in the spring of 2011. I used some of the data and wrote a draft article (eventually to become Johansson Krafve, 2011⁴⁷) with tentative attempts at analysis. But foremost, I started to work through the data to help me construct the strategy for the remainder of the study.

As data collection started again, I decided to 'shadow' the rule book designers during their workdays. I witnessed their actions and listened to their stories and lines of argumentation. They brought me to their meetings and I followed their interactions with other actors in and around the HQ, such as medical professionals at the care centres, politicians, chief executives, medical advisors, economists, representatives for patient associations and enterprises, government officials, and more.

The rule book designers employ a variety of instruments in their work, and most importantly, they construct the rule book. Their work furthermore spans several sites and intriguing situations where justifications are evoked, for example in meetings with diverse actors, such as care centres, politicians, and purchaser officials from other county councils. The rule book designers furthermore came to work as allies in the organizational setting that granted me access to the county council HQ as well as care centres, and allowed me to 'snowball' my way through to other interesting informants. They opened doors that would otherwise not have been accessible (see below on observations and interviews).

Observations

The shadowing methodology allowed me to observe events and interactions between different types of professionals involved in the primary care sector in particular, and the healthcare sector at large. In hindsight, I realize I was lucky to

⁴⁷ Briefly, the argument I pursue in the article is heavily ANT-oriented. It argues that purchaser officials frame the primary care market with the rule book. However, the ways free choice and competitive neutrality play out in practice overflows the market frame. Overflows are caused by multiple, and conflicting, modes of calculation enacted by the rule book. Therefore, free choice and competitive neutrality did not create the effects in the care choice system that policymakers expected.

be welcomed and granted access to do ethnography at this site. How would it otherwise have been possible for me to study a practice in which whiteboards, corridor chat, and swivel chairs make up important settings in which the primary care marketization takes form? I initially regarded myself as an outsider in those events, with an expectation of something different, yet familiar. From my undergraduate studies in policy analysis, I got to know county councils, yet this was something different. I pursued the shadowing methodology as a technique, but it followed me around as an attitude (Czarniawska, 2007); meaning that I gradually came to grasp the viewpoint of the informants on the events I was observing.

The most important reason for me to conduct shadowing is to witness first-hand events that would otherwise be unattainable for the researcher. And what is more, it would not suffice to have only the informants talk about the reform events, as what is going on has become almost invisible to them. Not least because it is a bureaucratic organization, all roles, events, and central objects have a formal and official description (the reader will become more acquainted with the 'structure' and formal description in Chapter 5). It concerns, for example, the image of the HQ as a rational apparatus that 'implements' the policies formulated by the politicians (again, see Chapter 5). Such images are depicted to outsiders. In contrast, observation of the work practice by county council officials allows me to study, record, and make sense of alternative stories about events that are usually, so to say, made sense of and black-boxed by the dominant administrative logic of the county council HQ.

The rule book designers' work is mainly carried out at the site of the county council HQ, but I also followed them on selected gatherings at the HQ and elsewhere: six follow-up visits to care centres; two national network meetings; one meeting with the Healthcare Committee; and a handful of conferences, seminars, and forum meetings. Rule book designers are organizational agents 'on the move' (Czarniawska, 2007). Apart from constructing the actual wording of the rule book, their work practice is much oriented towards articulation and formulation of statements and viewpoints on how to develop primary care

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⁴⁸ Of course, such official views are also of interest, as they are part of enacting valuation in the making of the care choice system, but they seldom allow indeterminacy and puzzling situations all by themselves. For that, it takes people actively working on something where they utter statements of justness, or events where devices and people invoke injustice or inappropriateness. It is particularly interesting with the tensions between images of organizations and how they play out in practice.

governance, for example before politicians, while making inventories of problems and looking for allies for suggested revisions to the rule book. One of the ways in which this takes concrete form is in relation to the 'whiteboard', where they compile 'issues' that need to be addressed. An 'issue' is often formulated as a critique of the rule book or of the care choice system at large. It could be formulated from inside the HQ, from medical professionals, from care centre management, from patients, or from politicians, among others (see below in Chapters 5 and 7).

Most data from such observations comprises field notes taken on a laptop computer in real time. In silent agreement with informants, I remained passive in the background at most observation occasions, taking notes (although there are a few exceptions were I was participating more actively). As soon as I could, most often the same day or the following day as an event was observed, I looked through and corrected all the field notes. This work entailed, for example, correction of misspellings, tidying the outline, and structuring the notes in chronological order. A few aspects were key to the notes. I worked with a note template (see example in Figure 4.1) in which I recorded the setting and context, the participants, the activities and relations, the dialogue, the taking turns in talk, the duration and timing.

Field Observation 9 16-03-2011 Date: Time: 8.30-11.30 Place: Conference room, regional hospital, Town II Present: Kitty (K) County council office Jeremy (J) County council office Larry (L) Medical advisor, district doctor Primary care director, local care organization x Management intern, shadows M Lo Care centre manager (a) Κį Care centre manager (b) Ke Care centre manager (c) Care centre manager (d) Before the meeting K: "I'm getting tired of the same old questions by now". This is the second to last followup meeting this year, this afternoon the rule book designers are going to town y. During the meeting I get the sense that M is the boss around here: '... as I'm expected to be some kind of hostess... The meeting starts with a round of presentations. Apparently, the care centre manager from care centre e is still missing. M: 'As I could choose for myself how it would be, even be alone...' M is referring to the invitation to the meeting. 'Now then, I will leave the word to you...' Lo: Is the capability to attract customers discussed in relation to procurement? Maybe you could bring in primary care as a clause there. We would like to be able to offer nice furniture and facilities too! M: That is not a question here! We will have to discuss that with the superiors. Kj: We consider that as a competitive issue! M: Yes, but it is a provider's issue.

Figure 4.1: Example of a field note template

In as much detail as I could, I recorded additional aspects that I felt were significant for grasping the full picture of the situation and event, such as unexpected incidents (and what seemed to be taken for granted respectively), informants' reactions to each other's statements, significant symbols, buzzwords, and some non-verbal messages, such as clothing or hierarchies. From meetings I observed, the resulting field notes are often structured like dialogues, with my own reflections added before and after the event. The conversations captured within quotation marks are verbatim. Converstions reported without quotation marks are paraphrased. My own comments, interpretations, and events I describe are in italics. For more unstructured events than meetings, I have

pursued a more freely descriptive way of writing down notes. All in all, circa 145 hours of observation resulted in over 150,000 words.

In my encounters with informants, I tried to make clear to them when my observations started and when they ended. Often, this meant the time during which my laptop was open and I was typing, although, I have treated some discussions held with closed computer also as sources. For example, I had the chance to lead more unstructured discussions with the main informants and other actors they encountered before and after meetings, during coffee breaks, and so on. Such events could, for example, be about informants expressing ideas on the events that had passed, their hopes and fears, or judgments about the actors involved. It could also be about their general reflections on matters of health care governance or primary care marketization. For example, on one occasion, I shared a car ride to a follow-up meeting together with rule book designers, in which they discussed different matters together while one of them was driving and I remained in the back seat. Most of the time, I took notes from such discussions, written down after the discussions ended. The notes were corrected afterwards, and I tried to recall the main structure and content of the discussion. I have not bothered to record conversations about private matters and personal life.

As exploration progressed, I continued to delineate and outline the valuation practice perspective during data collection (as presented in Chapter 3, the theory chapter). I had not yet fully developed the framework during data collection, but it felt as though the work practice of the main informants provided a rich site in terms of valuation enacted to get the care choice system in place. For example, I acquired data on diverse valuation techniques, such as written protocols to assess performance of care centres (for example quality reports); reimbursement principles (as in the making of the target-and-measure scheme); and forums for meetings between purchasers and providers (such as the format of follow-up meetings and the Primary Care Forum). What is more, I collected data on the arguments used, explanations given, critiques expressed, and justifications presented by the actors in relation to diverse tools and events.

I quickly learned that observation requires time, endurance, and a sense of timing. Fortunately, it often felt very rewarding. And in the course of the study, it was time and again confirmed what a decisive role the rule book played for actors involved in the making of the care choice system. Therefore, I argue that it is sensible to treat the rule book as the main source for codifying proper

conduct in the marketization process, and hence as the main tool for qualifying the primary care good. Not least was this due to the fact that the rule book is the key legal document for the relationship between purchasers and providers. It was furthermore a subject for intense discussion and debate. The rule book designers were constantly renegotiating the content of the rule book, and almost every time there was a meeting with other actors the rule book became a source of debate. It concerns people. Herein lies the reason for paying particular attention to the rule book as it stands – as a key device for the market – while also paying attention to the processes whereby the rule book is designed.

The observations I have conducted could be deemed systematic in the sense that I have been guided by an outspoken research interest, it has been planned, and it has been duly reported in field notes. However, the research strategy was, to start with, very open. As I shadowed the informants, I got to follow them, so to say, in their own footsteps. What they saw and encountered, I saw and encountered. I also followed the suggestions by key informants about suitable events that could enrich or provide a fuller view of what was going on in making the rule book. As I got mixed up in the daily events of HQ, a picture crystallized of what places I should be in. I followed the openings and entries to events that appeared as I went along.

This is the reason my data collection took me to a diversity of sites, even though the main hub was the corridor at HQ. My visits to HQ were planned weeks ahead, and for each new day I decided together with key informants what events I was to follow the next day. On most occasions, the rule book designers informed participants in meetings about my presence beforehand. In this way I was granted easier admittance to sites otherwise difficult to which to gain access. The vast majority of participants approved of having me present at meetings. However, on a few occasions some people were not informed beforehand about me coming there, and they expressed surprise when I entered the room. On those occasions, the rule book designers helped legitimize my admission by making reference to my 'neutral' status as researcher. Furthermore, as I followed the rule book designers around, I suspect that I was sometimes interpreted as being one of them, at least initially, at meetings. Sometimes, I got to explain more explicitly why I was following them around, and that often seemed to calm meeting participants. During meetings, I strived to remain at some distance to the events that took place. But I switched roles between instances. At the coffee table and during lunch, I felt I was mostly treated as an insider. This meant I

took part in conversations, made jokes, and talked to the informants about private matters.

I was barred from visiting three meetings. These were two cases of follow-up meetings with a private care centre and one occasion of Primary Care Forum discussions. The rule book designers told me that the reason was mainly because of opposition from one particular care centre manager, who seemed very cautious about letting a researcher in, as she perceived their work to be 'sensitive'. According to the rule book designers, this was also one of the managers that most clearly expressed suspicion of the care choice system as a whole, and towards purchaser officials in particular. I never asked the care centre manager concerned for an explanation as to why I could not participate, and I hence never received an explanation in person.

I highly suspect that my presence affected the events and situations I witnessed. This was not least due to the fact that there were purportedly many sensitive issues under discussion. I especially got the feeling that some care centre representatives became extra defensive in their attitude towards the purchasers because of me, particularly a couple of them who were rather new to their jobs. For example, on a visit to one private care centre the manager seemed to have perceived me as an expert on care choice reform. And at least from one other follow-up meeting, I sensed that some managers took the occasion to express some critique towards the system that might not have been otherwise uttered. However, it is highly speculative as to how my presence made an impact on events; I cannot know for sure.

Partly for this reason, the ambition is to protect individual informants and other actors from disclosure. I have furthermore chosen to employ pseudonyms or professional functions in presenting the case data. I have provided the key informants, the rule book designers, with the pseudonyms Kitty, Jeremy, Molly, and Robin. In Chapter 8 I have also named three meeting participants Tara, Sam, and Jimmy to be able to retell the event with a smoother, more story-like narrative. The use of pseudonyms is also a reflection of my ambition to acquaint the reader of the thesis with the mundane feeling of the work pursued at the HQ. At times I will use the pronouns 'she' and 'he' interchangeably for the informants. The usage does not necessarily indicate the gender of the informant.

I did occasionally pursue very active discussions with my informants, at least with the rule book designers and other staff at the HQ office. On three occasions, I took some 20 minutes to present my findings to a group of staff at

HQ. At one other occasion, in a meeting with the Swedish Association of Local Authorities and Regions (SALAR) around reimbursement models related to smoke cessation, I participated more actively in discussions and held a brief talk on a report (Nilsson et al., 2012) I had just taken part in writing up.

On all of these occasions, it is important to mention that my findings were presented as reflections and not to judge anyone, or to point to flaws with individuals. I presented my thesis project and the report as being about how work is actually pursued in practice, while not claiming that I could do the job better. I tried to remain sincere about my intentions with the study at large and with my presence at the observations. I was explicit with my interest in 'the handling of values' in the care choice reform practice.

A few times, some of the informants returned to me and said that they had thought about something I had told them, or spread the word about what I had said. One example is an image of a gymnastics floor I used in a presentation to the rule book designers to illustrate how I perceive their work to entail a certain complexity; that of modelling and following rules when there are multiple 'games' to be played along the lines painted on the floor. This particular image seems to have triggered something with the rule book designers. Another argument I presented to the administrative office at HQ concerned the idea of viewing the term 'system' in 'care choice system' as a system of values; that is, as a flora of versatile values as expressed by the legislation. At a Monday morning meeting, I first showed them a PowerPoint presentation with an excerpt of two paragraphs from the legislation. I then let all 'value' words shine through the text, while the rest of the text went into the background.⁴⁹

⁴⁹ Formally, as a researcher I have no say in the affairs of the county council. But that does not stop the research endeavour from being an interactive activity. I have during the course of the study taken part in continuous discussions with my informants, as well as having presented preliminary findings from my own analysis. We have led coffee break discussions, and we have discussed preliminary findings from the study. The research effort is thus not one of disentanglement between research object and subject; on the contrary. Importantly, the valuation perspective I here pursue rests largely on the informants' own theorizing on the matters they encounter. It is important to note that their problematizing of the topic is not the same as mine, although these might be tangential at times. They strive to make a functioning care choice system; I watch them doing so to be able to write up a thesis for a doctorate in Technology and Social Change. It is mutually beneficial; I strive to understand the reform process in terms of valuation, and the informants listen to my reflections on the matter.

Interviews

Interviews were conducted on seven occasions throughout data collection. They were conducted with the rule book designers as a group (four times); with one former rule book designer (at his new workplace); with a county council economist; and with a county council official working to reform home care from a primary care responsibility to a municipal responsibility. Five of the interviews were recorded and transcribed; for two of them I took notes on my laptop instead. The intention was to record all interviews. However, at the time of the two interviews not transcribed it did not feel appropriate to put a recorder on the table. The reason was that I thought it would interfere too much with the mood of the situation, that is, of the relaxation I perceived to be present. I decided in the moment that it was not critical for the results from those interviews to rest on word-of-mouth representation.

Three of the interviews were thus performed with only one informant and four were performed with groups of informants. The group interviews were conducted with the rule book designers, two or three persons at a time, distributed over the data collection period: one in early 2011, two over the year around the middle of data collection, and one in March 2012. Those interviews (all but the first, which was even broader in scope) helped me foremost to navigate the practice of making the rule book, as well as to gain insight and understanding of the practices I had witnessed when following them around.

Information from the rule book designers allowed me to 'snowball' two new interview informants. Those informants were identified by rule book designers as key individuals in the construction of various aspects of making the care choice system. These informants were either professionals, whom I had no opportunity to shadow, or they were officials I had studied/intended to study and wanted to hear them reflect on their work practices. Each of the interviews was centred on specific parts of the making of the care choice system. The economist was chosen because of her role in developing and maintaining the technicalities of the reimbursement system; the former rule book designer because of his experience in the early days of the rule book and the planning phase before the care choice system was put into effect; and the official reforming home care because of her involvement in a current boundary issue between different forms of care and changing government principals. I subsequently shadowed the economist for two meetings, and she was also a

participant in several of the meetings I attended together with the rule book designers.

The main reason for conducting the group interviews was that I found the making of the rule book difficult to comprehend at times. The interviews provided an opportunity for the informants to explain to me why certain measures in the making of the rule book were taken. It also allowed deeper discussions on topics of making the rule book that were not always well articulated in their everyday work practice, for example some justification and belief they perceived to play a role for the actions I had witnessed. The interview data thus makes up moments of reflection or clarification from the informants, as they answer my questions about their work practice. At times, this has the effect that the interview data is largely justificatory in tone.

I pursued interviews where we (researcher and informants) talked to each other and tried to make sense of how we understood whatever we were talking about. The topics of the interviews were schematized beforehand, and I prepared areas of interest that I wished to ask the informants about. I attempted to use familiar terminology for the informant (some of which the informants had to first teach me). At times all of the interviews however bordered strongly on being unstructured, as the main strategy during the interviews was to let the informants' associations steer the dialogue. I have been eager to follow up on their reflections. This strategy reflects the interview ambition to maintain structured according to a theme, yet sufficiently open for the informant to feel inclined to pursue his/her own associations and interpretations (Bryman, 2012).

I asked informants about experiences and behaviour, opinions and attitudes, emotions, understanding and expertise, and background information. The type of interview was fairly similar in all cases. The group interviews however rested more strongly on the informants posing questions and asking for clarification from each other. As the interviews slipped into more dialogic form I furthermore mixed in hypothetical questions, questions about ideal states, somewhat provocative questions and tentative interpretations of what they had told me just then or previously (cf. Kvale, 2009). I have tried not to interfere or argue with informants' statements, but instead asked for their opinions and justifications for their thinking/believing. Such statements could be when the

informants were theorizing about the role of markets and management, for example.⁵⁰

Using methodological situationalism, I assume that practical events and perplexing situations provide windows into matters of worth in a complex ordering of welfare reform. Subsequently, I have treated the interviews largely as a reflexive loop on the events that has passed, meaning I have taken stock of the judgments made by informants to cast light on the events. This approach to interviews provided complementary data to the situations that were observed. It takes seriously the capacity of actors to reflect on their actions, and hence provides space for acting differently. It assumes that it matters that valuation practices should allow actors to return from events, reflect on and articulate their thoughts. It respects the capacity of actors to learn from experience and reflects the ambition to be flexible and sincerely interested in the world views of informants (cf. Bryman, 2012).

Written materials

Just as researchers in their use of 'inscription devices' write obsessively to accomplish the world in an objective manner (Latour & Woolgar, 1979), so does the county council HQ produce quantities of written material to represent itself and its world. I treat written material as helpful in answering research questions about value enactment and as a highly significant aspect of the practices whereby valuation takes place. I assume that written materials partake in valuation inasmuch as their wordings and numbers bring forth certain versions of value and serve to materialize matters of worth.⁵¹

The documents actively used in the presentation of the case are protocols from the County Council Assembly and the Healthcare Committee from the time the care choice system was planned and designed (2006–09); versions of the

⁵⁰ One example was when a rule book designer explained his perception of why marketization in health care is difficult because of 'information deficit' (see Chapter 5). Instead of questioning his interpretation I asked for clarification.

⁵¹ I hence treat written material in much the same fashion that I treat the observation and the interviews. They are all practical manifestations in which value is enacted. Written materials perform ordering, and they enact valuation as they materialize the evaluative criteria, express values in numerical and generic (moral) form, and they equip situations for 'testing'. The argument is furthermore analogous to how constructivist studies have cared for texts as they perform organizations (Cooren, 2004; Smith, 2001), and how technology could be read as text (Grint & Woolgar, 1997).

rule book (one from each year starting in 2009) with the reimbursement appendix; the so-called Strategic Plan with three-year budget; and selected protocols from the Primary Care Forum and the County Council Executive Committee. ⁵² In Chapter 5, I will familiarize the reader with all of the above. As Sweden has an open public administration and a strong principle of open records, online access to protocols from boards and politically assigned bodies has been readily available. ⁵³

In addition, I have been given approval to read memos and internal reports written by rule book designers and economists about the status of the care choice system and the reimbursement system. The rule book designers gave approval to this after a discussion with the Health Care Director. These reports have not been considered secret by county council management, although not available online; they were handed to me by the rule book designers at their own suggestion. I have furthermore read some of the notes taken at work meetings which were usually only circulated to participants. These notes concern meetings by the reimbursement group, the Primary Care Forum, the target-and-measure task force and those made by the rule book designers at the early phase of planning for the care choice system. This was possible as I was allotted work space with a computer at HQ, where the computer had been used for taking notes during meetings over the years. I was allowed to roam freely over those maps on the computer.

Following a suggestion by the rule book designers, I was also allowed to follow selected e-mail correspondence between the rule book designers and other concerned parties regarding different issues of the rule book or the care choice system at large. In practice, it means that I have been 'copied in' on the

⁵² Bureaucracies tend to have a rather strict view of what counts as a 'document'. Documents are formally presented, they have a clear purpose and they function to spread important information. I try to have a more open attitude towards the written data I have gathered. Still, the texts are different in size and form, expression, and intended audience. They range from the rule book containing circa 50 pages, to mail conversations of a few sentences. I assume that they may have a role to play in enacting values in the making of the primary care market, albeit different roles. I treat this foremost as an empirical question, as I am explicitly interested in the forms of valuation active in making the care choice system; that is, *how* values are enacted, and with what wording.

⁵³ Only when possible without disclosing the identity of the particular county council, I show the precise wordings of the document in presenting the case study. Of course, this disclosure can only have real effect insofar as the reader is not an insider to the organization studied, or an expert on the topic with particular insight into Swedish health policy and regional politics.

correspondence moving out from the rule book designers mailbox, and been forwarded copies of their incoming mail. At its most intense period, I received several e-mails a day. It does however seem reasonable to expect that not all correspondence was forwarded; only that believed to be of interest to me as adjudged by the rule book designers.

However, after only a few weeks of this practice the rule book designers told me that they had received orders from senior managers that they were to be more restrictive with the practice of sharing e-mail. They also told me that, generally speaking, some of the content of documents and memos was 'controversial' in HQ eyes. I subsequently struck a deal with the rule book designers on how I could use documents, memos, and notes; we agreed the deal rested on 'common sense'. I have promised to use data within the spirit of protecting individuals. In practice, it means that I have used it for validation of my own interpretations and analysis of the data I present in the thesis, while I am unable to disclose the actual content of the 'controversial' data sources.

I do not claim the written data to accurately account for 'true' events, or that it is a source of 'facts' and 'truths' (which would be a positivistic stance, where questions of authenticity and accuracy reigns); I rather treat them as coenactors of valuation. The collection of written material is nevertheless also important for painting a background and context at the beginning of the case study report (Chapter 5). Just as I present key documents in Chapter 5, I used the written data to orient me to the setting and to give me a clue as to how informants tend to view the organization of which they were a part, or which they took part in shaping. As I have strived to understand the setting, conditions, and purpose out of which the documents grew, it is a way to get to better know the 'field of practice' of rule book designers.

The style, imagery, message, and language of the written material are all part of this constituting activity. It is key to be open to the statements put forth in documents. Documents are essential is enacting value, in at least two ways. First, I read them as helping to answer questions regarding what values are brought to the fore, in what terms they are articulated, and how they are expressed to matter in relation to each other. It thus rests on a close reading of the actual document. Second, documents are shown to be key materials for studying contested situations. I have been able to witness how documents are made, maintained, contested, and altered in very different situations inside and outside the HQ. Examples of this range from follow-up meetings where care

centre managers blame the reimbursement system for 'unfairness', to a rule book designer using a SALAR target-and-measure report in a meeting with statisticians in a process to determine the value of certain treatment (see Chapters 7 and 8).

From data to analysis of valuation

I take it that the collected data portrays the visual and textual enactment of valuation by the rule book as a device, while at the same time illustrating the argumentative discourses, justifications, and interpretations that rule book designers face, use, and enact in working with the rule book. How did I get here?

Coding and (re)writing as abductive methodology

From data I moved on to a form of case-based theoretical reasoning, and a continuous reassessment of interpretation of data. It could be described as some form of 'abductive' analytical methodology (Alvesson & Sköldberg, 2009). Abductive methodology concerns the ability of the researcher to take elements from both deduction and induction. A case is interpreted from a hypothetical theory, while the continuous theoretical work is adjusted according to findings in the data. Data functions as critical tuning to the theoretical framework, which is always tentative and subject to testing. In doing this, it pursues a view of data and theory as inevitably infused with one another. There is no such thing as pure data, and no such thing as pure theory. It is not possible to gaze at data from nowhere, but seeing is always perspectival. The process is essentially hermeneutic, while it is more devoted to issues of ontology and epistemology rather than rigidity of method. It views theory as a purified vocabulary employed by the analyst, aiming to represent some observed phenomena; but it is inevitably ingrained with the data it is said to represent.⁵⁴

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⁵⁴ There is a certain locality and contingency of the knowledge gained from this type of case study. The particular research site is only indicative of what is going on 'in the larger picture' (of welfare reform in western liberal democracies, for example). It is a specific place where some phenomena take place, albeit nothing out of the ordinary. I urge the reader to remember that the case study could not promise to be all-embracing in describing the case of the 'care choice system in county council X'. It is instead exemplifying events and situations where valuation is a practical matter. The study furthermore will not focus on how values explain outcome. It does not assume that values are inherent and static, therefore values are not considered to be measurable and easy to capture with static methods. I will not look at how doctors and others in the medical profession use the rule book. I will not take the vindication

In practice, it meant that after data collection, I started exploring my fairly shapeless chunk of prosaic material on valuation in the making of the care choice system. For field note and interview data, I printed this out and began a synoptic reading of it in April 2012. I tried to maintain open-minded towards recurring themes and events in the data, as this was the first time I had taken a step back to review the full extent of what data I had got in my hands. At the second reading, I worked to elucidate key words and themes, and made a prioritization of the relevance of the diverse data for the research interest. This was the beginning of the coding process. Subsequently, for interview and field note data I now started using coding-and-retrieval software to organize my material. Over two months I worked through all interview and field notes inductively with the software. The major work and with organizing, coding, and taking home interesting themes in the data took place over this period.

The coding resulted in a catalogue with over 100 codes. At this stage, I started to notice that most of the codes I had constructed could be labelled according to any of the categories: something that happened/an activity (for example 'follow-up meeting'); a substantial phenomenon/topic that was part of the activity (for example 'local areas'); expressions, judgments, and interpretations made by informants of activities and topics (for example 'this is imperative); and 'placeholder'-deduced labels (see Chapter 3) on studied activities (for example 'competitive neutrality'). Most interesting I found were couplings between different categories, as I could highlight data with more than one code. For example, this was how I was able to elucidate the connection

of values that come up in data 'at face value'; basically meaning that interview accounts will not be seen as explanatory. It will not be a smooth narrative with logical consequences, not so many answers to 'why', in the sense that it is logically possible to explain why actors did what they did. Rather, the study helps to put studied events into perspective, and hopefully yield an interesting, convincing, and trustworthy experience for the reader.

⁵⁵ I had however drafted an article from the first round of data collection, which means I had some sense of the direction of the aim of data collection underway in the spring of 2011, even though data collection was still running. I pursued the drafting of the article along with writing up memos and paper drafts presented to seminars at my home department, to The Department of Health Care Governance, iBMG, Erasmus University, Rotterdam where I was visiting scholar, and to a couple of international conferences. Over the time of coding and analysis (2012 mainly) I worked with tentative analytical attempts simultaneously (eventually to become Johansson Krafve, 2014). This work helped me tease out analytical strands and polish ideas, especially in the light of the growing scholarly interest in practices of valuation in economic sociology and market studies in particular.

between the placeholder category 'competitive neutrality' with utterances about 'imperative force' as made by the rule book designers. I could furthermore see that events where competition was at play occupied a large range of the rule book designers' activities. Here is one example of an interview where I have the importance of competitive neutrality explained to me:

There's a lot of talk about competitive neutrality, that one should have the same, both our own and for private ones, and so on ... And there you will find stuff all the time, things like, where we don't have competitive neutrality, and where one might give special treatment to the public care centres, for example. That one makes in a certain way. And so someone comes in: but how does that work against the private contractors? And then you get like, well, then they should investigate it, how it will be done with private contractors? Will there be, is it competitively neutral if we do it like this? No, but then we do the same against everyone, and so on. (Interview county council economist, April 2011)

Among other things, I take the excerpt to be indicative of the importance of competitive neutrality. This shows that competitive neutrality is an enacted value towards which the work to construct the rule book is oriented. And so it goes on.

In parallel to the coding and analysis of the interviews and field notes, I worked with analysis of the written materials, foremost the rule book as a device. The rule book appeared to me to provide a more structured piece of data, which I took to be easier to access for elucidating values; meaning that as I read the rule book material for expressions of value, the entities were more clarified than in observational and interview data (for example, people tend sometimes to contradict and shift positions during an interview, which is certainly interesting in itself). For example, this is how I approached the first paragraphs of the rule book (see Chapter 6).

Key for me in the analytical process was when I more actively started to assess and experiment with possible ways to present case data in the form of chapters for the monograph. The drafting of case chapters largely became as much of an analytical device as was ordering the same. The next step for me in approaching the data was to start drafting events and themes under headings and subheadings, such as 'the background to the rule book', 'local areas', and 'conflicts around the purchaser role'. The analytical sophistication of these texts was not yet at a developed stage, but the intention was instead to experiment with ways and structures to retell the studied events as a case study. As for the monograph, my emphasis was much on capturing and representing the case

study in depth. I paid a great deal of attention to how I would present the case chapters to capture the width of the phenomena I had studied.

Conclusion: Studying the making of the care choice system as a valuation practice

Eventually, the frustration I felt before of the messiness of the data was gradually transformed into an acceptance of the messiness of reality; a messiness which is actually good for a research endeavour aiming to elucidate the normative enmeshment of valuation practices. I began to realize that exactly the friction between enactments of value that is written, spoken, and observed respectively is what makes for a productive tension in research of a complex ordering process of market reform. Importantly, this is how I gradually came to treat my collected data so as to illustrate that work employed at the county council HQ entails the enactment and handling of values.

This is why I take this case study to be a valuation study performed *in situ*, where the matter of qualification of the primary care 'good' is at the centre of interest. Furthermore, the key concepts – qualification, device, and test – are operationalized in the following manner, which also builds the link to the first two research questions:

- 1. What values are considered by the informants to be at play in qualifying the primary care 'good'? The practices in which the rule book designers are working bring values to the fore in a variety of ways; that is, they entail practices whereby certain elements are expressed as valuable(s). The observational and interview data, together with the written material, captures material and discursive performances of value. For example, these come in the form of numbers and statements of justness. Taking these statements seriously paints an understanding of the values considered to be at play in qualifying the primary care 'good'. The result is an inventory of values portrayed to be in relation to each other and to play roles in and around the care choice reform situation.
- 2. How are these different values enacted and ordered in the practices being examined? Working to answer this question results in an inventory of the ways in which values are enacted and ordered. Such analysis will also take an interest in how it becomes possible for actors to make statements of worth and justness. It takes interest in the positions from which one/something could talk with authority and certainty. It furthermore

disseminates the formats in which it is possible to express value in relation to other thinkable formats, and how orders between values are displaced. It could, for example, zoom in on the relationship between written statutes, invocations of morality in a meeting, and numbers on a sheet of paper. The presentation of the case data contains value judgments, as well as materials and discursive positions that format the positions whereby judgments could/should be made; that is, what I refer to as 'testing'.⁵⁶

Now, let us turn to the presentation of the case.

outside of the studied practice (in this case 'valuation'). On what grounds do we assign concepts of phenomena to a practice not mentioned by the actors within it? Should I feel reluctant to assume that justification is inevitable and observable? The lesson from this problem may be a question of exercising caution every time I use the terms 'value', 'valuation', and 'worth'. Instead of deducting certain behaviour to a 'value' having its forces at play, it could be something like: 'I have observed this and that in a situation. This could be understood as appealing to the value of ... or drawing on the value of ...'. The concept of value can do work and might provide analytical leverage to a wide range of different social practices, but calls for caution. No doubt about it, the analyst will always use language that is not found in the studied practice. There is reason to be reflexive about it.

