6 Critical composition of public values

On the enactment and disarticulation of what counts in health-care markets

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Defining or composing public values–The case of health-care Markets

Within the emerging field of valuation studies, the question on how to care for values that are classified as 'public' is a key concern. This concern stems from a differentiation within the policy sciences between 'societal' and 'public' values: societal values are those that are desirable for society as a whole, whereas those values become 'public' if governments needs to intervene to ensure them (van der Grinten 2006). Public values thereby become not merely an important discursive achievement that allows governments to distinguish the values they need to ensure and the ones they can leave alone; they also present politicians with the pertinent problem what their 'intervention' might consist of.

In recent years, such intervention has increasingly taken the form of *defining* what values are public. This would suffice since, according to policy theory and practice, though government has a mandate to *classify* values as 'public', the actual work of *ensuring* public values can be delegated to other parties (WRR 2000). This is how market arrangements entered the scene of ensuring public values: they are seen as an efficient way to do so, since they require minimal state intervention. Positioning markets as a solution to the problem of caring for public values matched developments such as the rise of new public management (Pollit and Bouckaert 2000). A clear definition of public values by governments was however seen as vital for making this strategy work, as only then can market actors be expected to implement them properly.

The idea of deploying markets to ensure public values is far from undisputed. One of the most heated debates in this regard is on the role of markets when ensuring public values in health care. Every so often, the introduction of market mechanisms in health-care regulation leads to warnings that health-care

markets are an oxymoron (Godlee 2012; Palm 2005). But regardless of such critique, health economists' persistent claim that regulated competition can be used to implement public values, has been attractive to policymakers at least since the 1980s (Ashmore et al. 1989). Ever since, they have focused many of their efforts on ascertaining public values through the development of 'regulated' or 'managed competition' in health care (Enthoven 1988; Enthoven and van de Ven 2007).

In spite of their differences, the critics and the proponents of health-care markets share the assumption that, once defined, values remain static in the implementation process. However, as scholars from social studies of markets have shown, this is far from the case. Repeated studies have indicated that the development of market instruments actively shape the very values they were supposed to implement (Callon et al. 2007; MacKenzie and Millo 2003; MacKenzie et al. 2007; Sjögren and Helgesson 2007; Zuiderent-Jerak and van der Grinten 2009). Therefore, various authors have proposed a shift from the *unambiguous definition* of public values that can be ensured through delegation to market actors to a focus on the *composition* of public values in governance arrangements that are deployed to ensure and shape them in practice (Callon 1987; Latour 2007; Zuiderent-Jerak and van der Grinten 2009). As Bruno Latour has pointed out in his *Attempt at a* '*Compositionist Manifesto*', the word composition 'underlines that things have to be put together (Latin *componere*) while retaining their heterogeneity' (2010: 473–4). Public values are not therefore to be defined outside of the practices they are supposed to govern, but are assembled within them; they are immanent rather than transcendent. According to Latour, composition is therefore the opposite of critique. The main problem he sees with critique is that it is 'predicated on the discovery of a true world of realities lying behind a veil of appearances' (Latour 2004: 274–5). Composition, according to Latour, rejects such claims to deeper empirical truths as much as it rejects postmodernist rejections of empiricism:

> [C]ompositionists want immanence *and* truth together … [N]othing is beyond dispute. And yet, closure has to be achieved. But it is achieved only by the slow process of composition and compromise, not by the revelation of the world of beyond (Latour 2004: 478, emphasis in the original).

Consequently, the problem that compositionists have with markets for domains such as health care is not that marketization violates the complexity of practice by reducing it to quantified outcomes, as is often proposed by economic anthropologists (e.g. Miller 2002) and some authors within science and technology studies (STS) (Mol 2008). Rather, the issue is that within the present policy practice, the instruments for shaping these values in action are highly limited. This problem emerges since, as Bruno Latour and Vincent Lépinay have argued, both economists and economic anthropologists tend

'*not [to] sufficiently quantify* all of the values to which they have access' (Latour and Lépinay 2009, emphasis in the original). The privileged status that economics grant to financial measurement of values leaves other values insufficiently quantified so that they cannot be brought into the equation of what counts.