	Activity	Place	Present	Date	Duration	Note
1	Group interview	County council HQ, Town I	Project managers, county council officials	23-02-2011	13.00- 14.45	Recorded
2	Observation	Private care centre, Town I	County council officials, care centre management	08-03-2011	7.45-10.15	Follow-up meeting
3	Observation	Private care centre, Town I	County council officials, care centre management	08-03-2011	14.00- 16.00	Follow-up meeting
4	Observation	County council HQ, Town I	County council officials	10-03-2011	8.30-11.00	In-house meeting
5	Observation	Private care centre, Town II	County council officials, care centre management	14-03-2011	10.30- 12.30	Follow-up meeting
6	Observation	Private care centre, Town II	County council officials, care centre management, corporate group officials	14-03-2011	14.00- 16.00	Follow-up meeting
7	Interview	Respondent's office	Former county council project manager	15-03-2011	9.00-10.30	
8	Observation	Conference room, hospital, Town I	County council officials, public care centre management	15-03-2011	12.45- 16.30	Follow-up meeting
9	Observation	Conference room, hospital, Town II	County council officials, public care centre management	16-03-2011	8.30-11.30	Follow-up meeting
10	Participant observation	SALAR HQ, Stockholm	Managers of care choice reform from all county councils in Sweden	22-03-2011	9.20-16.40	Meeting with national network of county council officials
11	Observation	County council HQ, Town I	County council officials and economists, care centre management	24-03-2011	12.00- 17.00	Lunch meeting with managers of prospective care centre, in- house meetings
12	Interview	County council HQ, Town I	County council economist	12-04-2011	13.55- 15.10	
13	Observation/ interview	County council HQ, Town I	County council officials, politicians	10-05-2011	13.00- 14.50	Interview with officials, observations at the Healthcare Committee
14	Observations	County council HQ, Town I	County council economists	11-05-2011	13.30- 14.50	Meeting with Payment Strategy Group

15	Group Interview	County council HQ, Town I	County council officials	16-05-2011	13.00- 15.00	
16	Observation	Hospital, Town I	County council officials, Care centre managers	10-01-2012	14.00– 15.15	Collaboration meeting
17	Planning of study/observation	County council HQ, Town I	County council officials	27-01-2012	8.30-12.00	Planning of study/In-house meetings
18	Observation	County council HQ, Town I	County council officials	30-01-2012	8.30-15.00	
19	Observation	Bonnier Conference Centre, Stockholm		31-01-2012	8.30-12.00	Primary care conference
20	Observation	County council HQ, Town I	County council officials	06-02-2012	8.10-13.00	
21	Observation	County council HQ, Town I	County council officials	07-02-2012	7.55–13.00	
22	Observation	County council HQ, Town I	County council officials	08-02-2012	8.00-16.00	
23	Participant observation	SALAR HQ	County council officials, SALAR & the National Board of Health and Welfare	09-02-2012	12.00– 16.00	National strategy meeting performance payments
24	Participant observation	County council HQ, Town I	County council officials, primary care managers	13-02-2012	11.45– 18.40	In-house meeting + Primary Care Forum
25	Participant observation	SALAR HQ, STHLM	County council officials from three counties	14-02-2012	10.00- 16.20	Network meeting purchaser officials
26	Participant observation	SALAR HQ, STHLM	County council officials all county councils	15-02-2012	10.00- 16.00	Meeting with national network of county council officials
27	Observation	County council HQ/ Information's office, Town I	County council officials	16-02-2012	8.00-14.30	
28	Observation	County council HQ	County council officials	20-02-2012	8.00-17.00	
29	Observation	Public Care Centre, Town III	County council officials, Care centre manager, Health care professionals	21-02-2012	8.20-14.00	
30	Observation	County council HQ, Town I	County council officials, Care centre managers	22-02-2012	8.00-16.00	In-house meetings
31	Observation	County council HQ, Town I	County council officials	24-02-2012	9.25-16.00	
32	Observation	County council HQ,	County council	27-02-2012	16.40-	

		Town I	officials, Private care centre management		19.40
33	Observation	County council HQ, Town I	County council officials	29-02-2012	8.10–16.50
34	Observation	County council HQ, Town I	County council officials	02-03-2012	9.20-
35	Observation	County council HQ, Town I	County council officials	05-03-2012	12.55– 16.00
36	Interview	County council HQ, Town I	County council officials	26-03-2012	14.00- 15.45

Table 4.1: Compilation of data sources.

Chapter 5

'We Needed to Sort out Things We Never Had to Sort out Before': Ordering Primary Care Reform

This chapter takes the reader on a tour of a fascinating place: the county council HQ. As an undergraduate policy analyst I was taught that the county council HQ is a site of local governmental affairs and a place where welfare policy is made and implemented. In this way the contemporary Swedish welfare state could be conceived of as a network of welfare municipalities and county councils, each with its own bureaucracy and taxation capacity. In practice, it is also a site where the values of the welfare state are handled very specifically in the work to get a care choice system in place.

The aim of the chapter is to provide an overview of the practices, actors, and devices involved in the everyday affairs of managing the care choice system at the county council HQ. It therefore demonstrates how the marketization process of primary care is carried out and how it is organized. There are systems for how valuations are to be performed, priorities made, responsibilities distributed, and how conflicts are to be resolved. The reader becomes acquainted with the organizational features of how the county council works, and also gets a glimpse of the division of work and the historical development of care choice reform.

The chapter also has an important forward-looking task. By describing the organization of the care choice system, how it is performed, and what are the prevailing challenges with that process, it sheds light on the multitude of valuation practices involved in making a care choice system work in practice.

The chapter helps to direct the view towards the values at stake in the reform effort of primary care, and how that reform is justified and handled in practice, which is key to the remainder of the argument in the thesis.

A walk at the office: Central functions, roles, and tools

The county council HQ is located in one of the larger cities in the county. It resides in a 1970s office building in the city centre. The first things I encounter on arrival at the county council HQ in January 2011 are locked doors and a check-in desk. This place is not for everybody just to come and go as they wish. Only when signed in in the ledger, are you allowed on the premises. Eventually, I will be granted my own entry card. But for now, I sign in, the receptionist makes a few phone calls, and I head up to the second floor for the first time. This is where I conduct my first interview with the rule book designers in the administrative office. Subsequently, this is also the place where I will conduct the bulk of observations.

The principles of governance

The first encounter for newcomers in the world of county councils is from mainly textual representation, that is, texts and drawings of the organizational model. Such drawings and representations are to be found in documents on display in HQ, as well as in documents available to the public, lying in bundles at different places in the hallways and corridors at the second floor. One way to acquaint oneself with the image of the county council is to take a look at such documents.

One of the central tools to sustain the overarching managerial principle of the county council is the 'balanced scorecard'.⁵⁷ The balanced scorecard is a tool for giving diverse values an equally important status. The idea is that the ability to manage performance according to different principles (in the original

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⁵⁷ It is worth noting that originally, the balanced scorecard was an important innovation in the light of values and market reform, as it intended to bring different values and put them, so to say, on equal footing with financial values (see selected writings from Kaplan, for example Kaplan & Norton, 1992). During the 1990s, the balanced scorecard became a very fashionable managerial device in many Swedish county councils. Arguably, the tool has had profoundly performative effects on managerial practices in Swedish county councils in that it has formed the organizational world it was intended to portray (eg Edenius & Hasselbladh, 2002).

academic literature it was the values of finance, innovation, clients, and processes) requires different managerial measures to actively handle them together. If all of these are brought into play together, management becomes more balanced according to different values.

In this county council, the balanced scorecard is established through collaboration between politicians and officials. The overall managerial elements in the model are the Strategic Plan and three-year budget from the County Council Assembly, together with the yearly operational plans from the Executive Committee, the Healthcare Committee, and the chief executive respectively. The balanced scorecard claims that each of these actors is supposed to have an autonomous status in the organization. Though, in relation to some administrative procedures, for example in the Annual Report, it is claimed that the roles must be 'handled together'. The balanced scorecard employed in the county council works from four different 'perspectives':

- 1. citizen perspective: how to fulfil citizens' need of care;
- 2. process perspective: how to develop efficiency in working processes;
- 3. staff perspective: how the county council will develop collaboration and leadership;
- 4. economic perspective: how to control and manage the economic affairs of the county council.

This illustrates that handling different values lies very close to the heart of county council affairs, as the balanced scorecard portrays it. The balanced scorecard furthermore expresses diverse values, and puts value balancing as an integral part of management. The balanced scorecard puts economic valuation on par with other considerations of value in the form of 'perspectives'.

The Strategic Plan with three-year budget is another central document, as it contains the 'vision, strategic goals and economic framework' of county council affairs. The Strategic Plan is formulated by the ruling parties each year and passed by the assembly. When taking a look at the Strategic Plan, the first lesson taught is that according to the Swedish constitutional model, health care is by far the biggest task of county councils. The plan furthermore states that it is 'an elementary verity' that the Local Government Act (SFS 1991: 900) and the Health Care Act (SFS 1982: 763) codify the basic rules for all health care in Sweden. Regarding the Local Government Act, the Strategic Plan states that:

The [Local Government Act] contains the basic rules of what a county (or region) is allowed to do and how county councils can organize their activities. The Act stipulates the rules for elected officials (politicians), the regions' general powers, and the County Council Assembly's tasks in relation to committees. The Act also regulates the working methods of the council and the committees, and how cases should be prepared for decision. The Act also specifies how county councils will manage their finances; that counties must have a sound financial management in their operations. (Strategic Plan 2013–15)

The county is here portraying the Local Government Act as an imperative ordering device of county council affairs; it sets procedures and roles for how the organization will look and how it will execute political power. On the Health Care Act, the Strategic Plan states:

The [Health Care Act] contains the basic rules for all health care. The Act is essentially designed as a framework law. It sets goals for health care and requirements for good caring practices. Apart from that, there are rules that clarify the responsibility of regions, county councils and municipalities regarding different health services. The Act contains several demands related to health care quality, and that the quality of the activities will systematically and continuously be developed and assessed. The Act also contains demands that health care should be based on respect for patients' self-determination and integrity, to meet patients' needs of security in care and treatment. (Strategic Plan 2013–15)

The Act is thus portrayed as a framework for healthcare activities; it sets the overarching goals for Swedish health care and points to requirements for good care, and clarifies the responsibilities for local government in various aspects of health care.

The Strategic Plan furthermore states that citizens interested in influencing the county council have a right to elect politicians for the County Council Assembly. The county council is thus a local government, with the politically assigned County Council Assembly working to set the Strategic Plan and the three-year budget for the county council, to which all county council operations are obliged to adhere. The Assembly furthermore works with visions for the future, and formulates catchphrases and slogans for the county council. The Strategic Plan states that for subsequent years, the overall guiding vision for the county council is 'Good care and better health'.

Key roles: Politics and administration, purchasers and providers

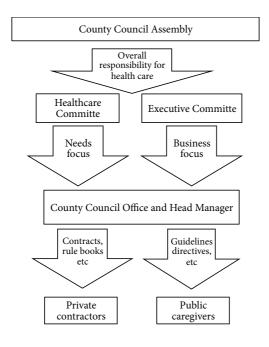


Figure 5.1: The county council business model, adapted from the Strategic Plan 2013–15.

The basic organizational principle is the purchaser-provider split. The purchaser-provider split rests on the key bifurcation between 'business' and 'needs' management. Figure 5.1 portrays a revised version of the organizational model from the Strategic Plan, as I have tried to simplify it. Not to make the explanation unnecessarily complicated, the Healthcare Committee is responsible for the purchaser function ('needs' management), while the County Council Executive Committee is principal for in-house healthcare provision ('business' management). The latter, the County Council Executive Committee, will 'lead and coordinate' the affairs of the county council. The Executive Committee is also responsible for coordinating the work of other boards and committees before the County Council Assembly. It consists of politicians from the political parties represented in the Assembly. The Healthcare Committee is a political

body that works to establish and make sure the needs of the population in the county are met. The idea is that the Healthcare Committee assigns providers of care and manages contracts with other suppliers.⁵⁸

The epicentre of the county council HQ chart is the county council office. Taking a look at the organizational chart again shows that the role of staff in the office is to serve *all* of the County Council Executive Committee, the Healthcare Committee and the Chief Executives with administrative support. The Strategic Plan explains the connection between the bodies in the following way:

It is the task of politicians to set goals, allocate resources and monitor performance against the decided targets. The County Council Chief Executive and production lines will form a professional management and ensure that results are accomplished in line with the policy assignments. The health care mission requires that the County Council Executive Committee's business management and the Healthcare Committee's needs management is coordinated according to a systematic and coordinated governance process characterized by dialogue and transparency. (Strategic Plan 2013–15)

The office is thus to provide administrative and managerial support for both provider and purchaser parts of the county council. This is an important characteristic of the office staff; many of them work with both these roles throughout the administrative 'cycle' of a year. The 'cycle' builds on something

⁵⁸ Politics is sensitive stuff. During my stay, I experienced this very definitely in two separate events. The first was my first (and only) visit to a Healthcare Committee meeting. The rule book designers were to present a briefing to the politicians in the committee. Before the meeting, the rule book designers accompanied me, and we waited outside for a substantial time before we could be admitted. Finally, the political secretary opened the door, turned to me and said: 'We had to take a separate decision just to let you attend the meeting', meaning this is a special occasion and there is a need for consideration and respect for the sensitivity of the event.

The second event concerns transparency. When I came to the office one Monday morning, I learned that a document containing sensitive information had been 'leaked to the media'. Apparently, it was an internal memo for one of the political parties. One politician had printed the document, and then went to get the copy. As he arrived at the printer, somebody had already snatched it. As the document contained compromising information about the policies of the ruling party, the chair of the Executive Committee was outraged. She went to the police and filed a report over the event, accusing the opposition of blameworthy behaviour and not playing by the rules. This made the scandal even worse and a *feuilleton* in the media, as Swedish constitutional law grants the right to all employees in the public sector to give any information to the media without being exposed or prosecuted. The case was closed. But all employees at the office had to attend a mass meeting with managers to talk about the event, including myself, before it was forgotten.

the rule book designers refer to as 'the spinner' [snurran], reproduced in Figure 5.2.

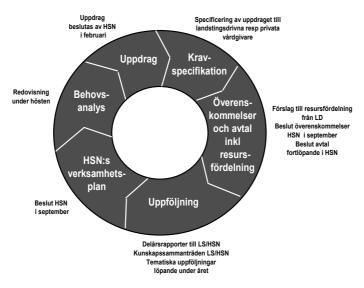


Figure 5.2: The spinner, provided by the rule book designer.

The spinner outlines that the work of the county council office is based on a yearly cycle. In English, the white text in the cycle reads clockwise (starting with *HSN:s verksamhetsplan*): the Business Plan for the Healthcare Committee; Needs analysis; Task; Demand specification; Arrangements and contracts including resource allocation; Follow-up.

The cycle rests on the office staff performing 'needs' analysis together with caring professionals. The Healthcare Committee then makes decisions based on such analysis, leading to 'tasks'. From such tasks, the office staff – with input from healthcare professionals – formulate suggestions for how 'resources' will be 'distributed in contracts and regulations'. The agreements are decided in the Healthcare Committee throughout the year. At the very least, the spinner provides a routine for what types of products are anticipated to come from the office to the politicians of the Healthcare Committee, and vice versa.

As I begin my field work, I become a frequent visitor at the office. The staff are based on the third floor at the HQ, and I am eventually placed alongside them in a temporary office space. The office is divided into subgroups working with particular emphasis at different administrative processes. Most of them sit

along the same corridors and often work closely with each other, while occasionally they are also working with medical professionals or staff from other parts of the HQ. The County Council Chief Executive is head manager of the office. Again, the Strategic Plan explains:

The County Council Chief Executive is responsible for the overall production organization and for all operations being conducted and developed professionally. The County Council Chief Executive has overall responsibility, through necessary decisions, for ensuring that the politically defined objectives are reached within the decided financial framework. The County Council Chief Executive is responsible for the administrative support for all of the county council's political bodies. The County Council Chief Executive shall – under the County Council Executive Committee – also issue the policies and guidelines needed to implement the council's Strategic Plan with three-year budget, the financial plan, and the plans from the County Council Executive Committee [and] the Healthcare Committee (Strategic Plan 2013–15).

The chief executive has overall administrative and executive responsibility for all affairs of the county council, as s/he will take decisions and formulate policies and guidelines that work to fulfil the politically established goals of the organization. To help in this endeavour, there are several executives delegated certain responsibilities of county council affairs. The Health Care Director and the Chief Physician/Development Director are next in rank to the officials whom I study most intensely.

The subgroup I get to meet on my first visit to HQ has as its main responsibility the management of contracts with care centres within the care choice system; hence my interest in seeing them. They belong to a larger group with particular responsibility for working on behalf of the Healthcare Committee to design contracts with public and private care providers in both primary and specialized care. This is when I learn that the main contract for primary care is called 'Rule book for care centres'. The work to design parts of the rule book is carried out by many different professionals, for example statisticians, economists, and medical specialists. But so-called 'strategists' – I refer to them as 'rule book designers' – have the main responsibility for assembling all the parts in the rule book and perform the balancing act of deciding what does and what does not go into the rule book. These professionals are my main informants. However, I was in daily interaction with others at the office as well, during meetings, conferences, lunch and coffee breaks. A regular event was the Monday morning meetings, attended by all staff at the office.

Negotiating the purchaser role and dealing with vagueness

Overall, the county council HQ appears to be representative of a modern bureaucratic organization, as it proclaims itself to be generally well ordered, lawful, and legitimate. It is a welfare authority, which employs a purchaser-provider split and pursues procurement with both public and private care providers. The care choice system fits into this organizational setting, but poses new challenges to and forces new managerial imperatives, while it tends to stir things up in a very practical sense too – in particular because of the values 'free choice' and 'competitive neutrality' enforced by care choice legislation. Recall that competitive neutrality demands that the county council should not discriminate between any of the contractors in primary care. In fact, this means that the rules must be exactly the same for all care centres. Free choice gives patients unanimous right to choose their own care centre, and they should expect the same quality from them all.

I witnessed how such challenges play out in complex ways for the making of the care choice system. Taking a look at the organizational chart again, one can see that the county council is strongly built on the idea that it is *both* purchaser and provider of care; meaning it runs some care centres, while it manages contracts with all care centres. Regarding the responsibilities related to 'business' and 'needs' management, there is thus a fundamental distinction between 'public' and 'private' care providers in primary care. The prefixes 'public' and 'private' entail a distinction regarding who owns and runs a care centre; the county council or private enterprise. Public thus means the care centres owned and run by the county council. The private care centres are operated by private enterprises, but reimbursed by the general health care system. The rules, as issued by purchaser management, are however to be exactly the same.

There is a total of 46 care centres in the county: there are 35 'regular' public care centres and three jour centrals (providing care outside from regular care centre opening hours) run by a consortium of public care centres in the larger cities, and eight private care centres. A care centre could be organized in several different ways, but will always comprise several particular activities. There is always a doctor's office; usually a district nurse; often maternity and childcare; and physical therapists. There may also be other professionals, like counsellors,

psychologists, and a laboratory (it thus entails much more than a GP's office). The rule book regulates the mandatory and voluntary function respectively.

Regarding the provider side of the county council, there are four local care organizations, one for each part of the county. A local care organization comprises both specialist and primary care. The size of the local care organization and the number of care centres belonging to each organization varies. For each local care organization, there is a local care director in charge, and one primary care manager responsible for the care centres in the area. Furthermore, these professionals have had special responsibility for the coordination of care between specialized and primary care, while also driving development in care processes between public and private care providers. The everyday work practice of the local care organization is treated as a 'providers' issue' (recall the business model above) and they answer foremost to management from the County Council Executive Committee, while they sign contracts with the Healthcare Committee. They thus have a dual responsibility towards both purchasers and providers.

There are strong ideas concerning what purchasers and providers do respectively, and why these tasks could not overlap. From the outlook of the administrative office, this poses an interesting tension in how care centres could be handled in practice. In the wake of care choice reform, this tension is a growing concern for rule book designers. In their view – as well as in the logic of the purchaser–provider split – the characters of the two sides must be formalized and clearly outlined. Rhetoric tends to portray such relations as unproblematic. However, there is a tension discernible in the rule book designers' work to sustain the competitive principle of the care choice system. The rule book designers reflect on this practice in a group interview:

Robin:

[O]ur role is ... to help it to be simple and allow for choice of care centre, to have neutral information about how to change care centres. But it is not our task to go out, we must absolutely not go out and say 'this clinic is better than that one', really. However, we put on the website and have info about 'this is how people have thought about certain care centres' when it comes to patient surveys and things like that. Then it is sorted out there in a clear fashion. But you are supposed to draw your own conclusions when you go in there and look at it, which care centre you would like to go to.

[...]

Jeremy:

What we can do is to create a system that feels stable and attractive, like this with competitive neutrality, it could be that it becomes attractive [to open a

business in the county] through the reimbursement system and that kind of stuff.

[...]

Kitty:

... our mission from politics is that, yes, if a care centre, someone gets a lot of enlistments and others lose a lot of enlistments, yes, then it is, it is the citizens' choice. This is a very explicit system for that. Our mission is to be, remain completely neutral in this respect. Except if, in any municipality there is a problem that a care centre cannot handle its mission and there is no other [provider]. Then it will be in a different position. But otherwise it is, we should be neutral and make sure that it is competitively neutral for all healthcare providers, and we contribute to the attractiveness to starting a business here too. That I understand as our mission also. (Interview rule book designers, February 2011)

Being 'neutral' is apparently essential for the rule book designers. There are different ways to sustain that neutrality. One is to give objective information via audit of quality and availability to patients. But there is no justification for going around saying that some care centres are 'better' than others. It is also important to provide for stability and attractiveness for businesses interested in starting care centres. If reimbursement is fair and stability in purchaser management is achieved, there will be fair competition. The care choice system is designed to follow citizen choices, even if it means there will be substantial effect on listings of care centres. Robin and Jeremy, quoted above, claim that purchasers have no right to interfere with the business management of care centres, only to formulate contracts and assess performance according to the contract specification (Kitty however points to an important exception: when there is only one care centre in a municipality; more of this problem in Chapter 7).

When the rule book designers are asked to explain their work and role, they formulate it in a clear fashion. When it comes to some of the practical measures employed in their everyday work, it becomes more complicated. One example was when the Healthcare Committee commissioned the HQ and County Council Chief Executive to draft a guideline for 'business management' for the provider part of the organization. The reason was that after the care choice system had been in effect for a while, there was a felt need from the administrative office to formalize and codify the purchaser and provider roles even further. The office thus formulated a 'positioning document' regarding the county's deeds as provider of primary care in the care choice system. Table 5.1

depicts some of the positions taken in the document, particularly regarding the financial position of public care centres as market actors:

[E]ach county council care centre will account for and carry its own expenses.

Funds could be transferred between public care centres, in case a unit is temporarily unprofitable. This only concerns reimbursement from the care choice system.

'Group contribution' to public care centres that cannot manage their finances is not allowed.

Table 5.1: A selection of policy positions on the county council as provider.

The document positions financial management of public care centres in an interesting fashion. The unity of public care centres as a group is made absolutely clear; they are under the same budget from the county council, yet they must be able to bear their own costs. It is not allowed for the county council to shift budgets between care centres as they wish. However, there is a possibility of transferring funds, as long as the funds come only from the care choice system; that is, from the reimbursement system as spelled out by the rule book. The precise meaning of this statement is that care centres must keep separate the funds they receive, as these might come from several different sources. It builds on keeping the bookkeeping of the care choice system separate from other sources of income. It is not only roles that are kept separate, but also different types of funds.

How come this was an issue, and why did it concern only public care centres? The problem must be interpreted in relation to the care choice system being put in place to be 'competitively neutral'. The conditions in which I learned about this being an issue are very intriguing. The event took place in March 2011 before a so-called follow-up meeting with a private care centre. I met up before the meeting with the rule book designers along with the medical advisor that accompanied them. At the pavement outside the care centre, they started to discuss one question that had caught the attention of the care centre manager whom they were about to visit. Apparently, he suspected that the public care centres were exchanging funds, he calls it 'illegitimate financial group contributions', among themselves, which according to him was not allowed in the 'rules of the game'. They were worried that this would become a

major issue at the meeting, taking valuable time from discussing the assessment of the performance of the care centre.

After a while, after the follow-up meeting had centred on some of the quality indicators, the care centre manager presented the rule book designers with a paper that was said to illustrate the public care centres' illegitimate action. There was a sheet of paper indicating items of public care centres' bookkeeping, purportedly showing how funds had been transferred between them. The care centre manager was upset, complaining that care centres doing badly were not punished by the reimbursement system. He said: 'When the numbers look like this the care choice reform is put out of play!' The rule book designers and the medical advisor claimed that they knew nothing about this (which in fact they did) and state to the manager that he must acknowledge the difference between 'purchasers and providers'; this is a providers' issue. The manager replied: 'But we have no one else to talk to!'

Incoherencies, vagueness, and ambiguity in roles and funding pose problems for purchaser management in a care choice system. And when different actors feel there is illegitimate and/or unjust behaviour, it often crosses the rule book designers' table. This theme arose as a major challenge in their work. The theme is intensified in relation to the big challenge: what to put in the rule book and what not to put in. And there might be different reasons for putting something in the rule book (or not). One of the rule book designers explains:

Things are not so easy, that you could think that you could break out primary care as a small thing of its own, which previously has been integrated in pretty much every other activity. And then you should take in the private actors too. And you should treat everyone exactly the same. But you cannot anticipate everything that will happen, and above all not predict how current county council business will react, when one has been accustomed to quick turn-around and say 'no, let's do it like this instead'. So you cannot manage private actors, but they must have time to make adjustments and things like that. And it must be competitively neutral and apply to all equally. That's really the big, major difficulty for the future. (Robin: Interview rule book designers, February 2011)

The informant describes a world in which competitive neutrality is held to be highly valuable. It is intrinsically related to the idea that everybody should be treated equally; private contractors too. It calls for specific roles and relations. The informant furthermore firmly acknowledges that this is not to be achieved by the accustomed means of governing public care centres. Even in the face of

the difficulty of anticipating the unfolding of events, primary care has to become governed by rules in contracts. In short, 'competitive neutrality' is held as a new valuable end requiring new means and the path is challenging, 'a major difficulty'.

According to rule book designers, competitive neutrality is a key imperative for the care choice system. With this imperative comes the idea that all contractors must be treated in the same way, which is easier said than done in relation to the practical activities performed in primary care (even more of this in Chapter 7). At the same time, care choice reform is very much *primary care* reform. It reaches deep into the county council organization with its reforming tentacles, as it singles out primary care as subject to marketization, while other caring activities are not. The rule book designers furthermore testify that some types of care are more difficult than others to single out and put in a rule book. One of the toughest examples is perhaps found in the boundary between the responsibilities of primary and specialist care respectively. As the care choice reform was put into effect, new and old issues started to surface regarding such boundary problems. One informant explains:

[I]t became the very obvious as care choice was introduced that these kinds of vague boundaries between specialist care and primary care, which had been such 'gibberish' questions for many years, became even more important to solve. [...] That was no good anymore in a care choice system, which would be competitively neutral and have equal conditions for all. So, it brought many issues to the table that needed to be resolved. No new issues really, but it became even more pressing to get them solved. (Kitty: Interview rule book designers, February 2011)

The importance of the dynamic between integration, separation, and disentanglement regarding roles, funds, and rules illustrates that primary care marketization is a multifaceted and complicated activity. Not least, a multitude of different values must be accounted for, some of which are considered to be more imperative than others. The informant acknowledges that many issues are not new; but they have moved into a more acute state because of the care choice reform.

The advent of the care choice system

The main lesson from the previous section was that the care choice system makes vagueness problematic; not least at the borders of primary and specialist

care, and at the border of purchaser and provider management. Vagueness in terms of roles, reimbursement, and rules is a prevailing theme for conflict and questioning of the care choice system at large, and for rule book design in particular. Taking a brief leap back in time serves to deepen our understanding of these tensions.

As I entered the county council office, the care choice reform had been in effect for some time. My first encounter with the rule book designers was in late 2010; the start of care choice in the county council was in 2009. When I talked to the rule book designers about the reform process, I was told the idea of a care choice system had long been prevalent among politicians in the county studied. Besides, market reforms are not new. The purchaser–provider split has long been used, and ever since 1992, care centres in the county have been financially reimbursed through performance measures related to quality in care.

But it was not until the mid-2000s that the idea that patients should be granted the right to choose their own care provider gained leverage in the county council's political landscape. In 2006 the political majority started a process for allowing primary care patients to choose which care centre to enlist with. Among other things, the county council politicians looked with great interest at other county councils that had just launched their care choice system in primary care. So, quite early on, before national government decided that from January 2010 care choice should be mandatory in primary care, politicians in the county council nurtured a strong interest in the idea of free choice of care provider in primary care.

However, it remained to be decided how to move the process forward in practice. The Healthcare Committee thus did what bureaucracies often do; they assigned a task force. This time, the aim of the task force was to analyse and assess requirements and conditions for implementing a primary care reform with care choice focus. Some of my main informants were involved in this task force, or in related groups that also had a say in the matter. When I asked informants who was around at the time to describe the process to me, they – albeit with a few years in retrospect – told me the process towards the new care choice model was 'smooth', and really nothing out of the ordinary (although, as far as my experience with interviewing bureaucrats go, this is a quite common response). Anyway, they claimed that the effect of starting the reform process before it became a hot topic for national policymaking was that the transition to the care choice system was smoother than they would have expected.

One early approach in the work for care choice reform was to make an inventory of 'opportunities for development' in primary care. The officials assigned to make the inventory sensed that the politicians and administrative managers expressed discontent with 'development and innovativeness' in primary care. In this case, 'development' thus has something to do with the promise of improvement, but also with the desirability for new directions in caring activities. In practice, this led to the officials (eventually to become rule book designers) performing a round of interviews and creating focus groups with medical professionals at care centres. I was told furthermore that the results from these interviews were to play a significant role later on. Many of the issues that came up – in the words of a rule book designer, some were of the 'gibberish' sort – led to 'specifications' for what 'issues' had to be handled. The reason for this was that it helped identify issues that were potentially difficult to handle in purchaser management, or issues regarding boundaries and roles, funding, or rules that had been not dealt with for years.

The task force also set up a couple of grand discussion meetings for medical professionals and other personnel in the county. Between these meetings, working groups consisting of primary care personnel and staff from the office were assigned to solve different problems and issues that came up from the big meetings and the inventory. Explains one of my informants (by then a rule book designer-to-be) regarding the process:

[I]t was also quite clear that some of the questions that went to the working groups, it was critical problems, while they were things that the politicians did not care so much about, so they got quite a lot of space to influence there. (Jeremy: Interview rule book designers, February 2011)

In the administrators' view, there are thus 'critical problems' with reforming primary care, problems that the politicians are not necessarily interested in handling. In the handling of such 'critical problems' (some of which are dealt with in Chapter 7 and 8) the negotiations between professionals were pivotal input for the reform. At the same time, politicians were interested in other issues:

And then there were the other things that the politicians, after lengthy discussions, had just decided. And they were so determined that you could say it outright: 'that is already political, it's no use to even discuss it'. And that was quite a distinction perhaps, so to say, that was pretty honest with what they could affect and what was not possible to affect, I think. (Jeremy: Interview rule book designers, February 2011)

An issue settled as 'already political' means that politicians have already taken a decision on particular principals and aims. The purchaser officials thus moved into the process emphasizing before the care professionals that the politicians of the Assembly and the Healthcare Committee had decided on some imperative principles from the beginning. The most important of these principles are codified in decisions and protocols from the Assembly protocol from mid-2008 (outlined in Table 5.2):

Strengthen citizens' status as patients through free choice of care centre.

Secure free choice by factual and accessible information for all, and ensure the free choice principle: i.e. the care provider must accept all who wish to enlist.

Give opportunity to all of the caring activities to develop working arrangements that facilitate citizens' choices, such as flexible opening hours.

The patient should experience a coherent caring process with all involved actors.

Special consideration must be given to care needs of underprivileged patients.

Ensure quality of care through an authorization process in which the healthcare providers have the opportunity to develop their activities over a certain first level of quality.

Obtain increased patient needs alignment, with a possibility of care centre specialization.

Ensure a balanced access to care through the county council (to the extent that legal grounds exist for this) controlling the geographic areas where start-ups of care centres take place.

Ensure that health promotion and disease prevention take place at the individual level and that strategic public health activities take place at an aggregate level in cooperation with other local actors.

Table 5.2: Policy aims of the care choice system in 2008.

The aims express the care choice reform in a nutshell; several of the principals are recognized from the legislation, at the same time as they have been given a distinctly local flavour. The aims range from patient encounters, procedures, priorities, rights, and duties, and express both abstract values and operationalized measures; all of which care centres were to accept as they were,

as politicians had expressed them. Some further ambitions expressed in the Assembly protocol are that care is to be 'centred around the patient', expressing 'availability, equality, and health promotion' as overarching targets of reform.

Taken together, the aims express strong ideas of what values should be promoted and realized in the care choice system. At the same time, it is clear that the work towards these aims is filled with considerations, judgment, and exercise of expertise of different kinds. It purportedly calls for detailed regulations and carefully written rules. Furthermore, patients and their choices are visible in several of the aims, but in different ways. In one way, the aims enact the choice of patients as a goal in itself. The patient is supposed to be an able consumer of care, capable of making choices, if only the right conditions regarding 'information' are met. At the same time, patients are expressed as a responsibility of care centres, as agents needing consideration and care, especially if they are 'underprivileged'. It is also worthwhile to notice that many of the aims are activities. Interestingly, there is also a goal to control the area where start-ups are opened 'to the extent that legal grounds exist' for it. My informants claim that this is not possible at all according to care choice legislation (though they have the power to construct the rule book otherwise to 'control' in other ways, see Chapter 7).

Patients have an unconditional right to choose a care centre as many times as they wish. It is thus a very particular form of choice; again, one that follows the intention of the legislation. Regarding competitive neutrality, which is emphasized as the vital hallmark of quasi-markets, this is not mentioned in the policy aims. However, in talking to the rule book designers, they testify that competitive neutrality is so important to the care choice system that it is essentially a goal too. The rule book designers also explained to me that free choice and competition in the care choice system leads to quality development and accomplishment of the policy aims:

[A]s we believe re-listing drives the development, we want people to list at the best care providers ... Changed listing is not good in itself, unless it has brought more patient-focused care, and all of the overall objectives we have with primary care. That is what matters, not people swapping places with each other. (Jeremy: Interview rule book designers, May 2011)

Hence, in talking to the rule book designers and reading the policy aims, free choice as well as quality are emphasized as goals. At the same time, patients'

choices are means to realize competition. Hence, they think that 'swapping places' should not be viewed as a success in itself.

Somewhere around the time of the grand meetings, it was decided that the outcome from the efforts of the task force would be an authorization document, or a 'rule book for care centres'. Following the narrative by rule book designers, the decision to produce a rule book, or authorization document, seems to have grown from county councils who were pioneers in the establishment of care choice systems, that is, before national government implemented the legislation.⁵⁹

At the time, there was also work going on in the county with contracting a private care centre in one of the major cities. And for that purpose, a specification document and a contract of service had been put together. In relation to the idea of authorization for the care choice system, the specification for the procurement served as a pilot and something to work from in making the rule book. Eventually, many of the formulations and ideas from the specification document were translated to the rule book. There is however a big step between contracting a specific care centre in a particular procurement process, to making the contract same for all providers. I have this explained to me by one of the task force members:

Linus JK: What was the goal for making this authorization document?

Molly:

It was simply that, to establish some sort of basic level of what was required, yes, as a kind of drivers' licence one can say, for what it takes to run a care centre. And then that it would somehow be some sort of engine that would drive improvement in the areas you were not so strong in. And in this way you could also make some comparisons with other care centres as well. And it was inspired also, I think, from these open comparisons that came a few years earlier as well, to somehow grade and compare themselves with one another. (Molly: Interview rule book designer, March 2011)

In retrospect, this informant thus expresses that is was a 'simple' rationale, to make sure that care centres were able to drive safely. It was expected that the document would be able to spur improvement, as what is expected from care centres would be more codified, and would allow comparison between them. He also mentions the open comparisons, which is an initiative from SALAR to set

⁵⁹ This claim is also supported by Anell (2009) and Forsell and Norén (2013).

up databases for comparing output in health care (such databases are intended for county council and municipal management to compare the output in various welfare sectors).

The informant here is painting a picture of primary care as a manageable activity. This manageability is characterized by several capabilities with management: that it is possible to establish a basic level of quality; that county council management could be modelled as an engine; and that outcomes are comparable. Our conversation continued:

 $Linus \ JK: \qquad Would \ it \ be \ some \ type \ of \ public \ procurement \ then, \ with \ care \ centres \ \dots \ How$

would the authorization process be done?

Molly: No, well, at that time, then there was ... There was a number of private care

centres already then that were procured. Then, well, then there were the public ones ... But ... No, there was like, no idea behind this, some kind of market making in the same way. But it was more about that it would be some sort of

quality level, simply. [...]

Linus JK: So, the authorization would be a kind of document that all care centres in the

county would agree that this is the minimum level?

Molly: Yes.

Linus JK: Ok, and if new players came, they would also live up to this level?

Molly: Yes, exactly. And this principle applies even in the care choice system today.

(Molly: Interview rule book designer, March 2011)

Intriguing couplings between qualities, benchmarking, and authorization emerge as a key justification for reform. From the above excerpt we learn that quality is expressed as prominent value, and that authorization is an important procedure as it enables quality assurance at minimum level. Benchmarking is a pivotal justification.⁶⁰ The informant furthermore describes that initially 'quality' was *not* directly connected to the idea of market making.⁶¹ Though, by the same vein, the informant articulates that the move from discussions on authorization and quality translated easily to the marketization efforts of the care choice

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 $^{^{60}}$ The attentive reader catches that the words 'authorization', 'quality', 'players', and 'minimum level' come from my own questions rather than the answers, while the informant affirms those interpretations. This is an effect of my having spent some time with the rule book designers, as I have to some extent started to master the care choice lingo.

⁶¹ Again, my impression is that the informant partly uses the term 'market' to satisfy my eager interest in the 'marketization process of primary care'.

system. It is also interesting that the link between authorization and the principle of care choice had by now become self-evident for the informant.

As the national government released the white papers on care choice in 2008, the county council began reconsidering their plans for primary care reform (although far from all county councils were in the process of reform; some opted for care choice reform only under the force of legislation from the government). Besides an authorization document, the legislation stipulates the need for an invitation for procurement, which is also to function as contract. As the rule book designers explained to me, this was probably due to the fact that several county councils had already worked with the idea of authorization documents. Because of this fit, most work that had already been done in assembling the authorization document could be reused in the spirit of the new legislation. Hence, both in spirit and in practical consequences, the county council already worked much according to the principle of the national government's intentions; which in due turn depended on the sentiment of current reform in several county councils.

Again, the result was that a particular task force at the administrative office started working specifically to establish a model for the care choice system according to the intentions of national government. In interviews with the officials of the task force, I was told that they worked closely together, and with a practical and pragmatic approach. It seems that the political leadership was interested in launching the care choice system rather more rapidly than is usual with respect to 'the spinner', which affected the working process of the group. They also testify that in an ideal type of formal bureaucratic order, one group performs needs analysis and another is assigned to implement the decision. In this case, the group members describe how they started the work with implementation before the decision was taken; to gain speed and exploit the momentum they had worked up throughout the ongoing process of authorization. It was thus perceived to be valuable to put the reform into place quickly.

The decision to proceed rather rapidly with the care choice system was thus largely moving along with the *zeitgeist* of the national government and other influential county councils. The operational approach worked up by the rule book designers was much influenced by what was happening in other county councils. Besides political influence, the administration's operational units were also in close contact with colleagues from other county councils, forming a

network of purchaser officials at SALAR. A sign of this is that there was quite an explicit idea from the beginning to have a particular county – county 'x' – as its main source of inspiration, especially in comparison to some other models of care choice. The reason, informants tell me, is that county 'x' and the studied county were 'much more alike' to begin with.

Apart from the legislation, inspiration and momentum were thus important. Another key factor in building the care choice system was for the reform to reflect the tradition of primary care provision in the county. As the informants tell it, they felt a need to emphasize and take care of the 'unique features' of current experiences from primary care in the county. The main emphasis was on not breaking up the relatively large care centres, with several different professions gathered in one facility. And this puts special demands on the reform efforts, claims one informant:

Well, it's all about writing the premises [of the rule book] based on the traditions that exist; that you want to keep this particular primary care organization that you already have. (Molly: Interview rule book designer, March 2011)

Being sensitive to tradition is expressed as vital to the reform efforts. There was something distinctly local and 'traditional', which was to be nurtured in the care choice reform. The making of the 'inventory' and interviews were also part of this effort. This is interesting in the light of the intentions of the reform; there are some problems in terms of possibilities of entering the market with this idea. The informant continues to explain the idea with tradition:

Molly:

This requires also, of course, a lot from the actors who want to enter the market, of course, because the requirement is to have all of this. It takes incredibly large investment, and it will be, of course, that not just anyone can go into such a market. It takes that you have some equity in the background. Unlike in [a larger county] where there are much smaller units, which are like GPs' offices. And it doesn't take, of course, not as much investments from, from the providers. Which means you get a different dynamic ... So, really, you can maybe think, from a market perspective then, so one might think it should be the other way around, that it was larger units [in the larger county], which is obviously a larger market, while other parts of the country would have a GP model that requires a little less investment. But it is not market aspects that are decisive, but rather traditions that are decisive. [...]

Linus JK: So tradition is more decisive than any sort of market theory then?

Molly: Yes, that I would certainly argue. (Molly: Interview rule book designer, March 2011)

Tradition is vital, but theoretical ideas about markets are clearly present in the picture. This informant seems to be rather versed in mainstream theories on marketization of health care service. She expresses concern that there might be too high barriers for entry at the market, which hampers the 'dynamic' of the market. She thus paints an interesting tension between market theory and the idea to nurture tradition. The interview continues on the theme of market tensions:

Linus JK: But you call it a 'market' today? When did you start doing that, or when did

you start thinking in those terms?

Molly: I would say that it was probably in the beginning, when, with this care choice

white paper it came, both locally in counties and also at national level. Because there was some kind of intention to actually create a market. (Molly: Interview

rule book designer, March 2011)

In the perception of the informant, the intention from government made it more clear that the care choice reform was forwarded with the idea of a market in mind. But she expresses doubt about the intention, and continues:

Molly: Then, well, I personally doubt if it at all works to create a market; at least not in

the same sense as for other types of goods and services.

Linus JK: Explain please...

Molly: Well, there is, there is so much uncertainty in health care markets. You, like,

don't choose to get sick. You might decide to buy something ... And besides, it's not that ... And the need for health care depends on other factors than ... So, what we have learned, if you go back in history, is that the more health care offered, the greater the need for health care, as there is the opportunity to do more things, so ... The question is, like, what is it that determines 'need'? It's usually not really the market forces that govern any kind of need of things, but there are other aspects that are decisive. And then there is this issue with asymmetrical information, e.g. that doctors often know more than the patient

does. (Molly: Interview rule book designer, March 2011)

Tradition is important, but there is a tension between the competing perceptions of reform, that there should be a certain 'dynamic'. On one hand, the informant is very articulate on the importance of tradition. On the other hand, she advances complex theoretical ideas about health care markets. In those ideas, we learn that the provision of health care it not like any good, because of

'uncertainty' and 'asymmetrical information', which are recognizable from economic perceptions of healthcare markets. These theoretical ideas were not new to the county – as market reforms had been enacted before in the form of the purchaser–provider split and public procurement – but the idea of care choice reform as a market started to flourish in the county council around the time of the white papers.

Taken together, the care choice system has a history with influences from different places and ideas. Market reforms are not new to the county council, but events in the policy landscape and elsewhere allowed the idea of care choice to grow steadily stronger. An authorization document – the rule book for care centres – became a central device for realizing the reform. The specifications of the first rule book drew on multiple sources for influence. Officials reviewed current primary care conventions and contracts in the county, and made an inventory of common denominators and areas for improvement. The idea that specifications of the rule book should be based on the prevailing 'tradition' of primary care in the county was worked out in the county council administration together with primary care professionals. At the same time, the rule book designers express knowledge in health economy and market theory. There are ideas that the rule book must be as general as possible, to attract new market actors, for example.

So, as described by the rule book designers, suggestions from the task force of officials in the initial planning phase for the care choice system were assigned great importance for the content of the first rule book. Significant for the officials' descriptions of the process is that their accounts sometimes provide for a very clear picture of how it all happened, and sometimes it is very ambivalent (i.e., they had their task force, and everything was done according to procedure, while at the same time the process was open-ended and handled 'gibberish' issues). When I propose this interpretation to the informants, one of them tries to explain:

If one drew a process map about how it happened, or how to say, it would have extremely many branches, for it is hardly possible to link what was decided when. For as that work was going on, you were forced to start writing the document itself, the actual rule book ... (Jeremy: Interview rule book designers, February 2011)

The terminology of 'bureaucratese' does not suffice for the informants to describe the process. However, even though the path towards the rule book

seems to have been rather meandered at times, the determination on behalf of county council politicians was evident. In December 2008 the Healthcare Committee decided upon the suggested rule book and conditions for the care choice system. The care choice system was launched on 1 September 2009.

If we take a leap forward in time here, the outcome from the reform has turned out to be ambivalent, and there are some unforeseen consequences. As of September 2014, the county council HQ is diagnosing the current state of the care choice reform in discussions at a so-called Primary Care Forum. A selection of the challenges is:

- Citizens do not have equal access/proximity to well-functioning care centres. There are more care centres in the cities, and care centres in the rural areas are struggling to stay in business. There have been no start-ups of private care centres in smaller communities.
- The yearly audit shows that there are significant differences in quality and safety for patients despite the rule book.
- Patients in the county are less satisfied with their care centres compared to the national average.
- Very soon there will be a serious shortage of permanently employed specialist doctors. This problem is particularly salient in rural care centres, which are already strained financially from hiring temporary personnel.
- Research in the first line is underused. Not enough research is conducted in primary care, and it is difficult for care centres to collaborate with each other and specialist care to put this research in place.
- An overall attractive vision for primary care is missing. This is perceived as a problem in the light of directions for improvement. (Primary Care Forum protocol 2014)

According to the rule book designers, how many of these challenges are due to care choice reform could be in dispute, while it is contested whether all of these apply to all care centres equally. It is furthermore disputed which aims and values have actually been promoted by reform. Anyhow, it opens an avenue of enquiry in which to take into account the work directed at dealing with such issues. For the purpose of this thesis, it stresses the reason to dig deeper into the practical deeds involved in managing the care choice system.

Conclusion: Care choice management as a site for valuation

The chapter presents the county council organization and its efforts to order and manage care choice reform. First, it presents the balanced scorecard and the Strategic Plan, and the three-year budget as a stylized image of the county council organizational model and practices in the everyday affairs at the HQ. The image of the organizational structure portrays clearly defined functions, which builds up the self-image and division of work at the county council office. The legislation of the Local Government Act and the Health Care Act are presented as systems for how priorities are to be made, how responsibilities are distributed, and how disputes are to be resolved. A vital principle of the organizational model is that there should be a purchaser–provider split, meaning that the county council organization will pursue two different roles.

The county council employs various market-making activities and tools; but the framing of the role and function of tools differs. Only certain forms of ordering seem to pass as 'marketization', of which the purchaser–provider split seems to be vital. There is also a difference in how the tools enact values, for example between the balanced scorecard and the rule book. They are perceived as pushing different types of organizational relations. The balanced scorecard assumes that there are 'perspectives', which are to be covered and pursued in all county council activities. The rule book assumes that there are actors pursuing different goals in their different roles, like the makers of the rule book (purchasers), care centres (providers), and (choice) patients.

Second, the chapter presents how the care choice reform was initiated, developed, and put in place. Choice in primary care has long been an intention of county council politicians, and the preparatory work for care choice reform was started in 2006. The purchaser officials worked with investigating the possibilities for 'innovation', while also protecting the 'tradition' of primary care in the county. They furthermore suggested that a 'rule book' for care centres would be a suitable tool for granting a minimum level of quality of care. The process brought to the fore some issues that had previously been ignored by purchaser management, for example regarding the borders between primary care and specialist care.

In so doing, the chapter presents some of the prevailing challenges purchaser officials face with regard to care choice reform. The rule book designers strive to make primary care manageable within a care choice system; it is easier said than done to keep roles separate in practice. This shows that care choice reform brings vagueness in terms of roles and funding very acutely to the fore. It calls for efforts in establishing and maintaining separation between different categories, such as 'politics' and 'administration'. On top of that, prevailing traditions and input from primary care professionals potentially exist in tension with the imperatives of free choice and competitive neutrality together with the growing intention to create a primary care market.

The prevailing challenge for purchasers is to develop primary care into a better-defined object of governance. Importantly, this struggle opens up a space for analysing care choice reform in terms of enactment of value. For the argument to carry through the thesis it is important for the reader to become acquainted with and bear in mind the central functions, roles, and procedures of the county council presented in the current chapter, as well as the prevailing tensions and challenges. The following chapters take on the task of digging into the rule book as a device (Chapter 6); the work of rule book designers (Chapter 7); and the making of incentives management (Chapter 8) respectively. More precisely, they each paint a picture of the values at stake in the landscape of care choice reform, and how the handling of values involves diverse methods of valuation.

Chapter 6

Marketization by the (Rule) Book

Chapter 5 introduced the county council organization and presented how the care choice system was put in place. Among several important aspects of care choice reform, the 'rule book' for care centres plays a key role. The rule book represents an ambitious attempt to assemble nearly all purchaser regulation for primary care providers within one document. It does not cover everything a care centre must adhere to in terms of rules and policies, but as a key regulatory document, it is the most comprehensive contract specification ever used for primary care in the county. And above all, the rule book is the first contract specification to look the same for all care centres in the county.

This chapter takes a detailed look at the rule book itself. The rule book makes tangible many of the abstract notions and values involved in care choice reform. The chapter shows how the rule book organizes the care choice system inasmuch as it establishes the rules of conduct and relations between relevant subjects and objects. Looking at the rule book is a way of spotting values, while analysis of the appearance of the rule book serves to bring the materiality of valuation centre stage. This takes seriously the idea that the rule book is a powerful device in enacting the care choice system *as* a market. Because of this, the rule book is a site for productive investigation of values and valuation.

The chapter furthermore presents the reimbursement system, which calls to attention interesting aspects in terms of valuation. Upon closer scrutiny, it shows that there are many different principles for reimbursement at play, and they relate in diverse ways to different values. It illustrates ways in which caring activities are framed and rendered as economic, rather than given as such. Money is not the sole denominator of value in such statements, but is intricately related to caring activities and other aspects of primary care. Therefore, even

though the reimbursement system is only one of several aspects of the rule book, it is worth taking a closer look at it. It provides for developing knowledge about the valuations that underpin the making of the care choice system. It is also a good case for developing insights about the practices of establishing economic motivation, compliance, and accountability in a care choice system.

Taking a closer look at the rule book

The rationale of the care choice system

The rule book begins with a declaration:

[The care choice system] aims to strengthen citizens' status as patients by free choice of care centre and an individually balanced voucher that follows the individual's choice. Citizen choice shall be secured by objective and easily accessible information, available to all. The aim of [the care choice system] is increased quality and availability in primary care through competition where care centres are free to develop within the framework of the mission to best meet patients' needs.

For patients/citizens the selected care centre will create security and be perceived as the natural first choice when in need of care. The care centre will provide advice and assistance to citizens on how they can maintain and improve their health. Contact with the care centre is characterized by great flexibility. Citizens will be well received and able to influence their treatment. To create a sense of security, patients/citizens must feel assured that assessment, treatment and advice is safe and of good quality, that the care centre maintains high continuity and takes responsibility for patients' care pathways, which comprise information on options of treatment, care guarantees, etc. Primary care practices will be characterized by cohesive care processes, which require deepened and broadened cooperation between care providers with different organizational affiliation and other concerned societal parties.

[The care choice system] means that primary care financed by the county council is operated by authorized care centres, public as well as private. For the supplier to provide care in [the care choice system] it has to be approved by the county council, that is, an authorized care centre. The authorization provides basic quality assurance and levels the playing field while allowing for a plurality of suppliers. The authorization requires the care centre to undertake the mission as formulated in [the rule book]. Pertinent priorities in the care choice system are health promotion and disease prevention, and cohesive care processes; and that special consideration is paid to the needs of underprivileged patients. (Rule book for the care choice system in primary care, 2013)

This passage sums up rather well the ambitions of the care choice system. The status of patients is held to be of prime importance to the reform; on one hand they are capable, choosing individuals seeking information, on the other hand they have needs and might be underprivileged. The list of values enacted by the

text is comprehensive: free choice, competition, quality, availability, security, flexibility, influence, safety, continuity, responsibility, cohesiveness, cooperation, health promotion, disease prevention, and consideration for underprivileged. Primary care seems to be a site where many values come to the fore, and this list provides a glimpse of the vistas of value where the rule book plays out (and serves to establish).

Regarding 'free choice', it is placed in a rather ambivalent position, as it is listed both as an abstract value and as a practical mechanism for competition. It is a value, as the rule book states that the care choice system 'aims to strengthen citizens' status as patients by free choice of care centre'. The intention is that patients should choose one care centre and remain with it over time, and not choose a new one every time s/he is in need of care. The patient is enacted as capable of making informed choices, that is, choices based on readily available and objective information. 'Choice' cannot be understood only as a means, given how the rule book brings it to the fore in this way.

As for competition, it has a dual character. It is a value, as it is expressed as a bottom-line rationale for the care choice system. And it is also a means, as the declaration frames the economic agency of care providers and enacts care providers as market actors who pursue economic interests by competing for patients, which will increase quality. 'Competitive neutrality' means all eligible care providers have the same right to open care centres and compete for patients in accordance with the specifications and regulations of the rule book. The rules for running care centres should be exactly the same for all providers, and are supposed to 'level the playing field', regardless of ownership. Thereby, the rule book frames primary care as a competitively 'fair' market and is set to control the behaviour of care providers.

It is also stated that the models' goals are to achieve high quality and availability. The road towards these goals is to be guided by the principles of free choice and competitive neutrality, as spelled out above. While the activities of free choice and competition are exercised as activities, the values of quality and availability will be strived for. By relating the values of free choice and competitive neutrality in the above manner, the rule book enacts a particular version of 'market force', which resembles the 'invisible hand' that Le Grand (2007) asks for.

The composition of the rule book

The rule book has continued to expand for each new version (so far one for each year, starting in 2009). The 2014 version consists of 51 pages. The bulk of the rule book consists of more or less detailed accounts of what has to be performed in order to be an authorized actor in the care choice system.

Taking the categories and headings of the 2013 version, the rule book is divided into nine sections plus a general introduction. The nine subsections of the rule book are in due order: (1) Primary care operations: this part codifies the obligations particular to primary care. It consists of concept definitions, what qualifies a patient, what are the demands in terms of availability, what activities are included in primary care, and what is demanded in staffing, cooperation, and joint development efforts on behalf of care centres; (2) General conditions of health care: this establishes the conditions to which all care providers in the county must adhere. It concerns issues such as adhering to evidence-based guidelines, caring for patient safety, and environmental concerns; (3) Auditing: stipulates that care providers' business will be monitored and audited in the form of a 'quality report' and in follow-up meetings; (4) Reimbursement: outlines and explains the reimbursement system and rules for invoicing; (5) Information and communication technology (ICT): the section on ICT is detailed and comprehensive in stating the demands for certain technical solutions and software to be used in, for example, medical records and online services; (6) General conditions: stipulates what can and cannot be done within the contract and what happens in case of conflict or termination of contract; (7) Enlistment: collects the rules for enlistment and the obligations for care centres in relation to these; (8) Authorization: describes the authorization process and what is required from the provider before starting a care centre; (9) Contract: this is the actual contract signed by the parties concerned.

The rule book advances a broad range of criteria, for example rules for staffing, opening hours, referral, and more. The wording of the rule book is heavily based on 'shall-propositions', not uncommon within the field of contract specifications. Here is an example of how it can look, picked from a typical page of the 2013 rule book:

Disease prevention

The Contractor **shall** actively work with living conditions as an integral part of investigation and treatment, as well as to take preventive measures. The Contractor

shall give advice and support for change. The Contractor **shall** pay particular attention to individuals and groups at increased risk of developing health problems.

Chronically ill

The Contractor **shall** take a particular responsibility for identifying, treating and doing follow-up of individuals with chronic disease. In particular, attention **shall** be given where there is a known problem with under-diagnosed chronic disease. The Contractor **shall** provide the patient with individually adapted information about the disease, treatment, medications, rehabilitation, and support patient self-care. (The rule book for care centres 2013; emphasis in the original)

However, there are a multitude of different expressions used, ranging from expressing a 'spirit' in very general terms, to a detailed description of, for example, computer software that must be used. An expression in terms of 'spirit' is for example: 'The provider **shall** work for the good and equitable health of the population through a health promotion approach', while an example of a detailed account is: 'The provider **shall** use My Health Care Contacts' (The rule book for care centres 2014; emphasis in the original).

Most of the pages of the rule book are devoted to stating rules of proper conduct. In doing this, it could be said to establish the relevant objects of the care choice system, while enacting the agency of the market subjects and their relations between each other. It stabilizes objects by stating the tools to be used – for example computer software, clinical records, labs, registries, e-services, and so on – and the subjects by pointing out the relevant market actors; that is, mainly the county council as principal, care centres as providers, and patients as choosers. Ultimately, the rule book states that there is a risk of losing an authorization. It states that the Healthcare Committee 'may retract the authorization of providers that violate the requirements stated in the rule book and do not make corrections within 30 days from written notice from the County Council.'

The reimbursement scheme

The so-called 'reimbursement system' lies at the heart of the rule book, both in terms of rhetoric and page number. 63 The reimbursement system is a scheme of

⁶² My Health Care Contacts is an online e-service that allows patients to request, cancel, or reschedule appointments, or refill prescriptions, and more. It is offered in all counties.

⁶³ As we saw above, it is only one section among many of sections in the rule book. It has however been given considerable attention in previous research (Anell, 2010; Anell &

prices and payment of services set up by the purchasing authority. Much like other parts of the rule book, the section on the reimbursement system is dense, complex, and speaks to a multitude of different principles. In one sense, the section on the reimbursement system is typical of the rule book; it states what rules apply to care centres and what conditions must be met for reimbursement to happen. However, there are more tables, figures, and numbers than words in comparison to other sections of the rule book. What singles it out is its focus on money. However, it is not money *per se*, but money in relation to different activities pursued in primary care.

It is not declared in the rule book, but one aspect of reimbursement worth mentioning is that there should be no 'free' services for care centres. The rule book designers told me that this is a solution for coming to grips with the 'unfairness' caused by the rule book. Since the rule book puts up so many criteria of how to employ certain resources belonging to the county council, for example regarding ICT, all care providers must have the same access to these. And the way to manage this is to grant everybody the same access via contract specifications. This basically means that all services, favours, and goods appearing in the care choice system should come with a price tag on them. Everything must come under the reign of the contract regime – including stuff that used to be free of charge for many care centres, for example access to labs and R&D.

From capitation ...

Table 6.1 depicts a condensed model of the reimbursement system from 2013. In an attempt to make sense of the system, I have boiled down the different principles at play to provide for more contrast; meaning I have put them together in Table 6.1. The items I have listed are the only ones that specifically attract reimbursement; all other activities undertaken by care centre are to be covered by these items.

Paulsson, 2010). The current thesis furthermore has good reason to look at it as a very composite construction in terms of values.

Basic payment	Variable payment	Capitation payment	Special payment
Base Dependent on number of listed patients. If more than one care centre in a community, no payment.	Coverage Payment for each patient up to coverage of 56% of listed patients.	Listed patients Payment per patient adjusted for age.	Patient fees
			Government grants
	'Infidelity' visits Payment for visits from unlisted patients. Deduction if listed patients go to other caregiver.		Development grants
Socio-economic Areas with lowest 10% of disposable income receive payment per listed patient.			Asylum seekers
	Pay-per-performance Variable, but in 2013: Diagnosis registration Health promotion Registration in clinical registries	Medicine Individual weights according to age and gender on both common drugs and focus drugs.	Patients from other county councils and foreign citizens
Geography For patients over the age of 75 living 11–25 or >25 km from care centre.			Interpreters
	Treatment pressure DDD (defined daily dose): minimum level and comparison to county average.		Education and internship
			Communicable disease control

Table 6.1: The reimbursement system 2013 (adaption by author).