The reasons for the preference for using *financial* market devices are, to some extent, obvious since, as Gabriel Tarde pointed out, they have one crucial advantage over many other possible quantifications: 'wealth is something much simpler and more easily measured; for it comprises infinite degrees and very few different types' (Tarde 1902, as cited in Latour and Lépinay 2009: 14). To counteract this tendency, Latour and Lépinay (2009) propose that economics focuses on the inter-comparison of a much broader spectrum of values, for which it needs to develop a much wider range of 'valuemeters'.

In the context of debates on health-care markets, this advice however seems quite similar to long-standing health economic initiatives to develop instruments for example to measure Quality Adjusted Life Years (Sjögren and Helgesson 2007), which means that the suggestion by Latour and Lépinay can be explored empirically in this field. In this chapter we therefore analyse the potential of extending the range of valuemeters in markets, to see whether the presence of such market devices indeed leads to a wider-ranging composition of values that extends value practices beyond the realm of financial valuation alone.

To do so we turn to an analysis of the introduction of 'diagnosis-treatment combinations' (DTCs) in Dutch health care. DTCs are a funding scheme that singularizes treatment processes into packaged health-care products consisting of diagnosis and treatment and for which one price is paid to hospitals by insurance companies. It provides an alternative to activity-based funding, where hospitals receive payment for each activity they perform. We explore the introduction of this new funding scheme in order to address three questions. First, what is the intended result of this Dutch market for hospital care according to various policy actors and market builders? Second, what work has to be done by various actors to make markets function? A focus on the visible and invisible work (Star and Strauss 1999) of making markets, allows for a symmetrical analysis of how unintended, as well as intended, effects come about in practice. Such work is often left out of the analysis of markets by jumping to their effects, which are then quickly classified as 'normal' effects of well-functioning markets on the one hand and 'market failures' as phenomena to be repaired on the other.

Our third and central question is: what values are enacted in the resulting health-care market practices? This question allows us to explore market devices as elements in the process of the composition of values, and thereby empirically assess the value of the composition-through-devices approach, proposed by some scholars within STS, for the study of value practices that

forms the theme of this book. The study consisted of longitudinal research on the consequences of the introduction of DTCs in Dutch health care (cf. Zuiderent-Jerak (TZJ) 2009).[1]

Market devices for hospital care

Since the 1970s, public expense in health care has been on the rise and by the 1980s, the introduction of market mechanisms was already being proposed within the Dutch health-care system as a possible solution to turn the tables on increasing costs (van Egmond and Zuiderent-Jerak 2010). Though initially not being met with much enthusiasm, continuous efforts by policymakers to develop market infrastructures prepared the ground for market mechanism-based changes in the governance of hospital care (Helderman et al. 2005).

The notion that the health-care consumer should have individual buying or co-paying power and thereby steer quality (Berg et al. 2006) has been heavily criticized for being practically unworkable and theoretically flawed (Jost 2007); Dutch policymakers therefore chose not to put this notion at centre stage in the construction of the Dutch hospital market. Rather, according to the 2006 Healthcare Insurance Act, the construction of the Dutch market for hospital care assumed that insurance companies, acting as proxies for individual citizens, could buy good quality care at a reasonable cost on their behalf. As health-care insurance companies are not automatically expected to want only the best for their clients, citizens are positioned as a countervailing power (Light 2000) by being given the option to choose their insurer. Insurance companies have to accept citizens as their customers and health insurance is compulsory for all citizens to avoid 'free riders' in the system. As not all citizens have equal health risks, an extensive risk adjustment instrument compensates insurers for inequalities in health risks in their populations (cf. van Egmond and Zuiderent-Jerak 2010). A nationally defined basic package specifies the care that all insurers must provide. It leaves

[1] Between 2005 and 2007, TZJ conducted ethnographic research in a large teaching hospital in the Netherlands on initiatives that were supposed to bring together quality improvement and a strong position for the hospital in the Dutch market for hospital care. In 2010, TZJ returned to this hospital for a series of follow-up interviews with a specialist nurse, the innovation manager of the hospital, a medical specialist who also chairs one of the specialisms in the hospital, and a division manager. He further conducted interviews with a purchaser for the largest insurer in this hospital's catchment area, with the development manager and an economic expert at the Dutch Healthcare Authority, a regulatory body, and with the expert at the Dutch Association of Insurers responsible for developing a *Diagnosis–treatment combinations purchasing guide* for insurance companies.

other forms of optional non-basic care (such as dental care, etc.) to be insured via voluntary insurance schemes.