Reimbursement to care centres follows a multitude of different rationales. Having put the different principles of reimbursement beside each other, it is worth noticing that payment depends on such different principles as the number of listings, the location of the care centre, how well patients fare in terms of socio-economic status, how much medication is prescribed, and how well care centres perform in promoting health. In this sense, the reimbursement scheme enacts particular versions of value and relations between values. The different posts and statements in the scheme are used as proxies to reflect beliefs about what is valuable in primary care. At the same time, Table 6.1 illustrates how the valuables are related to monetary values. The reimbursement scheme is thus a very practical expression of how particular items are made calculable and economic, which is key to how the relations in the care choice system could become more market-like.

From the start of the care choice system and up until 2013, the main rationale for reimbursement was 'capitation', i.e. to reimburse on the basis of enlisted patients at each care centre. The payment is fixed in relation to the age and gender of each patient and does not depend on treatment or other caring activities. The rule book for 2013 states that the county council has deliberately chosen to use capitation as the main rationale for reimbursement: 'Reimbursement for listed persons is a balanced individual-based compensation to promote comprehensiveness and responsibility.' The principle of capitation is thus claimed to be conducive to the values of comprehensiveness and responsibility.⁶⁴

As for capitation and medication, there is an important distinction between common drugs and focus drugs. The division is essentially based on the cost of the drug and whether it is usually prescribed in primary care or special care. A Drug Committee at the county council office decides on the division of what counts as common and focus drugs respectively. The basic principle is that care centres bear the costs for prescriptions of common drugs to their listed patients (even if another care provider actions the actual prescription), and also that they bear the costs for ordered medication. The rule book is also very clear that all care centres are obliged to accept that they are to pay their share of the distribution costs of drugs, while also enjoying the discounts the county council negotiates with drug providers.

There is an appendix to the rule book that contains the actual numbers for each year. The numbers in the appendix are very precise and serve to establish the values of patients in terms of weights meticulously calculated for reimbursement. For 2013, a capitation of weight 1.0 yielded SEK 1113; the year

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⁶⁴ Capitation is an old construct, already present in the NHS in the 1940s and discussed in terms of incentives (Titmuss, 1958, p. 156). Health economic theory treats capitation as suitable when the intention is to provide caregivers with an incentive to take a broader and more holistic responsibility for patients' welfare. It is also stated, however, that capitation might produce incentive inertia and unwanted consequences, which should be avoided (e.g. Robinson, 2001). The influence from health economy is clear and the writings are close in spirit in the rule book. Compare the rule book's intentions with the theoretical explanation of capitation: '[In capitation] providers are more inclined to decrease the costs for the treatment of a patient, for instance by eliminating inappropriate care. Also, health prevention and promotion might be stimulated more if these are more cost-effective than treatment ex-post. These activities will be performed more frequently to the extent that the period for which a provider is financially accountable for treating his patients is longer' (Jegers et al., 2002, p. 267).

before that it was SEK 1071. The amount is increased each year by a particular 'county council index', which is an index rate adjustment device used to index costs. There are different weights of capitation with regard to age. For example, a child aged 0–6 is granted a weight of 3.10; a middle-aged person between 45 and 64 is granted a weight of 1.63; and so on. Other tables establish the weights in common and focus drugs. These weights are taking both age and gender into consideration. An example regarding common drugs shows that a female patient aged 70–79 is given a weight of 2.71, while a man in the same age range is granted a weight of 2.63.

In addition to capitation, the 2013 rule book distinguished three other types of reimbursement. First, there was 'Basic' reimbursement, purporting to provide care centres with a basic level of reimbursement, depending on the unique conditions for each care centre (mostly determined by the location of the care centre). Second, there was 'Variable' reimbursement, purporting to provide incentives to improve performance in particular areas. Third, there was 'Special' reimbursement, purporting to reimburse care centres for activities they conducted that were not captured by the other reimbursement categories in the scheme, including patient fees. The rule book distinguishes between reimbursements in this manner, even though the signifier and transporter of value in all cases is money. It points to the complexity of the many ways in which monetary value comes to be intertwined with other values, expressed as desirable activities of primary care.

The basic reimbursement consists of three parts. The first is base reimbursement and is paid to care centres that are alone in their community. The idea is that this reimbursement will 'provide some compensation for the basic structure at every care centre and will primarily provide support to smaller care centres who are alone in their community'; 'alone' referring to (public) care centres located in the rural areas of the county. Base reimbursement is based on the number of listed patients at the care centre, but in a very different sense from capitation. There are three different levels of reimbursement. The highest level is paid for up to 7000 listed, the second level is for between 7001 and 12,000, and the lowest level is for between 12,001 and 17,000. The idea is that there are economies of scale in running a care centre; small care centres have proportionally higher costs, which is why they need a proportionally larger portion of base reimbursement. We also learn from the rule book which are the 19 care centres paid this reimbursement, since these are named.

Recall that one of the policy aims of the care choice system was to have at least one care centre in each municipality. There was also a wish to control the location of start-ups. However, that is problematic from a competitive neutrality point of view. In base reimbursement, the case is not that the number of listed patients is a source of competition. Rather, listings could be seen to make up a device that underpins monopoly for the care centres that are alone in their communities. This casts the regime of competing for patients into question. The base part of the reimbursement system is intended to make up for values that are not captured by capitation; foremost, proximity to a care centre for patients in rural areas. The rule book explains:

A study in 2011 showed that it is more difficult to make ends meet in a small care centre. Even a small business must have a certain basic staffing to meet its task. The task for a small care centre is the same as for a large one. In a small community, it is also more difficult to increase the number of listed patients. It is also more difficult for a small care centres in a small community far away from the major cities to recruit doctors, causing costs for rental doctors. (The rule book for care centres 2014)

Socio-economic reimbursement is based on the statistical income of the population living in the area of a care centre. For the areas with a population in the bottom 10% in income status, socio-economic reimbursement is paid to the care centre in that area. Geography reimbursement is paid to care centres covering a proportionally large area. For listed patients aged 75 and older, while also living over 11 km from the nearest care centre, geography reimbursement is paid at two different levels (11–25 km and >25 km). Essentially, basic reimbursement means that in practice, there are special contractual arrangements for care centres in rural areas. Again, this is potentially challenging to the principle of competitive neutrality; care centres are not allowed to choose their patients, but some care centres will earn extra reimbursement because of a statistical feature of their listed population.

The variable reimbursement explicitly relates to the incentivizing ambitions of the reimbursement system. It aims to 'provide incentives to improve performance in prioritized areas' within the care choice system. The first of the posts concerns coverage. The intention is to provide incentives for care centres to make sure they are visited by 56% of their total number of listed patients. For each patient visiting, a certain amount is paid, up to the threshold 56%. For a newly established care centre, it is assumed that it will reach its target, and it is thus paid a lump sum for 56% of the patients; one-twelfth of the total sum gets

paid to the care centres per month. The idea is that it is important for care centres to maintain contact with their patients, even if they may not seek care themselves that often. The number 56% is deduced from an expectation of visits at an average care centre.⁶⁵

The rules for reimbursement in relation to 'infidelity visits' are interesting. However, the term 'infidelity' is not used in the words of the rule book, but something I picked up as part of the lingo in the corridors of the office. The term 'infidelity' speaks to the county council's wish for patients not to go to the emergency ward, to private specialist doctors who are not contractors in the care choice system, or to care centres where they are not listed. For these events, the care centre to which the patient is listed is penalized. In a case where a patient visits a care centre where s/he is not listed, the caregiver receives a payment equal to the deduction of reimbursement to the care centre where the patient is listed, though with different amounts for doctoral consultation or other caring activities. As for infidelity visits to specialist and acute care, deduction is based on the capitation weight and the number of visits. The point is to put pressure on care centres to make sure patients go to them.

Target-and-measure is defined as a 'quality bonus' care centres earn if they perform well in certain areas. The total allowance and the targets and thresholds are decided for each year. For 2013, target-and-measure is paid for the following procedures: registration of diagnoses by doctors and other staff; health promotion in the form of tobacco cessation and prescription of physical activity; and registration in two clinical registries concerning health of the elderly. The first of these procedures aims to prepare for implementation of adjusted clinical groups (ACG) and the care need index (CNI) (see next subsection); the second is a long-standing idea to work with health promotion in primary care; and the third is of particular interest to national policymakers (the making of target-and-measure will be devoted particular emphasis in Chapter 8).

The final variable reimbursement is based on DDD. The DDD measure is calculated as an assumed mean value for usage of a particular drug. It is

⁶⁵ In health economic writings, there is a warning that capitation leads to under-provision of care. This post is constructed to counter such a (perceived) problem: 'However, if patients frequently change providers ... there may be an incentive not to invest in prevention, to undertreat patients, or even defer treatment [...] [C]apitation-based systems may endanger access of care for vulnerable patient groups as financing per capita may provide opportunities for risk selection by providers i.e. selection in favour of expected low cost patients, to the detriment of expected high cost patients ...' (Jegers et al., 2002, p. 267).

calculated for each 1000 listed patients, with the purpose of 'avoiding care centres under-prescribing and to ensure equitable care and to create credibility in front of the patient'. The ambition is to make sure prescription patterns do not deviate from the mean value of the entire county council. If that is the case, reimbursement is reduced. As such, the DDD post is clearly oriented towards isomorphic ambition, where deviation from the mean value is considered to be a failure. It should however be remembered that DDD says nothing about the prescribed or recommended usage of a drug for medical reasons, or what is considered to be the 'proper' mean value.

Besides the principles for reimbursement explained above, there are a number of other activities within primary care that are reimbursed, for example, caring for refugees, reception of trainees and interns, or whether there are any targeted grants from national government. As an appendix to the rule book, there is a document in which all fees are specified. It is indicative that these 'special' reimbursements are not as complex as the one explained above; they represent something the county council wishes to get done, but the scheme has not employed health economic theory for doing so. Finally, it is also stated that care centres *must* charge all of their services and that care centres are allowed to keep patients' fees. There is thus no way to compete by lowering prices to patients. This is deliberate, as competition is to take place at the level of quality.

... to ACG

For the 2014 rule book, a substantial shift occurred in the reimbursement scheme: a decision was made to abolish capitation and instead use a diagnosis related groups (DRG) model of reimbursement. The other items in the scheme remain largely the same, albeit proportionally smaller than before. Over 2014 and 2015, capitation will continue to amount to two-thirds and one-third of previous levels. In 2016, the DRG-model will be fully implemented, while the rule book states that 'care centres will be given time to change their working practice since it may entail large changes in the economic conditions' for running a care centre. 66

⁶⁶ Just as with capitation, DRG models have strong theoretical underpinnings from health economics (Van de ven & Ellis, 2000). The idea is to 'risk adjust' reimbursement to avoid adverse selection of patients (which is suggested to be a risk coupled with capitation). From this perspective, capitation is not considered to be competitively fair, as the workload caused by listed patients could differ considerably across care centres. Therefore, according to both

Specifically, in Swedish implementations of DRG models in primary care, the ACG module is used. ACG is a particular product developed at Johns Hopkins University and marketed in Sweden by the company Ensolution. The particular clustering and calculations performed by the system is not open to anyone, not even for county council officials, as it is protected by copyright. In short, the usage of ACG in primary care means to reimburse care centres according to the individual diagnosis profiles of their listed population of patients. The idea is advanced as simple and robust. For ACG to work as intended, all care centres are expected to register a comprehensive list of diagnoses accurately, and reimbursement will duly follow. In the 2014 rule book, about 88% of all reimbursement would follow from ACG, while 'the combination of diagnoses provides a weight that determines the level of reimbursement' to each care centre.

ACG is presented as a device to level out a particular problem with competition, with two facets. The first facet is that capitation is not considered to be fair to the complexity of patients' health, with the effect that conditions for care providers are not equal, as listed patients could be very different populations demanding different amounts of caring. Capitation was, as is visible above, weighted against age and gender, but this has increasingly been considered to be a poor representation of the care needs of patient populations. The second facet is that ACG adheres more strongly to the principle that rules must be 'competitively neutral' as in the 'same for all'. There is actually (and yes, health economists do acknowledge this, at least partly) good reason to differentiate market rules and reimbursement to care providers to make competition more equal. A rule to pay care centres according to the diagnosis profile of their population is equal for all, but gives very different effects in practice.

As ACG marks its entry to the rule book, several extremely particular acronyms and numbers start to show up in the reimbursement system. Here is an excerpt from the 2014 rule book explaining how ACG is a weighting granted to individual patients, and that this weighting determines reimbursement:

health economy and rule book designers, DRG is said to pertain even more strongly to the principle that reimbursement must be 'competitively neutral'.

From 2014 begins the transition from a system of reimbursement based primarily on age and gender to ACG-based reimbursement (adjusted clinical groups) ... The reimbursement consists of the following basic elements:

- compensation for the listed individuals based on residents' health care needs (ACG)
- compensation for citizens' care needs based on socio-economic factors under the CNI

[...]

Reimbursement for listed persons based on ACG is a reimbursement aiming to promote comprehensiveness and responsibility based on citizens' care needs [...] ACG is based on the diagnosis put on patients, during visits or indirect contact that replaces a visit, during the period for reimbursement. The combination of diagnoses gives a weighting that determines the level of reimbursement. (The rule book for care centres 2014)

It is worth noting that the expected values to be fulfilled by ACG – 'comprehensiveness and responsibility' – are exactly the same as for capitation. This is something of a paradox, since the difference between the two reimbursement principles is generally emphasized. The rule book continues to explain the next acronym, CNI:

A strong link exists between low socio-economic status and poor health; therefore reimbursement is based on socio-economic considerations. Patients with socio-economic problems may require a greater effort of care, regardless of diagnosis. As the basis for reimbursement based on socio-economic conditions in the listed population, CNI is used. CNI is individualized and based on seven different variables with different weightings:

age over 65 and living alone	
• born in a foreign country (Southern and Eastern	
Europe but not the EU, Asia, Africa or South America)	5.72
• unemployed or in labour market policy measure, age 16–64	5.13
 single parent with children aged 17 or under 	4.19
 person 1 year or older who moved into the area 	
• low-skilled, age 25–64	
age under 5 years	3.23
(The rule book for care centres 2014)	

As the analysis of the 2013 reimbursement system revealed, socio-economic considerations are not new. However, much like ACG, CNI is an indexed score for individual patients. The difference is that ACG builds on registered diagnoses, and CNI rests on checking the different variables of each listed patient against a national database. For 2014, ACG renders SEK 648.58 per patient (weighting 1.0) and CNI renders SEK 106.96 per patient (weighting 1.0).

In calculating revenue from ACG and CNI, the basic reimbursement is multiplied by a scored weighting. In calculating ACG the HQ automatically scans the clinical records for diagnosis registrations. In calculating CNI the county council runs listed patients against records of socio-economic data from Statistics Sweden. The employment of CNI builds on the belief that an increased number of indicators put to account for the socio-economic status of patients will more accurately represent citizens' health. On average, CNI accounts for about 7% of total revenue to care centres, but this figure differs significantly between care centres.

So, the ACG and CNI reimbursement system is supposed to be fairer when it comes to how care centres are reimbursed. Or rather, to better represent the prospect and probability of patients being ill according to a number of established criteria. Both ACG and CNI indexes enact the value of patients (in terms of reimbursement) according to their 'attributes' and hence perceived effect on the workload of care centres. Citizens' status is made commensurable according to a single metric, neatly defined beforehand in the reimbursement scheme. At the same time, however, it is said to be an attempt to accurately account for 'comprehensiveness and responsibility' for patients' lives.⁶⁷

The rule book as valuation system

The rule book represents the intention of the county council to have a compilation of rules of what services to offer in the care choice system and how to behave to be an authorized actor in the care choice system. There is a multitude of different codifications of what counts as proper conduct in doing primary care. Therefore, the rule book could be seen to represent an ambitious

⁶⁷ Grit and de Bont (2010) have looked into the dynamic between capitation (reimbursement of the average patient) and DRG-models (individualized solutions, such as client-based budgets) in long-term care. Their argument is that the use of devices such as the 'tailor-made' financial instrument transformed patients' 'needs' into the principles of 'economic demand'. This is because a market deal builds on *a priori* specifications of the service and the two parties who perform what has been settled in a contract – no more, no less. Grit and de Bont found that the difficulty of predicting in advance what the actual need is causes an inflexibility that threatens the care situation. It is not possible to establish beforehand what is the best care for an individual patient; it is instead the result of a daily process of searching for what is best. The act of caregiving needs some latitude. Therefore, tailor-made finance is actually less flexible to the needs of individual patients than is capitation. Capitation allows for some adjustments to be made through shuffling budgets in the organization and for patient 'needs' to be negotiated gradually.

attempt to assemble all purchaser regulation for primary care providers within one document. In this 'market frame', free choice of care provider and competitive neutrality between providers are supposed to secure the function of the market.

Both monetary value and other values are highly present in the numbers and words of the rule book. Therefore, as the above *exposé* illustrates, the rule book is very composite in terms of values. For example, it has a declaration of the purpose of the care choice system in which the values of quality, availability, choice, and competition prevail up front. It furthermore enacts a reimbursement system packed with non-economic valuables, such as comprehensibility and responsibility in relation to both capitation and ACG, just as there are monetary expressions of value and incentivizing ambitions.

This look at the rule book reveals that there are a multitude of considerations of values coming to the fore. Therefore, in its basic form, the rule book frames the economic agency of care providers and enacts care providers as market actors who pursue economic interests by competing for patients. 'Competitive neutrality' means all eligible care providers have the same right to open care centres and compete for patients in accordance with the specifications and regulations of the rule book. The rules for running care centres should be exactly the same for all providers, and are supposed to 'level the playing field', regardless of ownership. Thereby, the rule book is developed to frame primary care as a competitively 'fair' market and to control the behaviour of care providers.

The 'voucher' is an imaginary construct of the rule book, and is operationalized through the mechanism of the reimbursement system. It specifies the regulated choice of the primary care patient, while also specifying different values that serve as regulators of patients' choices. On one hand, the rule book secures an almost unconditional *right* of patients to choose a care centre of a specified minimum quality. On the other hand, patients' choice is presupposed to secure the effects of the market. Therefore, the rule book also performs *requirements* on patients. They are better to make some choices, or there will be no invisible hand. However, care centres are to respond to the rule book even if patients do not make active choices on where they would want to be listed. So, the rule book is supposed to be a forceful tool even if competition does not function very well. Basically, this means that the preferences of patients and

their actual choices have a limited impact on the 'good' that is supposed to be offered by the care choice system.

The reimbursement system is fairly complex as it is designed to be a representation of many different activities performed in primary care. The rule book at large objectifies and defines the primary care service, while also putting into words the objects (computer software, clinical records, labs, registries, eservices, and so on), subjects (the county council, care centres, patients), and relations (rules for competition, listings, reimbursement, conduct of actors) of importance to the care choice system's market situation. It is active in shaping the market inasmuch as it performs the market in words and numbers. It constructs a market situation, while it presupposes a market to be in place. This is to say that the rule book and what it projects is equally real as it is constructed. The rule book as a constitutive device of the care choice system is both a starting point of market reform, as well as a result of representational images of the care choice system.

Reimbursement as representing and incentivizing

There is both a representational and an incentivizing aspect to the rule book in general, and to the reimbursement system in particular. In terms of representation, the rule book designers want the reimbursement scheme to capture and appropriately account for the work performed by care centres. Here, then, the reimbursement scheme is enacted as a device ensuring that care centres are paid according to their actual performance. The challenge is to model the scheme exactly right, to be 'just' and 'fair' in relation to the work performed. The reimbursement scheme could also be seen to enact incentivizing properties. That is, the scheme has ambitions, and is intended to steer behaviour in a certain direction. This is most clearly articulated in the 'Variable' reimbursement category: 'The variable reimbursement aims to create incentives to improve the work in prioritized areas'. This category is employed particularly for those values that are prioritized as policy aims at specific points in time. The rule book for 2013 emphasizes, for example, health promotion as a prioritized area.

But under the surface, the scheme is laden with incentivizing ambitions in a more fundamental sense. Via both capitation and ACG, the scheme incentivizes certain types of engagement with patients. Let us begin with capitation. On one hand, there might be a risk of under-provision of care, as frequent patient visits will not render more payment in a capitation system. On the other hand,

capitation is said to foster longer engagements, rather than temporary relations, between patients and care centre. Capitation means care centres bear the costs of their listed patients; hence they have an interest in controlling the overall situation of patients. In this way, the reimbursement scheme also fills the principle of 'free choice' with a certain value and meaning. As patients and care centres are not able to influence price, the actual choice – that is, the movement of patients from care centre to care centre – is put centre stage as a competitive mechanism. It enacts free choice as a matter of choosing care centre; a very particular way of conceptualizing free choice.

The representational and incentivizing aspects of the reimbursement scheme could thus be seen in relation to different aspects of a marketization ideal. Capitation as a reimbursement principle foremost embodies political will, expressed as comprehensiveness and responsibility and long-standing relations between caregiver and patient. ACG and CNI appeal more to a representational ideal than does capitation. They have been mobilized to better account for patients as *individuals*; ACG is designed to account for diagnosis patterns of individuals, while CNI utilizes the socio-economic status of individuals as an indicator of expected need of care. In this way, the reimbursement scheme could be said to better represent the prospect and probability of patients being ill according to a number of established criteria. The value (in terms of the reimbursement received) of particular patients is determined by their diagnoses and socio-economic 'attributes'.

Conclusion: The rule book as valuation device

The rule book represents an ambitious attempt to assemble all regulation for primary care providers within one document. It organizes the care choice system inasmuch as it establishes the rules of conduct and relations between relevant subjects and objects; it is hence a powerful device in enacting the care choice system *as* a market. In this attempt, free choice of care provider and competitive neutrality between providers are supposed to secure the function of the market. The values of free choice and competitive neutrality appear as very practical matters when they are operationalized via the reimbursement system.

The 'voucher' is a construct of the rule book, and is operationalized through the mechanism of the reimbursement system. The system is fairly complex as it is designed to be an economic representation of many different

activities and values performed in primary care. Because reimbursement follows patients, the rule book frames the economic agency of care providers and enacts care providers as market actors who pursue economic interests by attracting patients. The rule book thus implies certain action repertoires on behalf of market actors, and these should build on the valuation enacted by the numbers and words of the rule book.

To conclude, this chapter has pursued the argument that the rule book is a device to enact a diversity of values. Those values could furthermore stand in complex relation to each other's realizations. The next chapter, Chapter 7, takes interest in the making of the rule book. It shows the work behind the enactments of value pushed by the rule book. This leads to an increased understanding of how values are handled in relation to governance tools, such as the rule book, and how the handling of values is integral to the practice of regulating a care choice system to become more market-like.

Chapter 7

Writing the Rule Book: Whiteboards and Swivel Chairs

It's a little embarrassing; right now it's just Kitty and me. Now we're even sharing office, so if you were to walk into our room, the suggested rule book alterations are on our whiteboard, it is at that level! It is extremely hands-on. [...] I think we can put up with anything! You may be on which meetings you want with us, we do not think we're doing anything secret. It is now that the rule book is revised. We had our first meeting on the revision of the rule book today, and it meant that we turned on our swivel chairs... (Jeremy: Interview rule book designers, February 2011)

Chapter 6 presented the rule book. It was a story about how the rule book makes the care choice system manifest as a market, and how the values of free choice and competition are given specific content. However, there are many more values than free choice and competition expressed, for example in the reimbursement system. The chapter furthermore brought to the fore how monetary value in the form of reimbursement is intricately intertwined with other values.

This chapter takes an interest in the making of the rule book. The rule book is intriguing in that it could be seen as a stable artefact that performs the care choice system as a primary care market, while it is an experimental device that is continually worked on and revised. It appears solid, yet it is constructed as a stable device and an open-ended arena all at the same time. Even more dynamic

than the previous chapter, this chapter shows that there are difficult aspects in making the rule book; that it sometimes goes wrong. It answers the question 'how is the rule book done?' with 'work', and outlines how this work is performed. The point is to illustrate the width of value-laden actions performed in constructing the rule book and endow it with its market-making capacity.

The chapter starts with illustrating how the rule book designers work to assemble 'issues' on their whiteboard. Then it shows how writing the rule book demands collective effort, with involvement from diverse actors. Particular interest is paid to two arenas where interaction between rule book designers and care centre representatives takes place, namely the quality report and follow-up meetings. The last part of the chapter is devoted to depicting a rather typical situation in which the rule book designers meet with other professionals to discuss the issue of competitive neutrality; this time in relation to the so-called 'Quality Board'.

The work of (re)writing the rule book together

The opening quote is from one of the rule book designers the first time I met them. In this utterance, the rule book designer does two things. First, he explains that the making of the rule book is extremely hands on. Whiteboards and swivel chairs take part of the everyday work in the rule book designers' profession. Second, he grants me access, and acknowledges that their work allows itself to be studied in all its substance. I was fortunate enough to be invited to study swivel-chair episodes *in situ*. As such events are indicative examples of the process of writing the rule book, it provides a good starting point to retell and think through in terms of the handling of values.

Whiteboards and swivel chairs

The first swivel-chair event I witnessed unfolded something like this: I was welcomed to join the rule book designers at their office, as they were to 'work through the whiteboard'. On the whiteboard were scribbled different keywords that related to different topics that were to be discussed in revising the rule book. I soon learned that such topics were collected over the year, either from issues the rule book designers had come across in their daily work, or stuff that had been called to their attention. Usually, it concerns a problem that jeopardizes

competitive neutrality. Why is it so important with competitive neutrality, and how does it matter for the handling of 'issues'?

On this note, where issues emanate and come from, it might be worthwhile to have a look at how the one economist at HQ explained the raising of issues with an example:

Economist: We're talking a lot about competitive neutrality; that all should have the same, both our own and the private one, and so on. And there you will find all the time, as well; things like, where we don't have competitive neutrality, and where one might give special treatment to the county council care centres, for example. That we do it in a certain way. And then someone comes in: but how does this work against the private contractors? And then you get like, well, then you should investigate it, how it will be towards the private, then. Will there be, is it competitively neutral if we do this? No, but then we do the same against them, and so on.

Linus IK: Do you have any example of such a thing?

Economist: Well, it could have been, for example, information initiatives that we got government grants for in the care choice reform, to make information available in the care choice system. And then you have, the information then, has gone out to our own care centres: you get to do these and these communication projects ... It has gone through our Information Office, and then you have used a private contractor for those brochures and what it could be ... And then it has been invoiced and paid for by the Healthcare Committee. It's just that, you start to feel like: how does this really work? For these private care centres, they pay of course as well as their own information activities and the like. So then it was like: well, how do we do with this then? Then we had to figure out a lump sum and pay it to them. For they've made their own information campaigns. It's just that they have paid it themselves. So then you gave them a contribution from these government grant funds that the county council had been given.

Linus IK: How was this problem revealed then?

Economist: It was me who just like realized when I sat and watched these bills; that it doesn't seem to be any private care centres in this. Then it's often random how somebody comes up, or that somebody happens to notice: but how is this towards the private care centres? Or has anyone thought of that? It is often ... And those of us who work here with competitive neutrality, we have it on the agenda and we talk about it, and so on. But it is perhaps more problems at other departments ... Well, we had one example now, at the ICT unit for example, where people realized that these e-service cards that everyone has. The county council has paid for them for our own care centres. And I do not know how it came up, that the private ones then ... It might even have been a private care centre that had heard of it and contacted us and wondered about it. So it can be sometimes.

Linus JK: So it may be that a private care centre, for example, feels that they lack

something that the public ones have, that we need to compensate in some way

for it ...

Economist: Yes ...

Linus JK: ... and then you go in and make a special effort then?

Camilla: Mm ... So it may be.

Linus JK: In order to try to even out the conditions?

Economist: Mm ... (Interview county council economist, April 2011)

Foremost, I take the excerpt to illustrate that competitive neutrality is a serious matter for the making of the care choice system. And it does not really matter who comes up with the issue that threatens competition; it is even difficult for the informant to explain how the raising of an issue takes place in practice.

Back to the whiteboard, time was moving closer to the date where the new version of the rule book would be presented to the politicians in the Healthcare Committee. The whiteboard is not significantly large – about one-and-a-half square metres – and placed at the centre of one of the walls in the rule books designers' office. As I enter their office for the first time, the rule book designers instruct me to sit so that I can see the whiteboard. The board has a dozen different points and headlines with some additional scribbling under them. Apparently, all these points are considered to be important to raise in relation to the revision of the rule book. I am being told that they attempt to bring up only things in the revision that they have 'flagged for' during the last year, to 'put pressure on the house'. The 'house' refers to the county council HQ, and pressure means to become more formatted to thinking according to competitive neutrality.

I sit therefore at the rule book designer's desk, with my back against the wall. They talk about the issues on the board; I listen and make notes. Sometimes they ask me if I follow them. Although, on occasion one of them said to me: 'Now we must make sure to formalize ourselves while you're here!' taken to mean they have to shape up, use the right bureaucratic terms and so on. The 'gibberish' that we encountered in the previous chapter – boundaries between specialist and primary care was the example used by the rule book designer to illustrate what 'gibberish' entails – is one example of the stuff that ends up as

'issues' on the whiteboard at the rule book designers' office. Often, rules that are not harmonized over the county become articulated as 'issues'. They might also, for different reasons, decide to take up stuff in the rule book that has not been there before, for reasons of clarification or to resolve (or avoid!) elements they consider evoking tensions or causing conflict.

The rule book designers use their 'issues' to put pressure on actors in the organizations involved in solving diverse problems. As far as possible, the rule book designers told me they have a wish to 'stay out of the way'. The more the rule book designers are able to stay out of the way, but still get solutions their way, the better they perceive the relations between purchaser management and the county council's own operations management to be. And it should be remembered: the key trump is competitive neutrality, a card played out frequently by the rule book designers towards providers and others involved.

Let us take a look at some of the terms written on the whiteboard. Two examples of such terms were 'housemen' [AT-läkare] and 'house doctors' [ST-läkare]. There are rules in the rule book for housemen and house doctors. More precisely, the rule book makes reference to a guideline on the matter issued by the deputy principal for medical training at the university hospital. Now the guideline has to be altered with some influence from the rule book designers. In particular, the rule book designers wanted the rule for 'one year quarantine' (meaning a rule that newly opened care centres will not get any house doctors placed on their wards in their first year in service) removed. I listen to the rule book designers trying to solve the issue. At a later interview, one of the rule book designers explained:

Well, it was not really that complicated. [The deputy principal] wanted to rewrite that guideline anyway, and so we helped a little bit. And that was one of the things we asked, 'couldn't we remove this rule about one year quarantine, because it is provocative for many and it really doesn't add that much'. Because if care centres couldn't meet the other requirements that [the deputy principal] had already written about: that one should have a diversified patient group and things like that, then they won't get it anyway. So really, and he has the full power to determine who has it, who lives up to these more general requirements for supervisory skills and so on. So [the one year rule] didn't really fill a function, but only served to provoke new care centres. (Jeremy: Interview rule book designers, May 2011)

Here the rule book designers brought ideas about competitive neutrality deep into the negotiation of professional judgment. The idea that there should be no hindrance to competition – together with the idea of preventing 'provocation' –

had a profound effect on the conditions for housemen and house doctors in care centres. This event is also indicative of the rule book designers' intention to 'facilitate' and 'limit' the plethora of guidelines towards conduct of care centres. According to the rule book designers, a guideline is foremost a logic belonging to the provider part of the county council. Said one of them sassily: 'It's our own business that likes to cover all eventualities [with guidelines]. Most often with directions they themselves are unable to live up to.'

Making the rule book is thus characterized by interaction. I have witnessed the rule book designers listen, read, argue, ignore, comment, remain quiet, take the lead, raise their voice, and much more. They spend only short periods of time in front of computer screens, and when they do, there is much e-mailing or fine-tuning of propositions for the rule book in a Word document. Occasionally, people drop by the rule book designers' office. Sometimes, it is just to say that a certain dispute has been settled, while at other times it is to call to the rule book designers' attention something that must be taken care of. At other times they need to ask questions (the chief financial officer: 'why do we use the term "care centre" in the rule book rather than "health centre" again?').

Pragmatically writing together and fighting unintended challenges

So far, the rule book has been revised for each new calendar year. However, the original intention on behalf of the rule book designers and their superiors was to have 'more continuity' than changing the content of the rule book each year:

Jeremy: [M]y picture was not that the rule book would be changed as often as we do

even now. I thought probably not every year.

Robin: My idea was that year one it would have to be changed, because you can find

things that you must do. But then I was hoping it would be three or four years

before the next revision.

Jeremy: Though, I wonder if it will ever be so?

Kitty: No, no ... It will never happen.

Robin: No, I do not think so either. Not as long as there are decisions from parliament

and government that may affect the content, so to speak, all the time ...

Kitty: Yes, yes ... So it is all the time. The world is changing. (Interview rule book

designers, February 2011)

Just as the world is changing, so do the formulations of the rule book. Some of these changes are done routinely, like increasing the reimbursement with 'the county council index', while some changes are called for because of unexpected events and developments in the county or in the outer world. Not all parts of the rule book are subject to the same revision. For example, the main principles of the reimbursement system have – up until the change to ACG – been rather stable, while the 'quality bonus' of target-and-measure has been changed more often, for example. Such examples illustrate that the work to assess the rule book and its function is conducted each day at the county council office. It takes place by the whiteboard in the rule book designers' office; though often in collaboration with other actors.

Even though the rule book designers formulate most of the exact wording of the rule book, writing is a collective process. The rule book designers are struggling to explain the intricacies and incoherencies of such processes in this group interview:

Robin:

[I]t's different people working with different things, that is, the rule book includes many elements that are purely, shall we say, purely commercial, like how you should deal with what is contractual, that's a big part in it. And there are people here who are working with procurement, where you can pick it up. Then there are also the parts: what is the mission? What to do in the care choice system, what service is exactly to be included? And there were different actors who looked at different parts, and then we had to bounce back. It had to be gradually, so to speak, put together. And that is much about turning words to find the ... For the political part, we would not go into lot of detail, but it would allow slightly different ways to work out there. In this way you could get this with the competition and the economy, and to streamline and stuff. So it got pretty broad, how the mission was described. Then there were some things that were very clear that politicians wanted to go into detail with.

Linus JK: Like what, for example? [...]

Robin: Care for refugees, for example, was specifically ... It is a small part of the whole

thing, but it was mentioned in the rule book that it should be taken care of and

so on.

Jeremy: What was it?

Robin: Care for refugees. And financially, it's actually a tiny thing on the whole. And

there was some things like these mentioned in the rule book.

Jeremy: Multimodal rehabilitation.

Robin: Great example!

Kitty: Yeah, exactly, it's a good example!

Jeremy: Important detail.

Robin: It was on everybody's lips for a while, everyone was talking about this

multimodal rehabilitation stuff, and so it had to be in there for some reason!

Kitty: Yes, but it was also a new and unknown concept, so it was, one felt a need to

clarify: what is it really? But now one can think ... pretty silly.

Linus JK: Why silly?

Kitty: Because it is such a detail. We tried to keep the rule book pretty, pretty

comprehensive. It would not be too thick, but it would be possible to read and understand. And therefore, we worked pretty hard, actually ... There are many lobby groups who want, like, their pet issues, and they want it to be detailed and extensive about it. But we tried to resist pretty well. But a few times we missed that. Multimodal rehabilitation is one of those ... One can see in hindsight that it is. It is mismatched with the other balance we tried to keep,

which is a bit more on the higher level, or general level, so to speak.

Jeremy: And it's creating confusion when giving the assignment, because people are

wondering: Oh, we wouldn't have to do that? Yes, but you've got the entire contract! Ok, but you are pointing at one particular thing here, why don't you do it in this area then? Thus, it creates confusion when you assign the mission. And then of course, it can quite quickly become obsolete, which means you

have to change it. (Interview rule book designers, February 2011)

The spirit of the argument seems to be that the rule book designers are struggling to formulate the rule book so as to strike a fine balance between the 'universal' and the 'particular'; a process in which the distinction between 'general' and 'detailed' regulation is negotiated and handled. One reason for the rule book to contain very divergent formulation and rules – over the entire spectrum from general to detailed – has to do with the multiplicity of actors that want to further their different issues. In the case of multimodal rehabilitation, the rule book designers regret that they let it pass through.

Several hands do the making of the rule book, and it occasionally entails tough negotiations. Sometimes the urge to write competitively neutral rules tends to stir things up. One effect of this is that certain challenges surface as problems in places where the care choice system is to be realized in practice. These issues must in due turn be solved pragmatically. Two examples where it

has been particularly pressing to get them solved are in relation to so-called local areas and rural care centres.

Example one of a pressing challenge: Local areas

The notion of 'local areas' is something the county council management use for several purposes. 'Local areas' is a division of the total area of the county, where each care centre has a certain responsibility for the area that is geographically closest to it. The borders of local areas are negotiated between the four providers organizations, with input from each of the care centre managers. When a new care centre is opened, the borders are revised. They could also be revised because of perceived 'unfairness' regarding the borders.

The rule book states that there are both rights and duties for care centres related to their designated local areas. For example, local areas play a role in deciding who is responsible for issuing death certificates and taking decisions about custodial care. Local areas are furthermore used for the enlistment of patients not making an active choice of care centre, for picking up new-borns and making sure they receive early care, and for automatic listing of people moving to the county. This function is called passive listing. Since the county council is obliged to care for all the people in the county in need of care, they must prepare for people not making active choices. Passive listing is thus considered to be a very important function of local areas in the face of the public mission of care centres.

Depending on the composition of the population in a local area, passive listing could be either a source of revenue to or a burden for a care centre. For example, the effect could be very different in a local area with many families with children, sheltered housing, or (un)healthy people in general. With sheltered housing comes a significant workload with little reimbursement, and with a healthier list of patients comes easy money with less effort. And above all, the size of the area matters much, as travelling times create expense for care centres. This is because they sometimes have to care for patients in their homes, some of whom live far from the care centre.

This verity is sometimes a source of discontent among care centres. A look at the reimbursement system reveals that the rule book designers have made attempts to counterbalance this effect with the 'Base' reimbursement. In the light of competitive neutrality as the 'same for all', this base reimbursement could seem strange; it fails to treat everybody the same in the strict sense of tying

reimbursement to listed patients or medical performance. In one of the interviews, one rule book designer hinted on another version of competitive neutrality, which could explain the paradox: 'A care centre cannot shovel away the patients, for others to work with them. Then it is not competitively neutral. They should all have exactly the same advantages and disadvantages.' This version of competition strikes a very intriguing balance between rights and duties in relation to revenue for patients.

The question now becomes to what extent a framing of competitive neutrality as the 'same for all' corresponds to a framing of competitive neutrality as the 'same advantages and disadvantages'? And how does it correlate to the free choice of patients, as the principle of reimbursement-follows-patient is all of a sudden put out of play? Another example might serve to shed more light on this matter.

Example two of a pressing challenge: Care centres in rural areas

As illustrated in Table 5.2, the county has a political ambition that there should be at least one care centre in each municipality. For the time being, this condition is fulfilled. But some of the rural care centres – all of which are public; that is, they are owned and operated by the county council itself – have a difficult time staying in business. As we have seen, the county council must not allot group contributions to them. On top of that, the legislation on care choice does not allow the county council to direct care centres where they are to open their business. How could this challenge then be treated from purchaser management?

According to care centre managers, policymakers, and rule book designers alike, the conditions for running a care centre are very dissimilar between urban and rural areas, not least when it comes to the composition of passive listings, as outlined above. The problem has many facets. The first problem is that there are often not enough patients to run a rural care centre according to the qualifications of the rule book. The revenue simply does not cover the costs required to live up to the rule book's demands. Foremost, rural care centres have huge problems in attracting doctors. To live up to the requirements on staffing, they have to spend large sums on rental doctors.

The second is that if there is no care centre in a municipality or nearby community, it is impossible to sustain and justify 'choice' for patients in these areas. There need to be a multitude of providers for patients to be able to choose;

that is the bottom-line of the entire care choice system! Some financial measures have been taken to address the problem, such as reimbursement based on population density and remoteness of listed patients for home care. For now, this allows the rural care centres to continue to operate, albeit under financial strain. Another perceived problem is that there are no private contractors in the rural areas at all, which undermines diversity.

Because of this verity, there is a difficulty in retaining the principle of competitive neutrality as in the 'same for all'. And in any case, the composite reimbursement system is already a compromise with the rigidity of this principle. So, in the name of competitive neutrality as the 'same advantages and disadvantages', purchaser management can adopt some measures to secure the survival of rural care centres; that is, the possibility in practice of free choice for the entire population.

There are ways to enable care centres to operate in rural areas. Besides adjustments to the reimbursement system, separate procurement arrangements could be made with rural care centres. However, these contracts are sensitive and difficult to get in place. Some contracts that were signed with rural care centres before the care choice system are actually still in effect. The rule book designers are rather reluctant to keep these, and do not want them to be known to a wider audience, since they principally violate the 'same for all' version of competitive neutrality. According to the Swedish Competition Authority it is purportedly all right to operate in this way, but the issue has not yet been tested in court.

Forms of collaboration

The description above illustrates that it is not always obvious – even for the rule book designers – exactly what is an 'issue' and who will do the solving of it. For sure, there is a multitude of actors who want, and are sometimes granted via the constitutional model and political decisions, the right to have a say in the formulation of the rule book, including politicians, national government, care providers, patient associations, and medical professionals. Occasionally, it also depends on the discretionary choices of rule book designers whether to let actors into the process. Either way, revision of the rule book depends on the collective work by many, and 'writing' is not done in solitude.

Stable and temporal connections

Over the course of the year, the rule book designers interact and stay in touch with many different actors within and outside the county council HQ. Some of the actors they face are tied to the rule book revision by formally codified rules, while others are more loosely connected to the process. Among the more formalized interactions are for example the Primary Care Forum, consisting of representatives from HQ and care centres, and the Healthcare Committee, which has responsibilities related to revisions of the rule book (i.e. they take the decision on a new rule book).

For example, the Primary Care Forum is a novel arena that gathers representatives from all care centres in the county, and the intention is to allow all providers to bring up, among other things, issues that concern collaboration or the formulations of the rule book. The consultation group consists of seven care centre representatives and four members of the county council office, with working groups assigned to solve particular issues. These representatives offer suggestions for solutions to general problems, function as a reference group to revise the rule book, and propose delegates for the working groups. The idea is to get coverage over size, locality, and ownership of care centres, and to have representatives mandated for some time and then move them around. The rule book designers rely on the consultation group to solve some of the issues of discontent and maliciousness towards the care choice system. To get a sustainable rule book in place, it must gain and sustain approval from health care professionals, other care centre representatives, and various people involved in formulating certain part of the primary care mission.

Other contacts are often of a more temporal character, or called for to deal with specific issues. One example was when one of the private care centres demanded 'a stop of listings'. A stop of listings means that the possibility of choosing a particular care centre will be temporarily stopped. The reason this care centre demanded a stop was that they had received a high number of listings in a relatively brief time span. Allegedly, this made it very difficult for them to live up to the demands of availability. Now, they are rebuilding the ward to manage a larger quantity of patients. The field note excerpt (Figure 7.1) illustrates a conversation on the matter between the rule book designers at their office.

K(itty): [The Health Care Director] sent a new mail to me regarding a 'stop of listings' for [care centre x].

J(eremy): This is not that easy a problem, I think.

K: We gave them one stop last year. They said that they would build a new ward, but they didn't. Now they want a stop again.

J: I also reacted to that. Have they done all they can, really? Rebuilt their ward? *They study the mail together.*

K: Reading from the mail: Conduct a comprehensive reconstruction...

J: But everybody has to do that regularly, why should they get to close and implement a stop of listings? Should we all have regular stop of listings?

K: It doesn't benefit patients.

J: "It is an exceptional situation": we couldn't have that every year? We wrote something about that, but I don't know where? *They read from the rulebook, "over a limited period of time..." restrictive interpretation...*". We will refer to that they must be able to handle a reconstruction of the ward without a stop of listings. What if the university hospital had to do that every time?

K: No, ok. I will write to [The Health Care Director] and say that they shouldn't get it.

J: Attach that formulation from the rulebook.

K: Yes. ok.

Figure 7.1: Excerpt from field notes 1, discussion between rulebook designers, March 2012.

The rule book designers have received an email from the Healthcare Director, who has received a request from the care centre concerned. The rule book designers reflect on whether to give the care centre the stop of listings or not. They negotiate among themselves whether there are good reasons to allow a stop. Eventually, they decide that the principle of free choice for patients is more important than meeting the demand from the care centre to temporarily stop listings.

Working with the rule book is thus highly varied, while it is not always easy to foresee what changes would have to be made to it, and how. However, there are a number of pillars around which the work centres. By pillars I refer to foundational events or interactions in the work of the rule book designers, that is, events that in some way or another provide input to the making of the rule book. Examples of activities that stand out as pillars are the making of the target-and-measure scheme; administrative routines at the office and decisions by managers; politicians assigning tasks or altering instructions; the making and usage of the quality report; yearly follow-up visits to all care centres in the

county; the administration of the Primary Care Forum and working groups; attending knowledge conferences and seminars; meeting with the national network of rule book designers at SALAR; temporary working groups and advisory meetings with medical staff, ICT personnel, and others at the office and elsewhere; significant contacts, policies, and information from national government; information material from SALAR or public authorities; meetings with care providers outside primary care; pressures and evaluations from the surrounding world; coffee breaks and corridor discussions with colleagues at the office; and so on. The following section focuses on exemplifying two such pillars whereby rule book designers encounter care centres.

The quality report

A 'quality report' is put together for each care centre for every year. It contains a number of quality indicators that are used in assessing the performance of care centres. As one of the rule book designers put it: There are many 'soft indicators that are difficult to draw conclusion from'. But to assure me that the report was not useless, he added: 'But there are some hard data as well!'

The making of the report involves the gathering of data from several databases. The headings for the 2011 quality report are knowledge-based care, health promotion and disease prevention, medical quality and patient safety, effective treatment, and availability. Indicators used are (a selection): usage of clinical registries, diagnosis registration by other than doctors, registration of tobacco use for asthma/COPD patients, antibiotic prescription, flu vaccinations for the elderly, prescription of physical activity, tobacco cessation, reports to the patients' committee, hygiene rules, prescription of antidepressants, opening hours and telephone hours, and staffing.

In some respects, the work to decide which indicators to put in the quality report resembles the work with the rule book at large. It is mainly a collective effort to assemble the relevant indicators and work to gather and assess the data that comes in. The report is however to be seen as one part of the 'quality control' performed by the office, which is way to account for numbers other than availability and open hours:

Quality control in primary care has emerged as a complement to the purely statistical audit, which we follow. The reason for this is that the county council wants to capture not just numbers, e.g. availability and opening hours, but to make sure that health care

content is what is expected based on the rule book's requirements and that the work is performed with good medical quality and patient needs in centre. (Quality report, 2012)

According to the rule book designers, there are three significant roles for the report. First, it is highly valued as an audit device, which means there is much work devoted into developing it and making it more accurately representational of care centre performance. Second, the input from medical advisors matters a great deal in keeping track of what really counts as medical quality; and third, the report is heavily influenced by what technology is available (good examples of how these aspects come together is presented in Chapter 8).

On several occasions during my field work, discussions on tuning the report were a hot topic. I also saw that the reports were occasionally a source of distress; but also that they are facilitators for taking decisions on the rule book and for facilitating discussions between actors. Distress – or perhaps disappointment is a more accurate notion – was caused by the report when it was seen to poorly represent the performance of care centres. According to the rule book designers, this was usually caused by technical failures of assembling the data, and sometimes there were misunderstandings of how the data was to be filed in the computer system. And occasionally, the data was just considered to be meagre and insufficient. On rare instances, the rule book designers told me that they suspect cheating with figures and up coding to be pretty common. But most often, the rule book designers emphasized to me the importance of the reports as tools around which to focus discussions, reflections, and action plans, often in on-going verbal dialogue with the care centres.

The best example of how the report was used in this way was in relation to the yearly authorization follow-up meetings with the care centres (see further in the next subsection, Follow-up Meetings). And interestingly, even though the content of the reports was sometimes seen as being inaccurate or even wrong, the reports fulfilled their purpose as starting points for the discussions that took place at the follow-up meetings. Said one rule book designer to a centre manager who looked with worry on the performance of his care centre: 'Don't worry so much about the numbers.' Furthermore, the rule book designers were periodically irritated by errors or inadequacies in the data, because the use of the report is an important tool in the realization and purification of the roles (purchasers–providers) demanded by the care choice reform. The rule book designers are however ambivalent in relation to the role of the report:

Linus JK: Was there a problem in the authorization follow-up this year? Was there an indicator that was not measurable in any good way?

Kitty: [W]ell, if we take [care centre x] then, there we have no reliable data. But this year, we have been less, not nearly as focused on availability as we were last year. So, that we have disregarded, knowing that [care centre x] is a well-functioning care centre in many ways. Telephone availability, we have not got a grip on. But for the rest, we know quite well ... And then we have let it pass.

Jeremy: But you surely could dare to say that this is the old style of governance within the county, which built a lot of trust. And, well, [care centre x], it's obvious; we know the care centre manager. And of course, she would not cheat with the numbers. And they will let us know in case they have problems. Because then they will request money from the county council. It used to be like that before. But that is changing now. Well, now we must also demand stuff. (Interview rule book designers, May 2011)

The quality report forcefully values the performance of care centres, but the rule book designers could choose not to let the data in the reports stand in the way of what care centre representatives express at follow-up meetings. They told me several times that they expected both care centres and county council technicians to learn and perfect the system of the report in due course. They furthermore believe that the intentions expressed and the abilities and seriousness demonstrated in personal meetings with care centres were as important as any report. The report as a device might not perform perfectly what it was intended to do, namely accurately represent the performance of the actors in the care choice system; but it is 'good enough', and seems to play a vital role as facilitator for regular talk at follow-up meetings.

I asked the rule book designers whether any results from the quality reports are presented to the public. From what I could understand about the idea of patients as 'informed' actors, this would not be too far-fetched. I imagined that – following the ambition to have accessible information for the 'market' to function well – the report could potentially be a measure in the direction of securing the value of free choice. The rule book designers gave me ambivalent answers on this question. They answered that some data are made public, such as availability, while they are more reluctant to reveal data on, for example, the categories under the heading of 'patient safety'. The reason is that the numbers are considered to be 'difficult to interpret'.

For example, what does it mean that a care centre may have many 'discrepancy reports'? Some care centres figure more in 'discrepancy reports'

under the heading of patient safety than others. These reports could, for example, concern complaints from patients regarding the service they have encountered at a care centre. Interestingly, one rule book designer explained that it is not always a bad thing to have many discrepancy reports, which I also heard him explain to one of the concerned care centres. He said furthermore:

What is a bit sensitive is, for example, safe care, because it's very difficult for a layman to interpret these data. Many deviations could actually mean that you are really good, because you work systematically with dealing with it. And it's also a very, an important area where you work a lot with that, to create a good dialogue between care centres and the patient safety unit, and then you don't want it to be judgmental. (Jeremy: Interview rule book designers, February 2011)

'Judgmental', as expressed by the informant, seems to mean 'make it public'. He thus perceives data on safety to be a bit too sensitive to see the light of the day, at least in publicly available reports. This could be interpreted as a way to enhance and promote trust between rule book designers and care centres as a value. However, the ambition is that the data should, in due course, be used to inform patients' choices. So, the conclusion on behalf of the rule book designers' perspective seems to be that information for patients is good, but there is some information in the quality report that is too sensitive to inform the choices of patients. This is an important constraint in what goes for the agency of patients when making their choices; safety is not supposed to be a key bifurcation point in exercising 'free choice'.

When it comes to data on 'availability', the tone of voice has been higher. Data on availability is spread widely and is one of the few indicators that are made public. It is a much used indicator for the publics' eyes meeting the website and media, for example. At the same time, availability is one of very few values, perhaps the only one, in which the county council have noticed improvement since the start of the care choice system. And it is a particular version of availability. One of the key indicators concerns the number of phone calls from patients that the care centres manages to answer, where the threshold for approved performance lies at 95%. Another indicator has to do with how quickly patients can get to see a doctor. In an intermittent report from the rule book designers, the noted improvement of availability was prided on in the care choice system, and I heard over and over that it was a true success story of the care choice system. However, on occasions, the rule book designers told me they were disappointed that this was all there was to it. At one occasion, I heard them

posing the question to each other: 'Whatever happened to the other policy aims?'

Follow-up meetings

One route to a deeper understanding of the role of the quality report is to study the unfolding of so-called follow-up meetings. Follow-up meetings take place when the rule book designers visit all care centres in the county each spring. The roles of actors at the meeting are supposed to be clear-cut; the purchaser officials and the care centre representatives take part in discussing the data in the quality report. If there are any incoherencies or anomalies in the data, the care centre must explain themselves to the purchaser officials, and sometimes come up with a plan for how to solve a particular problem.

Follow-up meetings are thus a formalized procedure for assessing the performance of care centres, but they play out differently in practice. For example, one major difference between private and public care centres (in 2011) was that the public follow-up meetings were gathered together in groups in their respective local care organization, while most of the private ones consisted only of the two rule book designers, one medical advisor from the county council office, two or three representatives from the care centre, sometimes the business owner, and me.⁶⁸ At the very least, there were always two rule book designers, one medical advisor from HQ, one care centre manager and one medically responsible physician representing the care centres.

A usual follow-up meeting started with a welcome, and then the rule book designers and the care centre representatives sat on opposite sides of the table, with one copy of the quality report each. When meeting with the public care centres, the primary care directors of the public care centres took a leading role and spoke on behalf of the care centres as a group. The rule book designers told me that they prefer to meet with only one care centre at a time. For them, big gatherings were considered to be a bit unfortunate, because they took the focus away from the performance of individual care centres. For private care centres, the meetings differed more; for example, in one there was only the manager, and

⁶⁸ I could also notice the difference in reception we (yes, I was most often said to accompany the rule book designers to 'study their work') got from place to place, most notably between the public and private ones, but also differences among them; some expressed suspicion, some were welcoming, some were angry, a few were grateful and a single one refused me as visitor. Some care centre representatives were nervous, while others could barely wait to get started, often because they had many opinions on what ought to be done differently in the rule book.

one physician present, in others there was a business group present (three care centre managers and a business leader).

Conversations held at follow-up meetings are structured around the headings of the quality report. The report is hence a structuring conversation device, a device for formally assessing the performance of care centres at the same time as its merits and drawbacks are discussed. The meeting situation most often plays out in relation to a discussion and assessment of particular indicators. Usually, a discussion is generated when a care centre performs particularly badly (or over-the-top well) on a particular indicator.

However, good or bad performance does not mean the same thing in all indicators. As noted before, availability has been a large concern. Another example, where the rule book designers fail to express much concern, is found in relation to 'vaccination to the elderly'. At one meeting, the quality report indicated that a particular care centre had performed badly on this indicator, and the rule book designers asked the care centre manager why. The manager replied that 'I would like to take that up' and 'the vaccination went horribly wrong last year'. He started to explain how his care centre had opened 48 extra hours for availability of vaccination 'while other care centres had been open very little. Thus, people from other care centres came to us and we had to deny them the vaccine: it was really dreadful and created a bad atmosphere'. He continues: 'Apparently, there had been some form of information from the central county council that you could go get your vaccine anywhere - but that doesn't reflect how it works in practice. The positive thing, that we had more hours open, instead became somewhat unfortunate. I would want the county council to specify the minimum limit for how much each care centre should be open for vaccination.' Kitty replies that it is 'noted' before moving to the next indicator. I take this to mean that she thinks the care centre manager has expressed a valid critique that she will take home to HQ; possibly all the way to the whiteboard.

The following excerpt (Figure 7.2) illustrates the same handling of the vaccination indicator at another follow-up meeting where performance is really bad:

Kitty: Did you really not register any vaccinations to people over 65

years? The indicator says 0% in the report.

 $\label{thm:care centre manager: Well yes, but it was also a 'misunderstanding. We have a good$

system for [the clinical registry], but it is not suitable for [the

clinical record].

Jeremy: That is good for us to know...

Kitty: Ok, let's not dig more into that then, it just seemed strange.

Figure 7.2: Excerpt from field notes 2, follow-up meeting private care centre, March 2011.

The care centre slips out of the grip for this time. But a key dimension for how a meeting unfolds is nevertheless whether a care centre performs well or badly on an indicator. First, an excerpt from a follow-up meeting (see Figure 7.3) where the performance is good regarding the indicator 'prescription of antibiotics' (which is supposed to be low!):

Kitty: Reduce antibiotic prescribing: You have performed really well,

'We have nothing to say.'

Jeremy: The indicator is there because of the national target.

Care centre manager: 'It is a great indicator' Consensus around the table: 'You don't

win over friends' when you are strict with prescribing penicillin

just because patients want it.

Med. resp. physician: There is a myth about private care centres prescribing more

antibiotics than public ones.

Kitty: But here we have the right data. *Triumphant humming around*

the table; the result helps to dispel the myth.

Figure 7.3: Excerpt from field notes 3, follow-up meeting private care centre, March 2011.

Second, how the situation unfolds where a care centre has failed to register its prescription of antibiotics at all (Figure 7.4):

Medical advisor: Prescription of antibiotics: It is directly deduced from the

[patient record]. One row of prescription = one recipe. Why do

you have zero?

Care centre manager: There is something that fails...

Medical advisor: Is it computer problems?

Med. Resp. physician: Whose responsibility is to address and resolve?

Kitty: 'It is mutual', 'it is not given.' You should react, and so should

we.

Care centre manager: Perhaps check with IT services?

Medical advisor: Do you have a channel in there?

Care centre manager: Barely

Kitty: We could check on our behalf as well.

Medical advisor: A brief talk that focuses on antibiotics; about the importance

and significance of the target value. There is also a portal on the

[intranet].

Care centre manager: Can we enter the [intranet] now?

Medical advisor: That you should be able to do. [...] I sense some sort of latent

system failure somewhere around here...

Figure 7.4: Excerpt from field notes 4, follow-up meeting private care centre, March 2011.

Taken together, the excerpts illustrate the infusion of matters of available valuation technology, the relevance of indicators for matters of quality, and relations between purchasers and care centres. A prevailing theme is that the quality report figures in the middle of the conversation; but it is more of a discussion arena than a sole determination of justice and quality. The values of particular indicators are pushed, but in a manner that allows latitude in relation to challenges and difficulties.

The death of a darling: Meeting with the Quality Board

Let us take a look at another event, in which the rule book designers are attempting to trim the attitude of actors in the care choice system to a more competitive mindset. One incident with the Quality Board could serve as illustration. Before the new forms of collaboration and the Primary Care Forum were put in place, there was a Quality Board for primary care at the HQ. The

general idea with the board was that managers of the public care centres meet together with leadership from the R&D department to discuss quality development in primary care. So there used to be representation of public care centres only.

I was told by one of the rule book designers that 'it's a long story' of how the board was put in place and made into a 'darling' and considered a success at HQ. However, the board suffered from a serious disease: in the wake of care choice reform, concerns had been raised that the format of the Quality Board might not adhere to the principle of competitive neutrality. Even though R&D is an important part of the primary care mission, as the rule book states that all contractors will be involved in quality development jointly, the private contractors are not part of the arrangement. Because of this, it was discussed whether there should also be representation on the board from private care providers. However, I was told by the rule book designers that there had been some 'problems' with this ambition, in that private contractors were not satisfied with the arrangement of simply joining an established group. This tension has caused some unrest within the organization, not least among purchaser management.

All this was told to me before I followed the rule book designers to a meeting with the Quality Board in February 2012. The signal from management is clear: the Quality Board will not survive in its current organizational form, but will be incorporated in the work of the wider Primary Care Forum. Says one of the rule book designers: 'There is not so much to be said. We will just tell them how it is.' The rule book designers here are moving with confidence. They see themselves as being on a mission to secure competitive neutrality against forces that jeopardize that principle.

The meeting is attended by a handful of people. The rule book designers have initiated the meeting and take charge of it. At first, the two rule book designers sit on either side of the table, fraternizing with the other participants. One of them starts with a very frank statement: 'This is the new organizational model, and it will change our work fundamentally.' She passes a sheet portraying the new organizational model around the room. She furthermore explains that the new Primary Care Forum will lead to all care centres, regardless of ownership, being on the same footing with the purchaser management.

Even though the issue appears to be settled beforehand, a discussion takes off. The designers continue their explanation of the forum: 'It is not supposed to

be representational in the conventional sense, but to contribute through diverging input, while it will better account for issues of "fairness" between care centres. The forum will assign working groups to relieve the Development Director in boundary issues, between what is primary care and specialist care, for example.'

I understand clearly that in this particular instance, the rule book designer's expression of 'fairness' speaks to the obligation to take part in development work as a duty. There have been some complaints from public care centres that some of them have to do all the development work, while other care centres are free riding. The Quality Board representatives stress their own importance in this regard. One representative starts describing the important role of the board; among other things she brings up the example of their role in target-and-measure. She tells us: 'The Quality Board has been a reference group to the development of indicators in target-and-measure. The board has taken the indicators home, and tried them in out in practice.'

As she says this, one thought comes to my mind. Before the meeting, the rule book designers told me that one thing that bugs them is that the Quality Board does not seem to have done as much work as was ascribed to them in the organizational chart. For example, in the work description of the Quality board, they are supposed to develop indicators for the quality report and target-and-measure. Said one rule book designer to me then: 'But we did that alone!'