In this regulatory arrangement, the role of insurance companies is to negotiate with care providers on the quality and cost of the care they wish to deliver. Such negotiations would ideally lead to 'selective contracts', with insurance companies no longer reimbursing care at all hospitals, but rather contracting only those care providers who provide the best quality at the lowest cost. This is supposed to provide an incentive for other care providers to raise their bar in terms of quality and efficiency to be able to become preferred provider for insurers. Insurance companies are expected to have 'buying power', as they represent large numbers of citizens and thereby many potential clients for hospitals. They are expected to apply this power to stimulate quality improvement and cost reductions.

Prior to 2005, DTCs were developed so that the negotiations between insurers and hospitals could revolve around care trajectories—say, all activities related to a total hip replacement—that were packaged in one product, instead of reimbursing separate activities hospitals carry out in the care for a patient—e.g. the separate payment for diagnostics, anaesthesia, surgery, inpatient days, etc. carried out when replacing a hip.[2] The Dutch Ministry of Health decided that DTCs would be divided into two groups: an A segment, with pricing fixed on a national level; and a B segment, with prices that could be freely negotiated between insurers and hospitals. The A segment mainly comprises complex treatments such as less frequently occurring oncological care or emergency care, whereas the B segment contains care that is less complex and occurs more frequently, such as hernia repair or cataract care. Though both segments can in principle lead to negotiations between insurers and hospitals (the A segment on quality and volume, and the B segment also on price), the fact that prices are fixed for the A segment has as a consequence that this segment is usually not referred to as a health-care market by policymakers, hospital managers, and care professionals. In contrast, the B segment, with negotiable prices, is discussed in market terms. Policy discussions on the development of health-care markets focus on extending the B segment to make prices negotiable for more types of care. Thereby, marketization policy equates 'markets' with 'money', which is exactly what Latour and Lépinay (2009) criticized. The fact that many actors follow the definition of the market as a *financial* instrument brings us to our next question: how and why does this market work?

[2] Since January 2012, the Ministry has introduced some changes to this system, by moving from DTCs to *Diagnosis-Treatment Combinations On the road to Transparency* (DOTs). Besides pointing to the elusive quest for clarity, these changes mainly involve a simplification of the DTC structure and a reduction of the available products. These changes do not impact on the analysis in this chapter and therefore are not discussed in detail.

How care providers and insurance companies make markets work

In the wake of the developing market arrangements, the Dutch Ministry of Health started a large scale improvement programme called 'Better Faster' which would 'prepare the hospital sector for the new care system' (Ministry of Health Welfare and Sport 2005). Better Faster supported hospitals in improving patient safety and logistics through a series of national breakthrough collaboratives and other quality improvement programmes. Hospitals started analysing their care processes in terms of waiting time, throughput time, length of stay, number of interventions in the process, and number of visits to the outpatient clinic. In effect, the hospitals analysed how their care processes could be organized differently and how quality improvement could lead to gains not only in terms of organizational efficiency and patient experience but also in terms of the profits that a hospital made on care trajectories or, to put it in quality improvement jargon, what the 'cost of poor quality' was. For this, improvement teams in hospitals developed business cases that compared current with desired trajectories to calculate the financial implications of their quality improvement efforts.