The representative continues to explain that the board tries things out in practice, and 'critically examines what is good and what works' at the care centres. The rule book designer emphasizes once more that the Quality Board will not be anymore, 'at least not in its current form. From the perspective of the private contractors,' she says, 'the board has been perceived to be of limited interest.' It is interesting that the rule book designer appears to speak from the position of private contractors, as a representative of their interests. There seems to be a perceived need for the rule book designer to emphasize that the issue is raised from the position of private care centres, and is not just a question of 'competitive neutrality' in principle.

During the conversation, I learn that target-and-measure and performance indicators are touchy issues. A board representative engages in conversation, on the offensive against current work in performance indicators: 'Our performance indicators are poor; they don't work well at all. In other county councils the R&D department takes on much more active roles in developing the indicators

that the National Board of Health and Welfare are aiming at. We need the Quality Board.'

The rule book designer again: 'We hope the new organization will address those issues better. Indicators shouldn't come from the administrative office.'

The board representative is now excited and replies: 'But we were not let in from the beginning! Our suggestions were dismissed when authorization was about to start.' Another representative, claiming that 'the process had been very systematic and many indicators were put forth – regarding medical quality as well as caring more generally,' backs her up.

The rule book designer responds: 'We know that. Each year we have forced through some indicators that were not really successful in target-and-measure. However, the input we have got from you on the board has been more long term; it has been very difficult to hear from you on specific decisions.'

The representatives stand down a little, but make the claim once more that R&D must be involved in working with quality, otherwise it will only be 'budgets and production in the minds of decision makers.'

The above discussion about indicators reveals a tension between management, research, medical practice, and quality development. There also seems to be a tension between the short-term practices of management, and the long-term investigations of the board, purportedly backed up by the spirit of the National Board of Health and Welfare. The rule book designers are dissatisfied with the extent to which the board has worked with indicators, while the board accuses management for only thinking in terms of 'budgets' and 'production'.

A discussion of the coming organizational reform follows. The quality report figures prominently in the discussions. The rule book designers let the board know that the report has been assumed to be a promising tool in the near future of the reform. In the conversation, both rule book designers and board representatives engage in pushing the quality report to the centre of coming development of primary care. They agree that current management practice has not been successful. According to one rule book designer 'there have been too many people from different parts of the organization involved in developing the report. Now that the Primary Care Forum will be the centre of the process, temporary working groups will be assigned to develop the report'.

The representatives, on the other hand, repeat their claim that the problem has been that they were not included in the process. They have been working continually for many years with quality in county council operations: 'And there

is a risk that the new group will be jerky and unstable.' This statement clearly signals a concern that the reform is destroying something that has been functioning well.

The rule book designer explains their take on the problem: 'One way to counter that problem is to use the quality report more actively. Then there need not be so much fuss over how we are doing in practice. But we must be very aware that it doesn't just become the economic parts. We want quality to be developed, but the report is not at a stage were it could help us so much in that now.' The report is again held to be key to a functioning care choice system.

The rule book designer continues: 'But let's assume that you are right, that the Quality Board is functioning well today, what could we bring home with that then?' This question raises a concern that everything that is good with the board should not be thrown away. But it is a question; the rule book designers have no straight answers as to what it is possible to pursue and how that will affect the organizational change and functioning of the Primary Care Forum.

A brief discussion follows, starting with the representatives laying the annual report of the Quality Board on the desk in front of the rule book designers. They explain and justify to the rule book designers what they have been doing. The conversation moves back and forth, sometimes smooth, and sometimes more disruptive and confrontational. It could be interpreted as a move between collective sense making and agenda setting on one hand, and a more challenging style to each other's justifications on the other. It centres on what needs to be done with the quality work.

One of the rule book designers utters a small but seemingly significant term, in asking: 'What must be *ordered*?' I take the question to have a double meaning of 'being commissioned', and of deciding what item or product to buy; what is the need to be fulfilled? Up until now I had not realized that these people buy so strongly into the purchaser–provider discourse. She follows up the question: 'The problem is that everybody is doing their own priorities, there needs to be somebody from the top making such decisions.'

The rule book designer is forcefully bringing the purchaser-provider split to the table with her utterance. One of the representatives seems anxious and explains: 'We have been seeing the managers from the care centres because they can take very concrete decisions at their own workplaces, because much of our work is very direct and involves the work of people on the ground, what will happen to that?' In her utterance, it must be remembered that she means the public care centres; the private ones are not included in this idea.

She continues to talk about the anxiety felt at some of the care centres, that results from some performance indicators will be made known to the public. 'To ease some of this anxiety,' the representative continues, 'the board assigns an award to care centres that improve or show good will and performance in designated quality areas. It doesn't rest on the rigid numbers of the quality report, but on systematic work that shows improvement in some indicators. The last care centre to be awarded worked to improve availability, as defined by their body of patients, of whom many are born abroad. But this resulted in poor performance in the availability indicator of the quality report.' Her story illustrates the perceived tension between different versions of 'goodness'; in this particular case between the qualitative good (systematic work) and quantitative one (poor performance numbers in the quality report).

Listening to this story, the rule book designer says 'I can now feel the anxiety over what will happen when the Quality Board is closed.' As indicated above, it is not news to the rule book designers that performance measures are a source of worry.

Another of the representatives explains: 'And we are also used to organize our own events, with awards and mass media coverage and everything.' Now the rule book designers lose their patience and start to engage in a taking turns in conversation, one of them showing the palms of her hands and leaning back, while explaining: 'These are not external pressures for reform, much of this comes from the internal county council organization, from us as purchasers. Therefore we have to start to talk about solving this in new ways. And it might be a discussion among providers of how we should do it.' Again, the purchaser-provider split enters the conversation. The rule book designers will not back down from this distinction.

The other rule book designer: 'This is the dilemma: the private contractors are opponents to the development that you wish to pursue. But even though they wish to do their own development, the public care centres must still do their own development.' Her statement here is intriguing, and allows two interpretations. First, the discontent of private contractors is again used as an argument against the prevailing order. Second, she acknowledges the tension and even uses the term 'dilemma' for it. It could be seen as a way to draw the conclusion out from abstract space – the principle of competitive neutrality will

not resolve it – and make room for a practical solution; because ultimately, the rule book designers perceive research and development to be valuable. She thus acknowledges that there must be a practical way of resolving the tension; the Primary Care Forum is suggested. The first designer emphasizes: 'It is crucial that this is not something done internally, but must be inclusive of more actors.'

The next utterance is interesting. 'Ok, but last summer we got mixed signals from management,' a board representative replies, 'on one hand, we learned that something was about to change in our organization. On the other hand, the Health Director encouraged us to work for the benefit of public care centres as long as possible, to develop quality, as we were ahead of our competitors. It could be seen as a competitive advantage that we have devoted so much effort in R&D, and should be acknowledged as such, that is, a competitive advantage. How private contractors decide to do it is up to them, not us.'

The rule book designers again: 'But you have to keep in mind that the county council is a very big actor; there could be no secrets. The Quality Board must rethink its mission. You can never go so far as to leave out the private contractors entirely.'

These replies are interesting as they express a controversy over roles in relation to a discussion of values. There are several perceived values present in the conversation: quality work, collaboration, competitive advantage, equal treatment, openness, inclusion, development, and clear-cut roles. The informants are leading a discussion that wraps its hands around how the values are intimately intertwined with their forms of realization. The board representatives are throwing a new position back to the rule book designers – 'it should be seen as a competitive advantage' – in the name of competitive neutrality. The rule book designers seem to be surprised, but respond that secrecy is not viable, since the county council is too much of a major actor in the care choice system.

Mostly like how it started, the remaining meeting time is devoted to discussing back and forth the borders of county council affairs, and the respective roles of purchasing and providing in it. The rule book designer pushes the distinction: "The question is "what is the county council?" We, who are here in the room, are the purchasers – we are not owners. For us this distinction is vital.'

One of the representatives replies swiftly with a practical example: 'But if somebody comes from a quality registry, for example, and wants to collaborate,

they will encounter the Quality Board of the county council and meet with us. And they could of course meet with private contractors as well. Because what we pay, we cannot give away for free, that would put our competitive advantage out of play.'

A rule book designer again: 'But then you have to rethink: is this a good start of the initiative with the registry at all? Well, maybe it isn't. You have to consider your role; you cannot go for everything that sounds good.' The other designer supports her claim: 'This is the fundamental difference. The Quality Board could remain, but only in another role for the public care centres. And that is none of our business; we only have to maintain the same relation to the development work by the private contractors. It sounds harsh that we would only be interested in the quality report, but that's how it is. If the Quality Board had been for everybody, we would have an obligation to spread the findings.'

Again, I take the discussion to articulate a controversy involving both issues of roles (who does and should do what?) and values (what counts as valuable?). A central theme is what the Quality Board is doing in terms of quality initiatives. It is furthermore important who (what primary care units) are to be involved, pay for, and benefit from this work. While a rule book designer argues that this needs to be 'inclusive', representatives of the board stress that they are part of the county council provider organization working with the public care centres. Moreover, the latter stresses, the quality work gives public care centres a legitimate competitive advantage (since they are paying for it, and there is a market).

'We have actually tried to share our findings and procedures and all', one representative replies. 'But the public care centres are paying for this service jointly, it is not sustainable to just give away stuff to private contractors.'

A rule book designer: 'And that is why we need the working groups from the Primary Care Forum.' The board member is concerned: 'Ok, but then we have to do everything double?!'

The argument is familiar terrain to the rule book designers: 'Yes, this is always a recurring question. Why do public care centres have to pay for stuff that benefits the private contractors as well?' Apparently, this is not the first time they face this complaint. She also has an answer to it: 'It is a provider's issue!' This means that she expects the providers (public and private alike) to strike their own deals over who will pay for what.

The meeting is rounded up with a decision to continue discussion later. The board representatives leave the room, and I remain in the room with the same company that I arrived with, that is, with the rule book designers. When the door is closed behind the board members, one of them says: 'This was worse than I would have expected.'

'This is always how it goes with these issues. We have to get rid of this idea of "symbolic value" and the like,' says the other one. 'Fine, they could carry on with that style, but the county council is a very dominant actor, these issues will continue to occur.'

'Well, we can't do much about that. But we could look after the other groups, so the Quality Board will not take over everything and undermine competition.'

'But that is always the risk. And the private contractors get upset. And I wonder: Is the Quality Board any good anyway, if the private contractors are not very willing to pay for it?'

They discuss the roles of the people they have just encountered and some of the managers for a few minutes. 'It is so obvious that these are sensitive matters, and that we don't stay in tune. Nothing of what they do is ever visible for us.' The other one replies: 'No, and why do they overemphasize their own role in developing target-and-measure?'

Just before closing my computer and going for lunch, I catch them saying to each other: 'Well, it is their darling that is about to be buried.' 'Yes, it is as old as it gets. And who will take care of the award now? I feel very brutal, almost as a management consultant' the other one replies.

Conclusion

The chapter has described how the making of the rule book is carried out, and how expressions of value, matters of roles, as well as practical complications, are important in that process. For rule book designers, 'competitive neutrality' often takes the role of a guiding imperative, which they express in the writings of the rule book and in the efforts to get the rule book in place. This often brings particular practical challenges, such as how to model the R&D collaboration between care centres, or how to use local areas, or how to keep rural care centres in business.

Problem solving and answering to 'issues' on the whiteboard are intricately part of the rule book designers' everyday work. Making the rule book is experimental, iterative, recursive, and reflexive. It is experimental because there is a certain element of trial-and-error methodology involved. There has been a perceived need to revise the rule book each year, and now, rule book designers can conceive of no alternative to that process. At the same time, rule book designers look back to the experience, and continually learn strategies to handle the challenges that appear on the whiteboard. Rule book designers are furthermore reflecting on their role, for example when it comes to the relations with care centres in quality reports and follow-up meetings.

Rule book designers are however not operating in solitude as they write the rule book; on the contrary. It takes an effort from many professionals to put the rule book together and to make it work as intended. The process entails people working to collect data, check numbers, transfer reimbursement, arrange meetings, and so forth. Different actors are brought in to the process to put their experience into words. Others are working to construct numbers. The job of rule book designers is to take all such work into account, make prioritizations, and attempt to condense them into coherent bureaucratic language to be put in the rule book.

Given that the work of designing the rule book is very hands-on, there is still much talk about principles, righteousness, and values. The episode where rule book designers are lecturing the Quality Board representatives in elementary purchaser–provider theory – and they fight back! – is indicative of this. Most often, such talk centres on the meaning of competitive neutrality. On one hand, the rule book designers push strong ideas of what purchasers and providers can and cannot do respectively, and why their roles could not overlap. The split is treated as a verity that all professional roles and functions must be concerned with, and claims are made that the qualities of the two sides must be formalized and more clearly outlined. On the other hand, it takes immense effort to keep them separate in practice. It is still a major concern for purchaser managers that practices resist the refined roles – even though the care choice system has been in effect for some years. It does not stop the rhetoric from portraying these efforts as unproblematic, but the chapter has illustrated that they must nevertheless be taken care of as practical challenges.

Chapter 8

The Making of the Target-and-Measure Scheme

Chapter 7 described the work of making the rule book. It illustrated the organizational efforts involved in formulating the rule book and getting it in place. In particular, it portrayed the challenge for the rule book designers to uphold the distinction between purchasers and providers and to push the principle of competitive neutrality. Writing is however a collective activity and is as much about altering the wording and numbers of the rule book, as it is about altering the organizational relations to make the rule book work as intended.

We are not quite ready to leave the making of the rule book just yet. This chapter – the final case chapter – explains the making of the so-called target-and-measure scheme. I have up until now kept the target-and-measure scheme much as a black box; not to frustrate readers, but to save the best till last. Recall from Chapter 6 the incentivizing role target-and-measure plays in the reimbursement scheme. It is thus a key device in enacting market agency in the care choice system. At the same time, there is much willpower and frustration in the process of getting the target-and-measure scheme in place. The rule book designers told me that target-and-measure gives them headaches. That they tell me this is fascinating in itself; but foremost it illustrates that target-and-measure is a puzzling and exhausting part of purchaser management.

The chapter presents two episodes that in different ways explain the efforts to design the target-and-measure scheme. Such events are illustrative of how values are grappled with discursively in a very concrete sense, for example, in speech at meetings. It also illustrates what happens in situations where values are articulated, disputed, and reappraised with calculative devices. The two episodes

are complementary and cover different aspects of values-talk and value handling in making the target-and-measure scheme.⁶⁹

Target-and-measure as a mode of governance

There are only a few permanent working groups centred on revising the rule book. One of them is the planning meeting for target-and-measure. These meetings gather several different professionals; apart from the rule book designers there are also other public officials of different kinds, such as economists and statisticians, along with medical professionals. The meetings could be said to constitute the hub in a complex process of making a target-and-measure scheme, with many stakeholders involved in different parts of the process. Just like the work with the rule book at large, I was told that the rationale behind this process is that:

[I]t is often broad discussion with different involved stakeholders that try to figure out, then, how should we think? And then it is really important to bring in different expertise that can look at the question from different angles. (Kitty: Interview rule book designers, May 2011)

At an early stage in the process there must be broad discussions on 'how to think'. The strength in working together with different professionals is also emphasized. This means that:

There is as much willpower in target-and-measure as in the rule book as a whole; as many people will provide their input, subtract and add stuff. (Jeremy: Interview rule book designers, May 2011)

The constellation of the working group varies slightly from time to time, depending on the current agenda. The meetings are devoted to the aims, general conditions, and technical questions of how target-and-measure will be developed and assessed. There are various considerations that need to be addressed, some of which go very deep in problematizing and justifying the existence of the target-and-measure scheme: What do the politicians want?

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⁶⁹ The stories makes no claim to portray the exact wording of the events, but are as close in spirit and content as I have been able to retell them. There is a certain element of dramatization; the intention is nevertheless to mirror the words I caught in my field notes.

Which government grants should be prioritized and taken up as target-and-measure? Or is target-and-measure even an adequate and just instrument for this and that performance? Do we need more or fewer incentives?

The case of 'information on medicine'

The following takes place in one of the target-and-measure meetings, a fairly ordinary Thursday afternoon in March 2011. Attending the meeting are the two strategists responsible for the rule book, two economists, one medical advisor, and one statistician. The meeting starts with an innovation in target-and-measure. For next year, there will be a governmental grant for those county councils that score well on the indicator 'providing information to patients related to their use of medication'. The officials want to prepare care centres to, as they say, 'take the grant home'. One, it is believed, fairly reliable method of doing this is to give them a county council specific economic incentive at this point in time, one year before the funds are granted. However, it is discussed at the meeting whether to run for the grant at all, and if so, should it be designed as target-and-measure or something else?

Usually, there are no straight answers. But there seem to be some imperatives that are more pressing than others. One of the most important, says one rule book designer, is that politicians are 'fond of target-and-measure'. And ultimately, even though the politicians are not that interested in the details of the scheme, the scheme as such seems to be very highly valued as a managerial tool. However, this fascination is not shared by one of the rule book designers, when she says: 'I get so sick of target-and-measure at times' and that it gives her 'a headache'. Still, she emphasizes that the target-and-measure scheme is a very central feature of the rule book. Another rule book designer explains:

Everybody monitors money on the margin. So target-and-measure money; that you cannot miss. It is purely a technical matter: if you perform as you should, the money comes to you without any greater effort. They just have to make sure to do the right thing from the start. (Robin: Interview rule book designers, February 2011)

The informant is here portraying target-and-measure as an everyday presence in primary care; it is nothing extra, or out of the ordinary, and everybody is aware of it. There is thus a particular coupling between the idea of using indicators and the practice it is intended to incentivize; it is a 'technical matter'. On another occasion, the rule book designer justified the target-and-measure scheme as a

'quality bonus'. This resonates well with the view on the target-and-measure as a technical matter; that the best performers are to be rewarded. But this is only one understanding of the scheme. One time, the rule book designers told me that the purpose is not so much to reward the best performers, as it is to 'put pressure on the worst'.

However, in this particular instance with the information on medicine indicator, another imperative is pressing; the will of national government. The government has issued a grant for county councils to improve caring situations to include more information to patients. For the county council to 'take the grant home', the county council will have to come up with strategies to improve performance in this area. The government is in this case, so to say, using an incentivizing grant to encourage county council management do a better job in making primary care perform better.

The statistician attending the meeting has looked at the case in advance and brings to the meeting a suggestion for a strategy to construct the indicator. He suggests that the thresholds for the payments could be linked to the results of the national patient survey. The national patient survey is a questionnaire answered by primary care patients regarding perceived quality of care. It is sent to the homes of a selection of patients that have recently been in contact with primary care providers. SALAR collects the results, and the intention is that county councils will use this data to develop and improve care from a 'patient perspective'.

The statistician says that he will skip over some of the details of how the survey could be used, but continues with his account to brief the others on his idea. There are three questions on information on medicine in the survey: (1) Did the doctor ask you about any other medication that you may be using? (2) Did the doctor explain in a way you clearly understood why you are being prescribed a particular medication? (3) Did the doctor tell you about possible side effects of the medication? He furthermore suggests that there could be three levels of payment that refer to three different levels of reimbursement, each one related to a certain score in the survey: Patient-Perceived Quality (PUK). PUK is a weighted value that brings together the answers to the three questions on one scale. When calculating PUK value, uncountable response options are not taken into account, such as 'not completed' and 'not applicable'. All responses are given a weighting in relation to their importance. The results from each

alternative answer are added together, multiplied by 100 and rounded to the nearest whole number between 0 and 100.

The statistician sends a document with the current results of care centre performances around the room. We are told not to care too much about how they perform individually (which is actually not very well), because we are to devote ourselves to a 'strategic principle'. He tells us that what is important is to increase the mean PUK value to 70. That is the intention of the national government anyway.

It seems as though the attendants at the meeting are following his presentation. But there are some objections to the suggestion. One official says that the major issue is that trust in target-and-measure as such is delicate, and could easily be jeopardized. To introduce a target-and-measure indicator in this way is to risk trust with the medical professions and care centre managers, because nobody really seems to trust the patient survey anyway. Still, the statistician persists: 'The question is not negotiable'. He claims that if they are going after the grant they must accept the whole package; such are the instructions from SALAR. This has been agreed higher up the hierarchy. A few moments of heated discussion follows where, on one hand, the value of the principle of information to patients is agreed on, and on the other hand that the target-and-measure could be very 'provocative' and must not be used excessively.

The national patient survey is considered problematic in itself. Several of the officials – especially the medical advisor, but also the rule book designers – hesitate over whether a patient survey is a just indicator and representation of this actual performance. In the case of information on medication, the first question in the survey is if the doctor asked the patient about usage of other drugs. That seems reasonable to expect patients to know; but the medical advisor attending the meeting points out that the question is not always relevant, since the doctor sees all prescribed drugs in the patient's clinical record. Instead, what might be interesting from a medical logic is, for example, whether the patient is using any naturopathic drugs. What if the alternative answers to the questions might have to be more open to capture such events? But somebody objects: then there is a problem of how to link an unquantifiable result to the thresholds in target-and-measure. Furthermore, what if the participation in the survey is very low and unevenly distributed over the county? The participants agree that problems might arise, especially in relation to small care centres where the

answering frequency might be too low to fairly assess it as an indicator for target-and-measure.

In the light of this discussion, it might not be surprising that the statistician turned to me and said that the ideas on how to use the survey are 'taken from thin air: there is no science behind it'. This statement is interesting in more ways than one. It could be interpreted as an excuse in the face of a perception of what constitutes 'good' positivistic science. Maybe he is considering their practice as far too pragmatic, and hence removed from the representation ideal of science. It could also be interpreted as hesitation towards the incentivizing ambition that they are struggling to calibrate. He is sincerely uncertain of how the indicator will be received among the medical professionals.

Anyway, it is decided that the suggestion from the statistician is to be implemented in next year's target-and-measure. And most other county councils decided to do the same thing. In this county, this part of the target-and-measure scheme allows SEK 9m out of a total of SEK 48m to be set aside for the entire scheme. For payments to be made, there are two measurements to consider. First, payment is made according to three different thresholds of whether a care centre can improve its result in relation to earlier years. Second, all care centres that live up to a PUK value of 70 get full reimbursement. There is thus consideration of previous performance, which is intended to give an incentive to improve, regardless of previous performance. The 70 PUK value is more of an absolute reference point, which responds to the intention from national government.

It is reasonable to expect that the sum allotted to the post – SEK 9m out of SEK 48m in total – emanates from the 'no-science-behind-it' regime of reasoning that was present above. It is also worth noting that 9m is the maximum amount that will be paid. There is thus a limit to how much will be paid on this indicator. In monetary terms, it is worthwhile for care centres to aim for a performance somewhere in between best and worst, and no reason for them to aim to perform best in class on this indicator.

The incentive scheme is used to interrelate the performance of care centres in designated areas, perceived to be valuable for primary care service, with monetary expressions of value. It is thus an incentivizing process that pushes (public) values via the mean of monetary value. Rule book designers reflect a whole lot about the use of incentives in this way, while also expressing doubt. One of them explains:

[I]n periods I'm very tired of [target-and-measure], because I think there are too many, too many chefs. I would like to have more long-term goals in this, and ... Yes, long-term goals that you could be committed to for some years and then you would, yes, quick-fixes should be almost entirely forbidden. Because it always causes despair with technology and registration and so on, and then there will be a lot of frustration and anger. And that devastates it all, of course. And also politically, or not only politically but in general, make sure that there are only a few goals you may have, actually, for it to operate properly. (Kitty: Interview rule book designers, May 2011)

The informant is complaining about several aspects of target-and-measure. There are problems with too many people involved, quick fixes, technology and registration malfunction, and the sheer number of indicators. She is sensing not only her own frustration, but also that of others. Yet the politicians are fond of target-and-measure, which means the purchasers will continue working with it. The questions regarding information of medication is one in a long row of indicators that have passed through the scheme over the years.

The process of making the target-and-measure scheme thus entails different forms of expertise, and it represents the handling of public values and monetary value. In a later interview, I felt inclined to push the rule book designers on the mention of the lack of 'science' in target-and-measure and threshold setting:

Linus JK: "This is not an exact science": you don't know where to put the levels, or, the thresholds ... How do you do it then? [...]

Jeremy:

No, but it's like everything else, there's no exact science; what is a good care choice system, what is a good primary mission? Everything is all about balancing various interests against each other. And yet that there should be a reasonable goal, and ... And the times they have tried to calculate things, or tried with an exact science, or what should I say ... Take the socio-economy that has quite advanced calculations and classification behind it. That is almost more difficult to communicate than a number that we just come up with, for example '96% is a good level'. It's almost more difficult to communicate, for nobody gets it anyway. Then it's almost better 'Well, this is a reasonable, considering this and that ...' Then people have easier to accept it than if one says 'yes, we have divided it by itself and then we have divided it into fifteen areas ...' Thus, it is much harder to articulate. And it might be just as wrong anyway. [...] Well, everyone knows that in both cases, it is an assessment. It's not, just because you have an advanced model behind it doesn't have to be more right. Instead, it is a balance of interests. And target levels are actually not so much discussion around which measure could be used ... For example this with availability; 'if it's like over 95%, then you are green ...' 'Okay!' Everyone has just bought that as well! So obviously, [care centres] must think that

it is reasonable. They would protest otherwise, they do it all the time, if they do not like something...

Kitty: Of course, it is actually not in the rule book, that 95%, or 90%, or 85% ...

Jeremy: No.

Kitty: ... should mean failure. Nowhere. But it has all been accepted without ...

Jeremy: Yes, the classic way to count according to open comparisons is that one-third is yellow [one-third is green and one-third is red, a relative value scale]. That you split it up. But I think it would be very strange, because then you wouldn't have been able to see the improved availability in [our county], for example, that we see now. It would surely not be made visible in such a system, for all would be equally bad ... It becomes also a way to show that we understand that 100% is not reasonable, that would go wrong. And then we cannot set one threshold; that you should have 100% availability. (Interview rule book designers, May 2011)

Jeremy is describing the rationale of developing indicators as a process involving both 'science', estimations, and balancing of interests. Available calculative techniques and 'the traffic light' model are used (though, in this case discarded) because they pose a solution, rather than addressing a problem. Because when it comes down to it, purchaser management via a rule book entails a balancing of interests and keeping contractors satisfied. It is more an assessment of 'reasonability' in order to communicate and legitimize the audit than anything else.

Backlash!

About ten months after the information on the medicine indicator was put in place I return to the field. The indicator has been in effect in the target-and-measure scheme for a while. On a Monday meeting, where the entire office staff is gathered, the disappointing news is delivered: Only three care centres met the lowest requirement in the scheme and only one managed to raise its PUK value. The rest failed altogether. In fact, I learn that the result is actually *worse* than before the target-and-measure was implemented in nearly all counties. If the grant from central government were to be paid this year, no county would have got a share of it.

The officials are perplexed and consider it a to be a 'fiasco', because they thought care providers would easily take the money home, and the incentive 'would be a source of joy' for everybody. It is big news, and discussion reaches from coffee breaks at the office to national network meetings for county council

bureaucrats. The issue opens up for much speculation. Most officials I hear discussing it doubt that it is *quality* that is worse compared to last year. An idea raised several times to explain the outcome is that doctors do indeed talk to the patient about use of medication, but rarely tell the patient about possible side effects. And this is based on professional judgment; the doctor does not want the patient to know too much about a particular drug, since it may cause the patient not to take it. Others suggest that the focus on the *doctor* posing the question is not always applicable, because much patient interaction in primary care is with healthcare professionals other than doctors. Why talk about medication when having a nurse removing stitches, for example?

Time and distance could have the effect of closing down doubt. There was some time lag between the implementation of the indicator and the delivery of the results. I had witnessed the officials expressing serious doubt over the indicator in the first place, while they were now genuinely surprised over the outcome. It seems that doubt was abandoned once the indicators were printed out on paper. But it did not take long before the officials unpacked uncertainty again, and were creative in investigating possible answers to the 'fiasco'.

An unexpected problem the poor result generates is what to do with the budgeted SEK 9m? I witness a hallway discussion between two of the officials. One claims that the money was supposed to be used as 'lubricant' in designated areas, and that for a particular reason. The lubricant metaphor could be interpreted with reference to the incentivizing ambition of the indicator; as a source of help to care centres to do the right things. The official continues to explain: as it had a precise purpose, this money could not be used freely for something else. The other official tries to imagine different alternatives on what to do, such as adjusting the target-and-measure scheme right away, or to allocate the money to other areas of the scheme. He is genuinely concerned. But the first official is sceptical of the suggestion: first, you cannot modify the scheme so easily. Changes are to be signalled to care providers with longer notice. Second, it is not very suitable to allocate the money to other targets, because then they would have 'an excessive amount of money' at stake.

The discussion continues later in the week. Somebody had suggested that the money should just be handed out to care centres anyway. But most of the staff at the office hesitate: is that really an option? Possibly, there is still a chance of transferring the money to another measurement. But it ought to be something that all providers score well on for them to accept it. One rule book designer says

that it has to be something more than just writing something 'on a paper' that is not valuable for patients anyway. Then they might as well get the money without performance indicators attached to them, to invest in improving their performance next year instead.

The bafflement over the failed incentive opens up a space for reflection among the staff at HQ. Several seemingly stable conditions are questioned. A first example is that the 'technical' aspect of target-and-measure is questioned via reinterpretation of the relations between purchaser management and care centres. The care centres are not seen as blind followers of instructions, and management are aware of several reasons for why that might be the case. A second example is that the pricing of the incentive – the SEK 9m – in relation to other prices in the scheme – is doubted. There is resistance to shuffling money between the different indicators in the scheme, since it could provide 'excessive' amounts of money for them. It is not surprising that money is seen as an arbitrator of importance and weight between the indicators. But it is interesting that there is resistance to handing out the money without correct performance. What the performance is worth is not just a question of money *per se*, but of the techniques of valuing it and how it is tied to representational and incentivizing ambitions.

I also hear a bit of grudging at HQ over the fact that central government had too much influence in designing both target and indicator of the incentive. I hear officials saying that it was not popular and is not considered worthwhile going for again. As already stated, one crucial factor for rule book designers in deciding the future of the target-and-measure scheme is how big the pressure is from politicians to try and go for the government's money. There is reason to expect that politicians will continue to be enthusiastic. Either way, it would seem that purchaser officials are happy to provide incentives to primary care providers, but not as eager to resign themselves to the same kind of apparatus from central government.

The case of target-and-measure at the Resource centre

The rule book designer Kitty tells me that I will be allowed to join her in a meeting at the so-called Resource centre. Even though I have been at HQ for a while, this is new territory for me, and I make sure to arrive in good time before the meeting. The location is a few blocks away from HQ, and upon arrival I am

kindly invited to sit down in the joint space in the middle, and have myself a cup of coffee. I have a fairly vague idea what the meeting will be about, and from the talk I overhear from open office doors, the staff is engaging in really technical stuff filled with statistical jargon.

When Kitty arrives, she lets me know that this is not very familiar terrain for her either. She usually corresponds with these people via e-mail. But she also lets me learn that these professionals are vital to the functioning of primary care management, because the technology to manage reimbursement and indicators and to assess performance are all dependent on complex technical ICT solutions. All is well when everything is working, but sometimes they fail. Those are the times when HQ are flooded with complaints from care centres; and in the long run this damages confidence in the care choice system.

After some time in the coffee area, the person we are there to meet invites us to her office. She introduces herself as Tara and begins to explain her work as a manager at the office. I have a hard time following the technical details and the statistical jargon. And from what I can tell by the expression on Kitty's face, the explanation does not seem to make much sense to her either. Two other people, Sam and Jimmy, are also present. After her brief introduction, Tara declares: 'Let's talk about target-and-measure!'

'We are starting to plan for next year's target-and-measure. We're in the brainstorming phase now. Last year, you were not involved in the initial phase, which was unfortunate. It is better to have the "technology" with us from the beginning,' says Kitty. 'Yes, and this year we know what the "technology" is capable of,' says Sam.

'All planning and preparatory work is due before summer. But the care centres want to have an early warning. And it is good we do it like this this year, we have confidence that it will work. We need the time before summer to decide what is reasonable and possible,' Kitty says, 'How was last year again?'

Sam replies: 'We didn't do much new stuff, the care centres couldn't handle any more demands.'

Kitty sighs and brings up the ill fate of the 'information on medicine' indicator: 'The patient survey was handed out in September, and everybody knew that. We had tried to make sure that they would get a fair chance to bring the money home. But it didn't work; now we have SEK 9m, and we don't know what to do with it.'

'You shouldn't use the survey as indicator!' Sam swiftly adds. 'No, perhaps we shouldn't', says Kitty.

The start of the conversation sets the spirit of the remainder of the meeting. The relations the informants are building up between management intentions and the viability of technology is following the meeting throughout. The activities in the county council are becoming more and more reliant on technological solutions. At the same time, the informants in this meeting – who are experts at the technology and statistical opportunities attached to the survey – warn against using it as an indicator.

Now the participants start to engage in the details on the prescription of antibiotics. Just as for information and medicine, there is a government grant behind the decision to bring prescription of antibiotics in as a performance indicator in target-and-measure. Says Kitty: 'We receive government grants for a bunch of stuff. And they are increasingly detailed, and we are supposed to bring them home to the county council, and there is increased pressure for us to bring them home. But there must be some reasonability in all this in target-and-measure. For example, we would be happy to get rid of "multimodal rehabilitation".'

'What do you mean, "get rid of"?' asks Tara.

'Just to remove it from target-and-measure, that's all, but keep the practice within the rehab organization instead of primary care. It's difficult to say what will become of it now. Care centres say they have a hard time getting patients to enrol in multimodal rehabilitation, and then it doesn't feel right to stimulate that. But we don't know, it might continue.'

Says Sam: 'But those diagnoses are not disappearing, it's just that we are not successful in promoting the method. It would be a shame to fail to help patients in need.'

Kitty replies: 'But I doubt that target-and-measure is the right method to stimulate all this. The rehab organization has difficulties in reaching out to all patients; people unable to attend group sessions, immigrants that don't speak Swedish, people that must travel. We may have to support that group of patients and professionals better. Thus not target-and-measure in primary care, but the rehab organization.'

Sam again: 'But these people come from primary care. Should we just stimulate primary care to write referrals then?'

'Well, primary care is supposed to come up with a care plan and participate with medical staff. But they are mainly reimbursed for the referral.'

Kitty and Sam are here expressing several examples of problematic aspects of the target-and-measure scheme in relation to care quality. The perceived problems with government grants and the limitations of target-and-measure are brought up again, familiar from the previous section. Besides, the problems of referral regarding multimodal rehabilitation are brought up in the same vein. The border between primary care and other types of care is not that easy when it comes to purchaser management of multimodal rehabilitation. The other meeting participants are also aware of the problematic side of getting the incentive tuned exactly right; this time regarding exactly what type of action will be reimbursed. In multimodal rehabilitation, one of the challenges is how to deal with who (primary care or rehab) is doing what (referral, care plan, treatment, staff), and how that relates to quality in care.

The conversation continues in much the same manner for some other challenging therapeutic areas, like cognitive behavioural therapy and varicose ulcers. I interpret these problems as having a common denominator; namely how to fit the rules for reimbursement and the incentivizing ambitions with the target-and-measure scheme with how care is/should be carried out in practice. Besides, there is always the lurking question of what technologically is possible.

Regarding varicose ulcers, the meeting participants agree that they are a big problem for primary care patients, especially the elderly. The discussion slips into a consensus that there could be a good idea to try to stimulate treatment of them in some way. The question is how? The transition towards electronic clinical records allows increasingly detailed data to be captured. However, last year, the difficulty was what to make of the registrations in clinical records. It is perhaps not the right way forward regarding these types of treatments. Sam suggests: 'We could maybe try to stimulate registration in the ulcers quality registry?'

'I think there are very few care centres inside the registry,' replies Kitty, 'And you cannot expect too much from them, because it means they will work double, to make registration double.' Tara follows up: 'Oh yes, I see, because data is not transferred from the clinical record automatically.' They both express a concern that registration in both clinical records and quality registries requires too much administrative effort from primary care.

'Apparently, there are different types of ulcers, but lack of knowledge on how to treat them,' says Kitty.

'Yeah, real lack of knowledge,' Sam says, 'In Norway some treat it with soft soap ... Nobody really knows what to do'.

Tara: 'Aren't there any guidelines?' The participants are unsure about that, but somebody suggests that there might be some information available inside the quality registry. Apparently, some of the nurses in the county know more about this than others. 'These nurses might have some ideas,' says Sam, 'They may not be using the registry right now, but there might be a classification code in the registry that we could use? I'm just considering what we could measure? How long is the time for recovery, is there a template, or are there any keywords we could link to a template? ... There might be many ways'.

'That might be a way forward,' Kitty says.

'If they use a template with keywords we could access, that should be possible,' says Sam. The issue needs to be investigated.

The informants are here actively searching for a way to wrap their arms around a measure that it is possible to capture, at the same time as it is adequately related to reasonable and valuable medical practice. The problem here is that they are uncertain about what is the proper treatment, as well as what types of data are possible to capture. Even if they get hold of a measurement, they are hesitant as to how to model it into an indicator.

In next year's target-and-measure, there will be a measurement for registering diagnosis at patient visits. The point is to prepare primary care for a gradual transition to ACG. The discussion around the table touches briefly on this. Apparently, there has been some discontent that visits where patients receive their vaccinations are exempt from the demand to register diagnosis. The participants discuss the tension between making the rules exactly the same for everybody and making an exception for vaccination visits. Sam: 'It could be problematic just to exempt *them* from the rules.' I interpret the emphasis on 'them' as a concern over the reasons why precisely vaccination should be exempt from the rule, when there are many of the same out there. Kitty again: 'But how come this became an issue, everybody knows that it is not a good idea to register diagnosis at vaccinations ... We have to talk to the medical advisors about this again.' The issue is closed for now.

A new topic is brought to the table. 'What about the elderly? We have done a few things, but we should have something more.' Kitty says. I read her

statement as being in line with another of the national government's prioritized areas. Just as with information on medicine and prescription of antibiotics, there is policy pressure from government to deal better with the elderly. The meeting participants are struggling together to come up with ways to handle it. Kitty again: 'What about "unnecessary hospitalization" for example? That has been used as an indicator in other parts of the country.'

'It is not such a big patient group. But we might try to do something with patients that are at risk of being re-hospitalized,' says Tara. 'Of course, that is a risk for all patients in a sense, but we should try hard to make sure that they don't come back.' 'That sounds good,' Kitty says. Hospitalization is expensive for the county council. Tara continues: 'We do a follow-up of hospitalization of people over the age of 80 in primary care assessments. But I don't think we can use that.'

'I don't understand, is it primary care patients?' Kitty asks.

'But re-hospitalization is caused by failure by hospitals, not primary care,' Sam says. 'Ok, lets skip that then,' Kitty says. But she makes one more reflection: 'But yet, SALAR had "unnecessary hospitalization" in their suggestions for performance payments. What do they mean by that then?'

'They are talking about the ones that are referred back to primary care,' Sam replies.

'But I don't get it,' Kitty persists, 'Old people are often hospitalized anyway, even though it appears to be unnecessary.' 'But what is considered to be unnecessary then, that you don't know,' Tara replies. This conversation touches upon the problematic of borders between primary and specialist care in a very pressing manner. The question of whose fault it is seems to be pivotal to the incentivizing ambitions. 'Well, there is always a medical assessment,' Sam adds.

'Or we could see how other county councils are doing it. There has to be some kind of rigour in it that allows us to measure!' Kitty says. She appears to be persistent now that she sees an opening for a just indicator.

The discussion continues back and forth between different possible measurements. Jimmy asks: 'Could we measure where the patients come from, follow their listing?' This reasoning seems to tie into the values enacted by the reimbursement system at large – responsibility and comprehensibility – by invoking the responsibility of care centres in looking over the full caring situation for their listed patients. Kitty replies: 'Well, yes, I suppose you could do that.'

'But then there is a risk that the care centres will stop sending their elderly patients to the hospital!' Sam adds, genuinely upset. He expresses a worry that the incentive might pervert and destroy a reasonable medical practice. 'Well, the patients might also decide to go to a hospital themselves', Kitty states. In such cases the care centres can do nothing. 'But maybe it could be that simple a measurement anyway?' Kitty wonders.

'We could retrieve that data from our records fairly easy,' Sam says. Jimmy agrees. 'We could try out a data retrieval to see what that would look like,' Tara says. This is key and speaks to the spirit of the meeting: first, assess roughly the reasonability and value of a practice, then check the do-ability, and then move on with further measures.

'I also presume that you have to relate that to how many elderly people are listed at the care centre, otherwise it wouldn't be fair', Sam says. 'Yeah, if you only have children listed at your care centre you could just take all the money home!' Kitty remarks. They don't want the money to be too easy to catch. 'Let us check that out,' Tara says. 'It might give us something to work with', Kitty adds.

Kitty begins to look through her paper regarding the suggestion from SALAR. However, she doesn't seem to be overly enthusiastic over the proposals she studies. She reads the formula for the indicator from the paper out loud: 'Dividend: number of patients with asthma, cardiac failure or the like. Denominator: number of listings at care centre ...'

The meeting participants look puzzled. 'How do you even determine if the hospitalization was "unnecessary"?' Sam asks. Kitty continues to read from the paper, something about the general idea that if you provide good care at a care centre, hospitalization should be avoided. 'Ok, but then you must have a minimum level or something,' she says. She starts to grapple with different thresholds and makes small suggestions. 'Ok, but what should it be based on?' Sam asks. Tara suggests 'Possibly a national mean value?' The informants are struggling here to find an indicator and threshold at the same time. There are different objects drawn in to the argument. The SALAR material is looming large, but there is an interest in not just buying into the argument proposed by the document. They even criticize it.

'This is an obvious weakness,' Kitty says. Sam: 'It is a desk-product!'

Kitty again: 'It might be, but it looks different in different county councils. Here, in our county, we are generally very cautious with this stuff.' She is referring to the usage of indicators in target-and-measure as a delicate matter.

Sam agrees: 'All measurements have to be credible otherwise you will only get questioned.' As they are trying to wrap their arms around reasonable measures, indicators, and thresholds, they have an idea of a valuable outcome. At the same time, they are highly aware that their actions are configuring the practice they are trying to represent accurately.

'But still, it could look very different from other county councils,' Kitty says. A discussion of different alternative routes goes on for a short while. A few other areas of target-and-measure and the quality report are discussed before closing the meeting.

Kitty and I leave the meeting together. On the way down the stairs I tell her that I think I understand her perspective – it is important to work at two ends of the problem when trying to get target-and-measure in place; that is, to work with what you really want and what is possible at the same time. She agrees and emphasizes again that she thinks it is vital, to work from both ends.

Before we part, I say that it is fascinating to see how target-and-measure could concern so little money on the whole (approximately 2% of total reimbursement), but that it has such a great symbolic significance. And it takes a lot of time and energy to employ and get in place. Kitty really agrees. She tells me that last year she and one of the economists tried to get rid of it. On one hand because it fails to provide much of an outcome, and on the other hand because it is so difficult to work with and takes so much time. But it was not well received. I take her answer to mean that the politicians or the healthcare director said they have to do it anyway.

Conclusion

The chapter has worked with two episodes in which the target-and-measure scheme is developed. The first episode illustrates how a particular indicator in the target-and-measure scheme was constructed, implemented, and assessed at the county council office. It showed the kind of reflective practices, technologies, and 'whims' used as valuation techniques for developing the scheme, or 'how to think' in making the scheme. In particular, it shows that a particular value – in this case it was the value of giving information to patients about their use of medication – is translated into a monetary value in order to incentivize the particular action needed to realize the sought after value. A recurrent theme is that the informants express caution with regard to the 'trust' and 'confidence' in

the scheme. In this way, the making of the scheme becomes a matter of 'balancing of interests'; that is, trust is expressed as a value that must not be compromised in employing target-and-measure.

The second episode illustrates how professionals assess the prospects for developing a new indicator for next year's target-and-measure scheme. It shows how they handle the function of technical tools together with justifications and articulation of values related to quality in care, for example avoidance of unnecessary hospitalization and treatment of varicose ulcers. They also assess the relation between relevance and the 'firmness' of indicators, and what the perceived effect will be. At the centre of the situation is the feasibility of different possibilities for the scheme. The discussion revolves around the technical valuation techniques, the values (different notions of quality of care), and the incentivizing ambition.

The episodes are indicative of how far the shadowing and situation-oriented methodology allows analysis to move under the skin of the value enactments pursued to shape the care choice reform and get it in place. They furthermore illustrate the enmeshment of different ways in which values are expressed; that is, as valuables related to quality of care, as material valuation techniques, and as monetary value. Now, through the course of the case chapters, it has become increasingly clear that the making of the care choice system is an opening in which to study the handling of values in welfare reform. This conclusion marks the way into the analysis and discussion parts of the thesis.

Chapter 9

The Composite Qualification of the Primary Care Good

In the light of the case chapters, we are now in the position to return to two of the research questions (the third question is kept for Chapter 10): (1) Which values are considered to be at play by the informants in qualifying the primary care 'good'? (2) How are these different values enacted and ordered in the practices being examined?

The chapter works with the research questions in three steps. First, it examines some of the diverse values at play in the primary care marketization practice, and how they are made to matter in relation to each other. Pertinent sub-questions are: How are key values defined and related to each other? What subjects, actions, and relations are said to be important in realizing the values?

Second, it examines the dynamism of how the rule book is supposed to be stable, at the same time at there is work so as to order the handling of values in the making of the rule book. Sub-questions are: Who are involved in such work and how is the work organized? How are disputes and clashes between values identified and settled?

Third and finally, the analysis is drawn together in a discussion about what kind of 'politics by other means' is entailed in the handling of values in the making of the rule book. The discussion highlights the tensions between values in qualifying the primary care good and asks: How does the work practice cement or challenge the intended values of the reform? What type of political order is enacted by the work practice?

Primary care marketization practice: Between means and ends

A plethora of different values appear to be important for the making of the care choice system. For example, the rule book expresses free choice, competition, quality, availability, security, flexibility, influence, safety, continuity, responsibility, cohesiveness, cooperation, health promotion, disease prevention, and consideration for the underprivileged. Besides the articulations of value in the rule book, there are yet other articulations in the studied situations, such as adherence to tradition, scientific rigour and/or pragmatism in relation to 'thresholds' and indicators, and transparency expressed by rule book designers and other professionals. There are furthermore a multitude of calculative tools employed that express numerical valuations, such as the quality report and the reimbursement scheme, and finally, there are weightings of diagnoses, treatments, and patient cohorts.

The making of the care choice system is thus highly evocative when it comes to a wide diversity of values, which are all part of qualifying what is 'good' with the primary care service. The rule book designers struggle intensely to make different values meet in one rule book, where their choices have profound effects on who gets what and which values are safeguarded. But how are key values defined and related to each other? What subjects, actions, and relations are said to be important in realizing the values?

Defining choice and competition as means and ends

First, let us take a look at the values of free choice and competitive neutrality that purportedly stand in a particular position in care choice reform. The rule book expresses free choice as an end-in-view as well as a means; as an abstract value and as a practical mechanism for generating other valuables (competition, quality, and availability). The 'status' of patients will be increased by free choice, which will realize the aim of 'increased quality and availability in primary care through competition where care centres are free to develop within the framework of the mission', as expressed by the rule book. Patients making choices in primary care is thus expected to enact competition, which will spur quality. However, free choice cannot be dismissed only as a means, given how

the rule book brings it to the fore in this way. Choice is furthermore expressed as a policy aim, meaning to 'strengthen citizens' status as patients through free choice of care centre. Free choice means the right to choose primary care provider, while the county council pays for the provider service.

As for competition, the rule book expresses it as a bottom-line rationale for the care choice system to work as intended; it is *through* competition that other valuables will be realized. Competition is thus a means that frames the economic agency of care providers and enacts care providers as market actors who pursue economic interests by competing for patients. The rules for running care centres should be exactly the same for all providers, and are supposed to 'level the playing field', regardless of ownership. Competition is the process whereby a particular calculative behaviour is generated, that is supposed to trigger care providers. At the same time, from the outlook of the rule book designers, competition is enacted as a value for the care choice system, as they express high belief in the righteousness of competitive neutrality; that rules must be the same for all. They have in view a care choice system where care providers are competing for patients; without competition, there will be no safeguard of the values of quality and availability.

The road towards quality and availability in care choice reform is thus to be guided by the principles of free choice and competitive neutrality, as spelled out above. Because reimbursement follows patients, the rule book frames the economic agency of care providers and enacts care providers as market actors who pursue economic interests by attracting patients. Reimbursement is also the technique for compensating care providers for their work. Its expression is in monetary value. Thereby, the rule book is developed to frame primary care as a 'fair' market and to control the behaviour of care providers. Free choice and competitive neutrality are thereby modelled so as to become means, or drivers, for other values perceived to be of importance in primary care. In this sense, the values of free choice and competition are enacted as both goods in their own right and as very practical matters; that is, they call for action from rule book designers to write rules and assign reimbursement. This work deserves detailed analysis.

The complexity of accounting for different versions of 'fairness', 'quality', and 'competition'

The handling of values in care choice reform appears to be inherently prone with difficulties (see more in the next subsection). The work by officials to fit all regulation of the care choice system within *one* rule book is easier said than done. The qualification efforts are fairly complex, as the rule book is designed to be an representation of many different activities performed in primary care, and several different values that are to permeate provision of primary care.

The effect is that the qualification of the primary care good leads to complex regulatory constructions, which gives the effect of conflicting calculative behaviours. It complicates the making of the rule book, since it becomes difficult to sustain both the 'same for all' or the 'same advantages and disadvantages' versions of competitive neutrality at the same time. There have also been some seemingly ambivalent regulations put in place; the example of local areas is particularly telling. Care centres have obligations in local areas, regardless of listings; it means that the responsibilities of care centres are not directly related to their 'ability to attract patients', which is the rationale of the competitive mechanism.

Efforts to bridge difficulties result in very complicated writings of the rule book. The 'incentive scheme' is inevitably forged by contending values, versions of quality, and ways of doing competition. Apart from the intentions of market regulators, there is no 'single incentive'. The rule book is not disciplining the market behaviour of care providers coherently, as the calculative spaces modelled by the rule book have been put there to account for different values that are supposed to permeate the care choice system. The effect is a complex qualification procedure of primary care, in which the expected market behaviour becomes very ambiguous. Care providers are to perform highly different types of calculations simultaneously, even though they are to operate under a single care choice system.⁷⁰

⁷⁰ One example of such tension is that care centres are supposed to nourish their competitive advantages, while at the same time they must not deviate from the standard contract. This is visible as regards R&D, where the Quality Board wishes to pursue their work as a competitive advantage, but they are not allowed to shut the private contractors out (see Chapter 7). It is furthermore visible in the incentive structure to attract patients. On one hand, healthy patients put less strain on the care centre. On the other hand, care centres will be reimbursed extra if they meet up to 56% of their listed patients each year. And if patients are unhealthy

What is also adding complexity is the expected role of the patient. Sometimes the patient is enacted as a capable customer, while sometimes it is not there as an individual, but as a distant figure representing a value considered to be good care in general (as in the case of responsibilities in local areas) or a numerical value said to represent the actual patient (as in ACG and CNI). The rule book furthermore states that the care choice system 'aims to strengthen citizens' status as patients by free choice of care centre' and that 'citizen choice shall be secured by objective and easily accessible information'.

The patient is supposed to be a countervailing power to care providers as it is supposed to vote with its feet. The patient as individual is thus supposed to be judge, executor, and the one who benefits from its action in the care choice system. But patients are also, in a very fundamental sense of the word, portrayed as being in 'need' of care in the rule book; care centres must 'provide advice and assistance to citizens on how they can maintain and improve their health', and patients should 'feel assured that assessment, treatment and advice is safe and of good quality, that the care centre maintains high continuity and takes responsibility for patients', and so on. One thing is certain though: the purchaser providers do not want patients to have all the power to define what quality is. It is thus a very delicate matter for them to put the choices of patients in the driving seat, while attaining control over values and what counts as quality in care.⁷¹

To conclude, the urge for rule book designers to write competitively neutral rules in practice entails a whole lot of configuration of the values it is to secure. Competitive neutrality is supposed to be a mean – that is, a tool that forces all contractors to live up to the same contract to enhance choice and quality – but easily becomes a value in itself that might crowd out other values. Furthermore, the rule book stipulates that patients are supposed to choose, at the same time as the rule book sets up strict criteria for what counts as proper conduct and quality. In practice, the rule book designers handle quality as a matter of both

and/or poor, they are expected to be in need of more care. At the same time, they yield a higher ACG/CNI score.

⁷¹ Forsell & Norén (2013) have formulated a critique of this constitution of an ideal-type customer – a 'McPatient' – that does not decide the outcome of the service through choice. Instead, they argue, county councils tend to formulate demands that are to work with or without the choices of patients. This McDonaldization' leads to far-reaching standardizations in health care provision, which risks excluding patients that do not fit the standard scheme.

choice and regulation, which leaves the qualification of 'fairness', 'quality', and other values rather blurred.⁷²

The marketization effort thus produces deep ironies: in the name of competitive neutrality, every care centre is supposed to be treated exactly the same. This calls for a levelling of the playing field to the extent that quality is conflated into availability, because that is the only indicator that comes with a clear-cut percentage. At the same time, this governance practice moves responsibilities, so that the purchaser cannot be held accountable for worse care to citizens, in the name of treating contractors exactly the same. This is far from a stable state of governance, which deserves to be discussed further.

The handling of contending values: (Re)writing the rule book

From the outlook of applicable legislation and organizational charts, the county council organization has systems for how valuations are to be performed, priorities made, responsibilities distributed, and how conflicts are to be resolved. Essentially, at the 'top' of the pyramid are politicians, who are assigned to lay down the (public) values, and to decide on proper prioritization regarding policy aims. This role largely rests on the idea that values are generic and possible to implement; think of free choice and competitive neutrality, quality, and availability.

However, as we have seen in the case study chapters, the ways in which values are handled in everyday work practice at the HQ are not directly deducible to such formal routines and unidirectional processes. The work to get the care choice system in place is delegated to sites – where the purchaser officials work – that must specifically handle diverse accounts of value. At such sites values are filled with particular meanings, they are translated into rules, and

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⁷² One facet of this verity is found in relation to the two different reimbursement systems; both capitation and ACG are said to foster 'comprehensibility' and 'responsibility' for the entire patient. The rule book explicitly states that the same goals are thus emerging from seemingly different repertoires of evaluation. As different objects (types of reimbursement) are coupled with the same values (comprehensiveness and responsibility), the values gain different meanings. This is visible only insofar as the analysis takes qualification as practice, that is, both the rhetoric of the rule book and the detailed calculability of the object, into account. This illustrates that seemingly paradoxical relations between values are always practical matters for the actors involved.

they are balanced against each other. The overarching principle of the purchaser–provider split assigns professionals with different roles, but the split itself can never solve the handling of values. The purchaser role enters in a non-decisive way into such situations; one situated example is follow-up meetings. The handling of values in qualifying the primary care good therefore rests on interesting frictions between values, roles, and valuation techniques. How are such frictions handled in practice? How are disputes and clashes between values settled?

Struggling with manageability: roles, representations, and incentives

The rule book does a job in administering the care choice system, and the rule book designers do a massive job in making the rule book work as intended. They are thus working energetically to make primary care manageable. This makes rewriting the rule book an important activity, which takes a great deal of effort and resources. The construction of the rule book rests on different professionals working together, illustrated mainly in the situations outlined in Chapters 7 and 8. Writing the rule book is a collaborative effort and entails the 'balancing of interests'; I take this to mean that the rule book becomes a device for handling compromise between contending evaluative criteria.⁷³

One challenge in this work concerns how rule book designers employ tools to produce relevant representations of the world, that is, words and figures, for example in portraying the performance of care centres. They collect data on availability and other indicators and gather them in the quality report. We have already seen that what comes to count as 'quality' is a complex matter. The rule book designers express hope that the quality report will in due time become a better representative device; yet it will never be fully satisfied at a distance, as 'trust' is a delicate matter.

⁷³ This finding is something other than purchasers and providers acting as 'principal' and 'agent' trying to maximize their outcomes, or a functional separation of 'policy' and 'implementation', or 'optimization' of 'preference alignment' as expected from quasi-market theory. In contrast, quasi-market theory assumes that the 'preferences' of principal and agent can be expressed coherently. And of course, some aspects of this view on preferences are important for rule book designers, as when one of them explains his view on information in markets: 'There is so much uncertainty in healthcare markets' and 'this issue with asymmetrical information', and so on.

Another challenge is to make use of such figures, together with input from professionals, policymakers, and others, in making the rule book; that is, how the perception of the qualities of the care choice system translates into rules and qualifications for intervening in the care choice system. It entails a balancing act, which largely translates into 'incentives'. The usage of incentives relates to a wish to reduce the complexity of primary care by simplifying the motivations of care centres. However, while rule book designers acknowledge the importance of complexity in proliferating in qualifying the primary care good, they also want to increase control over events. One way this is done is to put a price tag on activities that are to be performed and place them in a reimbursement system.⁷⁴

A key challenge in this activity is what the rule book designers expect the addressees of the rule book to be like (this dynamic is portrayed mainly in Chapter 8): what are care centres' preferences and motivations? How could an indicator be designed so as to be 'reasonable', 'just', and 'trustworthy'? Informants have accordingly testified that subordination to the rule book and the target-and-measure scheme is seen as a 'technical matter': if the scheme is well designed and everything is normal business, the performance of care centres should be satisfactory. At the same time, they express doubt and pragmatic sentiments about the relation between care centre performance and incentives. They reflect on the 'technical' capabilities, the 'reasonability', and the 'justness' of indicators in relation to 'trust in the scheme', for example.

The rule book designers furthermore employ different representations of demand and supply.⁷⁵ The purchaser officials are assigned to account for the

⁷⁴ This makes for an interesting tension between sameness and diversification. For example, there is an intention that care centres will compete with each other over listings of patients. There is thus some need for diversification of output in terms of quality. However, the rule book's role as 'drivers licence' and criterion for approval is to foster sameness. That is why it needs to be so comprehensive. It appears as a paradox, but has been well supported in studies of market reform: what used to be a question of command-and-control must be formalized and made predictable to make marketable. Instead of a diversified market there is a risk of organizational and market actor isomorphism (Zuiderent-Jerak et al. 2015).

⁷⁵ I take it that qualification of the primary care good differs from a conventional understanding of a market good. Economics usually answers the question 'what is the good and what are the boundaries of the market?' by pointing to customer demand. The boundary of the market is decided by the substitutability of goods in buyer demand. The primary care good, on the other hand, is both supposed to be substituted (as patients choose between different care centres) and not (because all providers must abide by the rule book and answer to demands on 'quality').

'needs of citizens', which means that they translate ideas about 'what is good for the patients' to 'what could be demanded from care providers'. This activity calls for activities to pinpoint and model demand, which could be spotted in patient questionnaires, and by continually discussing what patients want and what they need with medical professionals and policymakers. Again, need becomes standardized in the expressions of 'good' caring practices, while it empowers and encourages patients to make their own choices. Patients 'needs', as expressed by good caring practices, become hesitant in relation to the idea that patients are supposed to choose their care provider.

Supply, or rather the constitution of performance on behalf of care centres, is constructed (incentivized) via the rule book and spotted (represented) in quality reports. Rule book designers work with this input-adjustment back and forth and take decisions on how to alter the rule book, which in due course establishes new expressions of both demand and supply. As the rule book designers construct both demand and supply, their work qualification towards these ends at the same time. Rule book designers struggle to let these qualifications be coherent, which is not easy. It is a two-sided problematic, in which they want both (objective measures of) quality and free choice as drivers of improvement. They are very reluctant to let go of notions of good and proper conduct in primary care as expressed by rules and reimbursement. Who knows best?

One complicating factor – although deliberately legitimized by the rule book designers – was the intention to build the rule book from 'tradition' and 'areas of improvement' as expressed by care centres. The rule book designers employed methods to capture such 'areas of improvement' before launching the care choice system, and they even claim that it was more important to adhere to 'tradition' than 'market theory' in this process (see Chapter 5). They thus express the idea that they might complicate the care choice system and its rules in this way. One informant expresses concern that the urge to account for the 'prevailing tradition' in market reform has no place in quasi-markets, as it might hamper easy entrance to the market. But she also testify that it makes sense for the rule book designers to stress 'trust' as an important feature of (experimental) management. Rule book designers acknowledge that the expected 'market force' do not work all by itself; writing will never end.

Since then, officials have developed more structured ways to represent the current state of affairs in primary care, as well as to harness the willpower of professionals. The Primary Care Forum especially is designed particularly for that reason. The forum however builds on taking into consideration a wider variety of 'traditions', as there are new care centres and more private contractors. What is considered to be 'tradition' is not stable over time, neither could 'trust' be the same thing. It builds on continually assessing and establishing new relations between market actors and to organize new ways to handle diverse values.

So, the rule book designers indicate that the urge to represent and be 'fair' to medical professionals is a significant concern in the ongoing design of the rule book. However, that does not mean that ideas on the force of competition or evoked ontologies of the motivation and behaviours of professionals (and patients) are not present in these situations. Rather, on the contrary, they are an ingrained part of the incentivizing ambitions present in the work at meetings around the target-and-measure scheme, for example. But these elements are not constructed to be detached from the concerned caring practices. Actors are actively brought in to formulate their concerns and intentions regarding medical quality, and the rule book designers themselves express highly different versions of the good on such occasions.⁷⁶

The qualification problematic comes down to what similarities and what differences between care centres are to feature as competitive principles in the care choice system. And this is a recurrent challenge for purchaser management: in what dimension is competition to take place and allow diversity, and in what dimension are care centres expected to behave in exactly the same way? One cannot help but be intrigued by the reasons and justifications for choosing some 'problems' to be put in the rule book, while others are excluded. What does it take for an 'issue' to arise and be entered on the whiteboard?

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⁷⁶ Again, one of the areas in which this paradox has led to challenges is in R&D. Rule book designers are explicitly concerned about the 'underused' potential of conducting R&D at care centres. One is led to believe that a rule formulated so as to enforce more research could, potentially, improve on the solution to the problem. Yet rule book designers testify that they are very reluctant to express too 'much detail' in the rule book, as it might prevent business from entering the market. Meanwhile, the Quality Board complain that they are not allowed to pursue their work, while the private care centres are not interested in participating in the current format of the Quality Board.

Quality revisited

What becomes of quality then, one of the main justifications for doing care choice reform in the first place? For the public, quality is largely operationalized as availability; simply because that is considered to be the only measurable outcome of care choice reform. At least rhetorically, quality is conflated into availability, which travels easier to media and politicians. The numbers are easily operationalized in the form of percentages, and the traffic light colours of red, yellow, and green are used to illustrate the results.

Yet there are other aspects of quality that the organizing work and devices employed in the care choice system are capable of spotting; there are many different indicators called quality indicators, and there is a quality report for each care centre. The county council HQ has furthermore arranged other arenas in which there are possibilities for a multitude of different accounts of quality to be uttered. Follow-up meetings, the Primary Care Forum, and national network meetings are all methods for capturing and representing things that, for one reason or another, need to be taken into account in the continuation of the care choice system.

There is not always, indeed, a problem with 'information deficit' regarding indicators. Sometimes, there is much information readily available, often regarding things that are truly perceived to be the *real* quality of care. There are indeed great hopes in the quality report. Rule book designers do not treat the quality report as a non-problematic representation of care centre performance, but it is used indicatively to stabilize discussions about quality. This tells us something about the quality report and devices in general; there is no straightforward relation between quantified data and force of a device. Instead, they are potentially shaping or transforming the very values they were set to portray and capture.⁷⁷

⁷⁷ The two terms – 'quality' and 'report' – serve to push the object forcefully into situations where matters of quality are at play. The powerful combination of the plasticity and authority of the quality report often gives it a jump-start into situations, for example at follow-up meetings. The report typically lies at the centre of the table, with representatives from the county council HQ on one side of the table, and care centre representatives on the other. The report frames the conversation, but it is not decisive for what happens. It appears to lend the discussants some stability in the situation, but its numbers are not the sole arbitrator of justice. The people present at the meeting are familiar with the authority with which the report speaks, but also with the problems of accuracy with the numbers. Another example of the usage of the quality report is for online information on quality performance intended for

To conclude, there are formal procedures and divisions of work between politicians and bureaucrats, and between purchasers and providers. However, the work to get the care choice system in place is delegated to sites that must specifically handle diverse accounts of value. And at such sites values are filled with particular meanings, they are translated into rules, and they are balanced against each other. When it comes to the making of the rule book, the practical work employed by rule book designers could be seen as politics by other means. I do not suggest that this is the sole arena in which to determine the development of the care choice system; but that it is indicative of the types of value-handling inherent in the efforts to model devices for market reform. This means that the rule book is an situated construction and is one of the reasons rewriting will never end.

The politics of the rule book

The values at play in the course of reform, and the ways in which they are handled, illustrate the importance of studying the making of a care choice system *in situ*. Therefore, the practices whereby values are handled via the rule book could be seen as a form of 'politics by other means'. The case chapters illustrate that there is much more value-handling going on in situations to get the reform in place, than is portrayed by the contours of a 'care choice reform' as expressed by legislation, policymakers, and quasi-market theory. Such findings open up a space of enquiry: What type of politics is enacted by the handling of values involved in modelling the details of care choice reform?

Testing and challenging care choice reform against quasi-market theory

Interpreted from quasi-market theory, the care choice system promises to solve two perceived problems. First is the principal-agent problem; and second the problem that care providers are not living up to the wishes and needs of

patients. In this case, the numbers travel more 'blindly'. The numbers are perceived to be hard facts. There are no negotiations and discussion around a table; no room for excuses, penance, and forgiveness. Ignorance is now a blessing, as it allows clear answers to difficult questions: 'Care centre A has more satisfied customers than does care centre B' (Not: 'the number on this indicator seems to indicate that you have a problem, please, tell me more?' 'Oh, is that so, I see.').

individual patients. Free choice and competitive neutrality are particular ways to enact 'fairness' and to push care providers to behave knavishly. The ability of actors to establish and sustain a coherent care choice situation calls for them to embrace market agency. It calls for patients to choose care centres according to their 'preferences', and for care centres to attract patients. In this way the studied practice ties into a registry of worth firmly anchored in a profound 'realness' of quasi-market theory, as well as living up to the intentions of LOV legislation.⁷⁸

The care choice system is supposed to hold as a market situation, and it employs devices for this. The rule book is intended to function as a 'robust incentive scheme' as it enters into situations, for it enacts primary care to become more market-like. It spreads the usage of common terminology and ideas of what are worthwhile activities. The objective is by now established as a so-called care choice system, and whoever claims something else is considered to be at fault in the face of the administrative logic. All the relevant elements with regard to the quasi-market polity are present. From the outlook of the rule book designers, all 'tests' of worth with regard to the care choice system should therefore be made in relation to a perceived quasi-market order.

However, the case chapters illustrate that there are other elements present in the care choice system and the qualification of the primary care good brings in values that create discord with the dominant quasi-market order. The practices whereby actors 'draw on' or challenge key notions from the quasi-market theorem, like free choice and competitive neutrality, are much more messy than policy expects: there are non-market elements of responsibilities for patients; there is special consideration for patients unable or unwilling to

⁷⁸ It might seem far-fetched for the analysis at this stage to bring back quasi-market theory; especially as its explanatory value had already been discarded at the beginning of the thesis. There are however obvious connections between the reasons and justifications as they are given in the situations studied and the rhetoric of quasi-market theory. As the current discourse of choice welfare reform and legislation are formulated the way they are, it is reasonable to expect that actors have become familiar with the notions via vast investment in policymaking and popularized versions of quasi-market theory: the white papers have been constructed to form confident statements about the roles of free choice and competition; and the LOV legislation establishes such principles as legally binding. The legislation becomes an object packed with the normative content of quasi-market theory – and a privileged set of notions: free choice, competitive neutrality, the voucher, incentive schemes, the invisible hand, and so on – with the force to enter a wide range of different situations.

choose; and there are policy aims targeted towards values such as proximity between care centres and patients, for example.⁷⁹

The rule book designers furthermore testify that tensions between values did not stop proliferating in primary care because it was made into a care choice system; rather the opposite. Profound tensions entered forcefully into the qualification procedure, and perceptions about primary care service were fiercely brought to the surface; one rule book designer calls them 'gibberish' issues. The rhetoric and terminology of policymaking and legislation might claim to be working within a single framework; that of 'the care choice system.' But informants experience tensions and the case study practically illustrate their ability to organize and handle discord – exemplified for the most part by the practice of rewriting the rule book according to the 'balancing of interest' and 'reasonability', the negotiations between purchaser officials and care centre representatives in follow-up meetings, and the Primary Care Forum – which shows that the care choice system is continually designed to handle highly diverse accounts of value within the overall 'care choice system'.

One of the key responses to critique have been to rewrite the rule book and rework the organizational forms to make it even more 'competitively neutral', meaning the 'same-for-all-rules'. It is supposed to be fairer according to a strictly competitive logic. At the same time, rule book designers are struggling not to let too much detail sneak into the rule book, while they work intensely to handle detailed challenges with competitive neutrality, such as local areas. The 'same-for-all' adjustment is however geared towards a new round of performativity, to make the same quasi-market theory work by other means. I have been able to capture how this brings complex contradictions and counter-performative elements built into the predicament of the rule book.

In the case of outsiders looking at the organizational chart, or for patients approaching the website for availability data, the care choice system might appear to be more 'formal' and governable than from the inside. The care choice system is not an ideal-type market of the sort imagined by classical economics or archetypical health economics, meaning that a 'market' is an arbitrating device

⁷⁹ Again, remember that looking at the values of free choice and competitive neutrality in principle can help give the thesis a certain depth in terms of political philosophy and ongoing debates about the normativity of the welfare state, but it is an analysis of practical measures of justification that helps develop new knowledge about the handling of values in the practice of market reform!

for relieving tensions of value and allocating goods in an efficient manner; the evaluative logic of a market is that righteousness is price, and vice versa. It is furthermore not an outright application of quasi-market theory. Instead, the officials are actively working to construct situations and qualify the primary care good so as to take into account values other than price. Price (in this case reimbursement) is not all there is to it. In that case the rule book would be only a tariff list.⁸⁰

What is more, the studied practice appears to fundamentally challenge the policy-implementation and purchaser-provider dichotomies implied in the organizational chart. Instead, what we have seen is that the evaluative criteria are continually worked out via revisions of the rule book and indicators. The modes of ordering the handling diverse evaluative criteria in this way were not anticipated from the start of the reform. And to be fair, over time, continuous organizational work has led to more stabilized assessment techniques. One example is the follow-up meetings; they make up some sort of combined graduation ceremony, performance review, and joint elaboration of worth for care centres. Such events help qualify situations that hold together, in which participants can attribute value coherently. The talk at follow-up meetings stabilizes the assessment of care centre performance, as well as establishing a sense of what is important.

Designing the rule book as to enact a composite political order

Even though care choice legislation is forceful, the purchaser–provider split is prevailing, and the politicians are fond of target-and-measure, there is some latitude in the rule-book-making practice. Legislation could never fully capture the precise meaning of key values such as free choice and competitive neutrality, as they are modelled in a practice of writing a rule book. Neither could

⁸⁰ The critique geared towards the rule book, for example from care centre managers, is often justificatory by nature ('it is not fair!') and it pushes alternative value positions. Although, this is not unique for this market situation. Marketization commonly calls for different assemblages and political ordering for calculation to work in practice (Kjellberg & Helgesson 2010; Helgesson & Kjellberg 2013). Yet that does not stop hopes expressed diving right into the heart of market rhetoric. Several claims are reminiscent of liberal political economy, for example, the agnosticism expressed by one rule book designer with regard to peoples' preferences.

policymaking fully operationalize the ways in which values are handled practically when modelling the rule book.

Meanwhile, if purchaser officials mobilize various objects (legislation, rule book, reimbursement scheme, quality report, etc.) in a skilful way, they remain in control over the evaluative criteria of the care choice system all the time, even though travelling between situations. This transport of worthiness becomes a privilege for them, to the extent that they regain the upper hand in establishing 'their' objects – foremost the rule book – as imperative.⁸¹ But this is only because their key objects – again, first and foremost the rule book – have been modelled to be composite in terms of values. They could enter forcefully in situations to establish the situations also insofar as they are also continually re-writing the rule book as to capture diverse values.

It seems to be no easy task to bring about change in the care choice system when there is so much administrative, procedural, technical, economic, and legal investment in the quasi-market form of worth. It is often not enough that criticism within situations is invoking other versions of worth as legitimate; one small utterance of disbelief and lack of trust does not carry far. The investments bring stability that is difficult to challenge; rule book designers often manage to evoke competitive neutrality as imperative. §2 However, that does not stop many

⁸¹ Sometimes, the rule book is not enough. The work of rule book designers therefore moves beyond the mere writing of rules. Occasionally, when the elementary principles of the care choice system are challenged, they might resort to other organizing measures. The meeting with the Quality Board (Chapter 7) is indicative of this. The Quality Board episode is furthermore reminiscent of the example of 'situated complexity' Moreira (2013) encountered in studies of clinical guideline development. It however remains an empirical question whether such episodes solidify in new 'orders'. In Moreira's example, the example of the guideline development was 'to be taken neither as morally compelling nor as epistemologically grounded' and as a 'rare, brief event' (ibid.). In contrast, for the Quality Board it is perhaps a viable and reasonable way forward for them to nurture their 'competitive advantage'. It builds, after all, on a (quasi-) market form of agency. The administrative logic of the purchaser–provider split leaves an ambiguous space, in which the Quality Board cannot be allowed to continue their work, at the same time as their expertise in R&D is taken as a prerequisite for improving the quality of care.

⁸² What is more, I have not encountered so many examples of critics relying on objects from other worlds, and few of the actors involved choose to go into outright conflict. One exception is the private care centre manager that challenged the business strategy of public care centres. But the rule book designers managed to render his challenge invalid. His claim: 'When the numbers look like this the care choice reform is put out of play!' is dismissed as a 'provider's issue'.

of the situations from being perceived as ambiguous by the actors. Most often, simple quasi-market rhetoric is not much to count on in such situations, especially not when challenged. ⁸³ No transcendental rules could govern particular situations in making the rule book; the appropriateness of different ways of handling values is determined in situations, not in abstract space.

To conclude, the rule book as a device is highly elastic: even though it may find its justification in quasi-market theory it could be mobilized for determining different versions of justice. As handling of values is a practical endeavour, the qualification of primary care good is by default highly composite. The life of the purchaser officials and the rule book tells us something of the capacity of devices to account for highly diverse values. The rule book is full of statements of what constitutes proper conduct in market terms, but it is also packed with statements about what constitutes good care and valuable outcomes regardless of market worth.

Therefore, rule book designers can testify that complete stability of the care choice system is utopian. 84 Yet they strive to hold it together, as if there were no alternative. They claim that the rule book will never be finished, at the same time as they are constantly struggling to improve it. There is always a tomorrow in which primary care will be given and received. The primary care sector will have to create output, whether it is called a quasi-market or not, or something else entirely.

⁸³ However, the vision of the care choice system as a primary care market has proponents in many places throughout the welfare state. For example, one of the main effects of the national network meetings is that they legitimize and bring sense to certain practices taking place in the county councils. It is seldom referred to as a 'political metaphysics', but nevertheless serves the role of building a collective matrix through which to stabilize the discussion, at least among rule book designers. Such a language is then brought home to the county council.

⁸⁴ Previously, it has been shown that there might be divergence in behaviour and valuation in markets where the frame is much contested or even multiple (Beunza and Garud 2007; Norén, 2003). What is more, this might become an permanent state in which the calculatedness is not necessarily significantly stabilized over time. However, rather paradoxically, this might be a guarantee of efficiency for the market. The reason is that the market might become better at realizing different values, if these are not tied down to a rigid market frame. Whether the care choice system under study in this thesis is actually 'functioning' is up to others to decide.

Conclusion

In this chapter I analyse how the values in (and of) the care choice system are constituted (1) by the methods for their practical manifestations; and (2) by the organizational work to put the 'market' in place. The analysis allows sight of how for example free choice, competitive neutrality, the needs of patients, quality of care, collaboration, trust, and so on – are practical matters in the work of rule book designers, while they are justified with regard to ideas of higher generality in quasi-markets and different perceptions of proper conduct in primary care provision.

I also take it that key devices – foremost the rule book, but also the balanced scorecard, reimbursement scheme, and target-and-measure scheme – enact different values, and furthermore, that the practice of making devices entails the handling of contending evaluative criteria, along with perceptions of fairness and reasonability. The practice whereby the primary care good is qualified is *not* an outright application of quasi-market theory; the values at play are formed in the local setting and not defined at a distance.

The effect is a complex fusion of values, which compete, cross-fertilize, and evolve together. Competing versions of values are found in relation to different meanings of free choice, for example (patients as both able and needy; as resources and obligations). Values cross-fertilize in the reimbursement system, where numerical versions of value become a transport and proxy for other valuables, exemplified by such diverse measures as 'base reimbursement' and 'quality bonus'. Values evolve in relation to joint collaboration and 'trust' between rule book designers and care centres, or where the Quality Board renegotiates their position as a 'competitive advantage'.

Therefore, the key finding is that values such as competitive neutrality are intricately entangled in other values and in their form for realization, that is, organization work and devices. Making sense of the care choice reform cannot only be about the common notions of quasi-market theory or the care choice legislation – free choice and competitive neutrality – but must be about the specifics of such a system; it is the detailed construction of a particular political order with the help of a rule book values are rendered valuable. Such a practice inevitably entails a form of 'politics by other means', in which values gain and shift particular meanings.

Chapter 10

Conclusion: Valuation in Welfare Markets

This chapter rounds up the thesis with the third research question: How does the analysis provide input to conceptual development regarding the handling of competing evaluative frameworks in the welfare state? For the discussion to be viable this question should be rephrased and sharpened: What should we demand from further conceptual developments given what we have learned from this case study?

Studying valuation in welfare markets: Reflections and a look ahead

The analysis showed that the handling of values in the process of reform defines the precise content and meaning of values. For example, it showed how competitive neutrality was transformed from a means to an end. This finding dismantles 'essentialist' notions of value at play in welfare reform. At the same time, it complicates the picture from the performativity assumed in the valuation practice perspective. In practice, a multitude of different versions of worth are drawn into the process of qualifying the primary care good, but become married in a non-decisive way in the making of the rule book. At the same time, the analysis shows that there are certain investments to make sure that the 'wrapping' of the care choice reform as a market order becomes imperative; the

clearest example is the legislation that strongly forces the principles of free choice of care provider and competitive neutrality.⁸⁵

Importantly, we must not assume that the market grammar in welfare reform is by nature a given, but we must perhaps understand that in the politics of reform, certain values could become established as rather stable reference points for actors to express worth in the setting under consideration; in the case of care choice reform, it has become impossible *not* to consider the idea of 'competitive neutrality', for example. At the same time though, analysis should pay great detail to how values are treated as elastic over the means–end-continuum in situations of market reform. It happened to be in this particular case study, that competitive neutrality took on an ever more solidified form of a value in the reform process, which pushed aside other values. I therefore suggest that valuation analysis must be open and not stabilize values as either means or ends, but instead study how they are employed in situations.⁸⁶

A key finding is therefore that the values of welfare reform do not stay the same over an implementation process; instead, they are actively shaped by the methods to secure them. This finding breaks the opposition between policy and implementation in valuation of welfare markets. In a common understanding of public administration, policymakers are deciding beforehand what are the public values at stake. This makes sense in an 'implementation' logic, that is, where

⁸⁵ Yet, again, what stand out from the case study are the indeterminate features of the practical work to model the 'market'. It also means that some of the ideal-type critique of marketization should be reinterpreted (e.g. Greener, 2003; Mol, 2008) Mol is criticizing ideal-type logic of choice, but does not pay much attention to the concrete activities and enactments that model and change it. Not entirely foreign to this type of critique, the rule book designers actually have their hands wrapped around precisely the issue of what is the 'logic' of primary care. How to qualify the primary care good is precisely what is up for grabs in working with the rule book. The rule book is thus a powerful device to enact the 'logic' of primary care as entailing elements both of 'choice' and of 'care'.

⁸⁶ One of the consequences is that to make meaningful a discussion of valuation in welfare markets, it must touch on a matter concern (Latour, 2004) that feels worthwhile to discuss in the first place; in the case of care choice reform I suggest that the dominance of competitive neutrality is such a concern. There is also a critical edge to this ambition. This is rooted in the belief that – perhaps paradoxically – to formulate a viable 'matter of concern' there is a need to question the problem definitions imperative to the studied practice. And this also goes for rhetoric in both academic texts and in policymaking, since these lie very close in spirit to each other in market reform. An important task for research, in order for it to matter, is therefore *not* to take the problem definition of informants for granted; otherwise, it will just end up in a feedback loop that never has the capacity to renew itself.

policymakers first established what the goals are, and then other parties could be assigned to make sure that happens. This is often how policies of markets in public service are supposed to function; politicians set the goals while the performers (of primary health care for example) are only doing what they have been assigned to do. This is furthermore a key requisite in quasi-market theory; policymakers define the objectives and free choice and competitive neutrality in the form of the voucher working in that direction.

However, implementation of welfare reform can no longer be a matter of defining (public) value at a distance and implementing it in practice – not even for marketization reform. Just as the making of the rule book could be interpreted as a 'politics by other means', the plantation and evocation of values in the design of welfare markets is both a moral question and a matter of equipped organizational work. Politically, I think this underscores the importance of vitalization and democratization of our understanding of valuation in welfare markets. Theoretically, I think it tells us something about the capacity of decoupling and recasting values via objects in a process of reform.87

At the same time, we should not shy away from the experience that market devices do not always do their job as intended; a performed normativity might be layered, become partly or wholesale disputed, and also highly composite. It is vital not to get stuck in an essentialist account of how the rule book performs the care choice system as a market. The performativity literature has possibly been a bit too deterministic when describing the capacity of devices (and their built-in theories) to shape practice according to intended policy effects. Of course, it acknowledges that performativity might also work counter to its intended performativity (eg MacKenzie et al., 2007), but the performative thesis usually

⁸⁷ Recall the composition and 'valuemeters' argument by Zuiderent-Jerak et al. (2015). In the face of this case study, I feel reluctant about their suggestion. Not least it is problematic in the light of the tendency in valuation studies to zoom in on valuation as numerical, quantifiable, calculative, and rateable, and to be conceptually blind to 'values' in general, or rather, a tendency to restrict the scope of analysis to numerical expressions of value (Kjellberg et al., 2013). We might need to do more to question the imperative of economics to stipulate the 'investment in form' (Thévenot, 1984) that formats the possibilities to express worth in welfare reform. There is a prospect in valuation studies of working against the tendency to rely heavily on the influences of economics, which would pertain more strongly to the original spirit of pragmatism that valuation studies so eagerly claims to honour (Haywood et al., 2014).

makes strong claims at explaining outcomes in reference to economic theory, which is something I do not attempt to do.⁸⁸

The execution of the care choice reform is fluid, emergent, experimental, and spans a diversity of values. I think that this illustrates that we need to open our imagination to alternative views on what values are, how they come to be, and what they do in welfare reform. I propose that the next step could be to replace mechanistic, legal, and agency-focused metaphors and open up to new questions: How could an alternative conceptual apparatus help in understanding how ideas about values relate to their form of realization in the practice of reform? How does it help in understanding how methodologies for knowing values relate to the normativity of values? How is it related to different forms of agency in a democratic order?

A proposition: The notion of 'ecologies of value'

From the challenges identified above, there are a number of requirements to which the conceptual development should answer. I propose that the notion of 'ecologies of value' might answer to those demands. The ecology term was suggested by Star (Star 1988; Star & Griesemer 1989) as a way for STS to refuse 'social/natural or social/technical dichotomies' and for 'inventing systematic and dialectical units of analysis' (Star 1988, p. 199), which would answer better to the spirit of STS than the mechanistic metaphors employed in earlier ANT. The point is to take a broader stance to the unit of analysis that takes in 'all elements of the ecosphere' (Star 1988, p. 200). Zuiderent-Jerak (2007) has furthermore proposed 'ecologies of intervention' as a way to acknowledge the complexity of action in situated interventions in health care. The notion of 'ecology of values' has also been employed by Stark (Buenza and Stark, 2004; Stark, 2009) to describe the complexity of morally unsettling situations.

⁸⁸ There should furthermore be no obsession about *economics* shaping devices. It just happens to be, according to Callon (1998b), that economists have done more work than other actors in modelling devices that favour their theoretical models. According to commentators such as Thévenot (2009) and Zuiderent-Jerak et al. (2015), actors can express other public values effectively with the preparation of devices. In principle then, the device approach takes us beyond the domination of economic theory. Again, there is however a need to be sensitive to the 'invested' (market and otherwise) form of coordination that structures the possibilities of alternative politics in the course of welfare reform.

I take it that there are six conceptual requirements for which the notion of 'ecologies of value' could help, as it allows:

- 1. thinking about values analogous to biological systems, where one part is determined by what other parts are doing; that is: 'the relations between organisms to one another and to their physical surroundings' (Oxford English Reference Dictionary, 2002). Translated into the 'organism' of values, this means that particular configurations of values exist together and make up the whole of a situation. It gives us a way to treat welfare reform as a relational system, where different 'organisms', that is values, depend on each other. It affords studying how ordering work results in a particular ecology with a certain configuration of values; the organizational work involved in the care choice system is an example of how this could look. It is thus thoroughly oriented towards matters of morality and the normativity of political engagements, but with a highly pragmatic approach to the practical problems and contingency at hand;
- 2. being fairer to the messiness of multiple normativities and their form of realization than is the economistic and ideal-type metaphor 'economies of worth'. It thus problematizes the rigidities assumed in sociology of justification, and allows more indeterminacy in how values coexist in particular welfare reform settings. The ecology notion is furthermore more consequential with regard to the wholeness of the situation than is 'enactment of valuation'. Besides, the ecology notion sensitizes the valuation practice literature to the plasticity of devices in enacting value, which means problematizing the obsession with the performativity of calculative devices and economics. Such orientation allows a fuller picture of what roles devices have in a reform process;
- 3. being significantly open-ended to value composition and the normative complexity of situations in which values are actively modelled in a particular reform setting. It aims to understand open and dynamic reform practices in constant normative flux. It thrives on the plasticity of values, which helps in highlighting the active, complex, interdependent, and political sides of reform. It entails analytical symmetry between accounts of diverse normativities that partake in forming the wholeness of situations. This view on values provides for very different outlooks on what could be seen to be legitimate, worthwhile, and desirable actions and events in welfare reform. Values are still invoked in reform processes with resource to different 'grammars' of value, which do not necessarily belong to a 'world'. This is what makes values appear as both constructed and solid in the face of actors, but never haphazard. This is both an

'emic' and analytical standpoint that bridges and flattens *a priori* distinctions of values between informants and analyst;

4. accounting for diverse ways of acting at diverse points in the reform process. It is devoted to process, but does *not* contend to rigid ideas of what is the proper centre of analysis. If it were to rest on too strong an assumption about configuration of action *a priori* (for example the purchaser–provider split, or the performativity of devices) it would miss that valuation can take place in a diversity of ways. For example, there might be actors that work to preserve a particular ecology. They could construct tools so as to cement the relation between values in a certain way (rule books, legislation, and other objects). But they might also work on a meta-level by theorizing about the justness of an order (scholarly work tends to help much in this). Consequently, there might also be an attempt to make a more fragmented ecology, to propose a different relation between values, or to throw some of them out. All of these possibilities must be able to be accounted for;

5. capturing the complexity of handling values which takes place 'in the wild', where both analyst and informants are enmeshed in enacting normativities that are not stable throughout a reform process. It expands the matters of concern implicated in a reform process and for reflection about how the researcher is entangled in such practices. It opens a space for analysis and critique of how situations are equipped to judge what should be taken into account in welfare reform. It enacts a reflexive critique and recognizes the handling of values as pivotal to all reform activity. It advances understanding of how different versions of righteousness can exist together, without casting judgment from the outside. It demands from the analyst to be attentive and take seriously the ways in which meaningful action can be justified in a multitude of different ways. I therefore take it that one of the tasks of the analyst is to highlight that we must never lose track of the political nature of our epistemic engagements in ecologies of value. We must maintain symmetry in relation to how we affect ecologies by employing methods to portray and understand;

6. awareness that economic technicalities must never obscure our vision of profound political issues. Tendering ecologies of values is an incomplete and never-ending process. There is no possibility of keeping it clinically clean. In ecologies, you need the garbage and the dirt; it is part of ecology. The messy value handling actors are doing in the HQ is not a poor practice, but inevitably something that needs to be taken care of. It is experimental to the full extent.

This also means that the view in sight of reform is the promise of a state that will never be; it appears as a wholeness that guides action, when it is in fact a wholeness that never existed. At the same time, it is precisely that wholeness that gives meaning and provides guidance (or opposition), forms a unity (or provokes conflict), and moral orientation (or dispute). But it always entails the dirty work of handling values substantially.

Closing remarks

The thesis illustrates the contingency and situated foundation of a case of welfare reform, in which values are grappled with in practical situations. This interrogates taken-for-granted assumptions of what welfare markets can and cannot do, what values they will promote, and what values they will suppress. There is a pressing need for policymakers, researchers, and the public alike to be equipped with notions to understand such situations, as they have profound effects on how we view and act on marketization and welfare reform.

Care choice reform, building on legislation with roots in quasi-market theory, purportedly beats a new path between classical concerns in welfare delivery. However, the promise of a 'robust incentive scheme' is chimeric, and care choice reform has not resolved ambiguities usually associated with non-market solutions, but rather brought them more acutely to the fore. The reform, in all its technical aspects, is not devoid of difficult handling of public values, rather the complete opposite. The making of the care choice system is highly susceptible to attempts and formulating what public values are to be taken into account, which is politics by other means. Fundamentally, it inevitably entails compromise. It is a transformative and experimental practice, and actors are grappling with moveable matter and are flying relatively blind with regard to what the care choice system is and what it can and cannot do in practice.

As valuation in welfare markets inevitably is a matter of practice in the course of reform, it is not very fruitful to try to anchor it in the right-wrong continuum. Yet it could always be otherwise. I would urge county councils and other public administrations to employ critical discussions around employed devices in relation to quality. Quality could not be laid down too rigidly; especially not in relation to a strict competitively neutral management regime. And just as I call for reflexivity about valuation practices in the course of welfare reform, so must I take responsibility for this thesis in equipping a public debate

that terms care choice reform a 'primary care marketization'. To the extent that the thesis partakes in ongoing discussion about valuation in welfare markets – wherever this debate takes place – a particular vocabulary might imply certain readings.

Hopefully, the notion of ecologies of value turns out to be a generative device in the debate. For example, it could stress the ability, and responsibility, of the public sector to take seriously and embrace the value handling that inevitably arises in welfare reform. That could lead to a much more inclusive market-designing practice, together with a change in perception of the 'technicalities' of market reform. It highlights the pertinence of continuing to study how the devices are made and altered over time, rather than casting judgment over the performance of devices from the outside.

At the same time, the thesis opens up a space for progressively engaging and intervening in welfare reform settings, with or without devices. It brings a democratic call to deeper understanding of the normative folding of reform practices, which could provide actors with insights that can truly enhance their capacity to act. The ecology notion could open up reflection of political capacities and orientation. If nothing else, this is a good reason for letting the composition of values and devices become a more democratic matter in welfare markets.

Finally, let us return to the ill fate of Mr B; not to end on a low rather than a high, but to stress pragmatics in dealing with the stakes raised in the thesis. There is a risk that too definite conclusions regarding the death of Mr B closes discussions on valuation in welfare markets, when we really want to open up a new space for analysing and acting differently. This is why we have to engage in practical discussions of welfare reform, and I think the thesis opens up spaces for enquiry and generates as many questions as it delivers answers: What do purchasers do to handle value conflicts in other welfare sectors? Are there any viable alternatives to having a central device such as a rule book as proxy for public values? I look forward to studies that take these issues on. Remember that there will always be a 'meanwhile, at the county council office...' in valuation in welfare markets.

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