However, these business cases required hospital financial departments to know the cost of, for example, individual interventions, outpatient clinic visits, and the cost of staff. This was not the case. For most hospitals it was a huge task to produce costing data and they tended to prioritize calculating the costs of interventions in the B segment over calculating costs that were only relevant to the A segment. Once available and integrated in these business cases, the costs sparked interesting discussions between hospital management, doctors, and quality managers. In many cases quality improvement and cost reduction seemed feasible by reducing length of stay or by omitting redundant interventions that at times were the result of poor coordination between professionals (Pronk 2006; Zuiderent-Jerak 2009).

Improving care processes and assessing financial consequences were not the only tasks hospitals started to carry out. They also developed 'dashboards' for internal steering, to ensure that once a care product had been sold at a low price, it would also be delivered accordingly, rather than falling back to the previous (more expensive) situation which was no longer reimbursed, and which would lead to the hospital facing financial loss. For colon cancer patients, overviews of the number of visits between colonoscopy (diagnosis) and surgery (treatment), for example, were readily available and were contrasted with the norm for such care set by the improvement team for this care trajectory (see Figure 6.1).

Even with all of this being achieved, hospitals still had to face the substantial challenge of getting care insurers interested in quality improvement. This

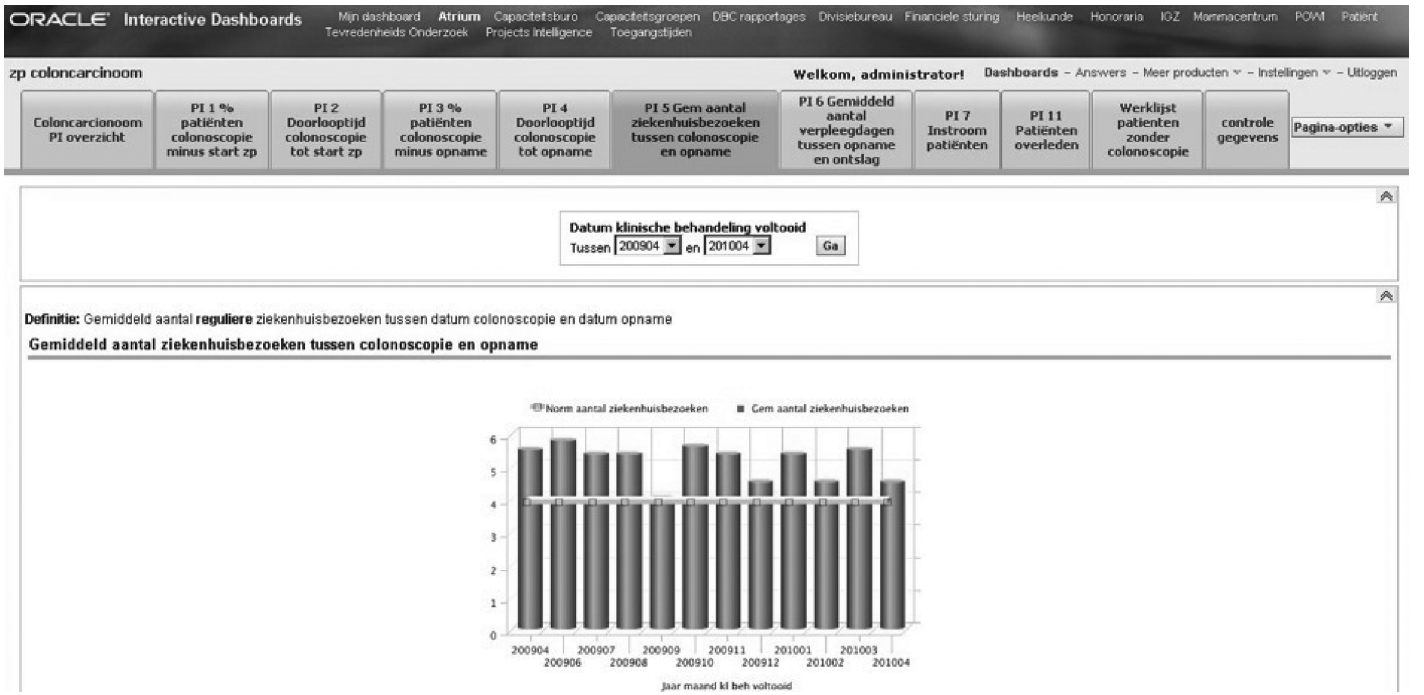

Figure 6.1. Purchasing guide for contracting care by insurance companies

turned out to be particularly hard work with insurers who did not always display the expected level of interest in quality matters during negotiations. As the quality manager of the hospital put it: 'It's up to us to bring everything to do with quality to the negotiating table, and they're hardly interested'. Since insurers did not seem to have an a priori focus on quality, the hospital went to some lengths to position quality as a relevant issue, trying to pitch their quality achievements. At times this led to fairly archetypical forms of commodification. The quality manager continues:

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

Despite producing such sales brochures, it remains hard for a hospital to sell quality in the terms they would like. In the debate on health-care markets, negotiations are sometimes more focused on financial aspects than on medical quality. Both health economists and policymakers often explain this phenomenon away by pointing to prevailing 'information asymmetry': if information about quality is not readily available to all parties, the negotiations will focus on the information that *is* available, and that tends to be of a financial nature. The solution for this problem is generally not seen as a problem of markets as such, but is scheduled into a promissory future: as long as quality gets defined in terms of quality indicators, these can be brought into the assessment. The notion of information asymmetry supposes that once transportable performance indicators *are* available, they *will* be taken into account in quality and price negotiations. However, in this case the problem seems to be that even readily available quality information only becomes part of the equation in very particular instances. And those instances tend to be where cost, again, is a central factor. As the purchaser of the insurance company put it:

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

So even *when* valuemeters, in the form of indicators for throughput time measured in dashboards and presented in brochures *are* readily available, quality becomes relevant only when it saves on costs. If quality always came at a lower cost, this would pose no conflict, but in that case health care could

do with simpler techniques for measuring best quality at lowest cost. As this was the initial assumption for many players in the hospital care market, the market in this hospital ironically worked better in terms of negotiating for quality and price in the early years based on relatively poor information (Zuiderent-Jerak 2009) than it seems to be working now, after a longer period of sometimes frustrating experiences, but based on better information on quality and cost. The dashboards on quality and cost parameters per care trajectory that were only managerial dreams in 2007 had actually materialized by 2010, and yet in some cases it proved harder to bring quality and cost together in annual negotiations.

This problematizes both the notion of information asymmetry and of value-meters, and brings to the fore the importance of market belief in making market instruments work. On the other hand it shows the importance of sustained analysis of how markets develop over time. Market practices change, which can have dramatic consequences for how capable market practices are for coming to a composition of values which is not dominated by price.

When an insurer defines quality in terms of cost reduction, hospitals seem to have two possible strategies to continue improving care that may come at a higher cost, both of which the hospital is pursuing: creative bookkeeping (not necessarily in the usual pejorative sense of the term); and playing the patient card. Creative bookkeeping has of course become associated with scandals, greed, and the misappropriation of funds. Leaving such normative judgements aside, hospitals have imaginative bookkeeping strategies, creatively ensuring that the costs incurred for delivering additional quality are borne by insurance companies. Such creativity sometimes leads to adding up certain items in order to then be able to charge a different DTC. As a division manager explained:

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

Bookkeeping DTCs so that various interventions get turned into a short admission, is a strategy that health economists refer to as 'upcoding' (Steinbusch et al. 2007), which is defined as 'the practice of miscoding and misclassifying patient data to receive higher reimbursements for services provided' (Lorence and Richards 2002: 423). What may be seen as a pragmatic solution within the present definition of quality insurance companies embrace is seen by some health economists as a 'hospital-acquired disease' (Simborg 1981). One of the main problems with upcoding is that there is no

countervailing power that prevents creative bookkeeping from turning into simple money-grabbing. For an efficiently organized hospital it may be a way of making ends meet, but it is easily seen as endangering the public value of affordable care.

An alternative that does not involve upcoding is to play the patient card. In the model of the Dutch hospital care market, the countervailing power of insurance companies are individual patients who are expected to 'vote with their feet' and change insurer if not satisfied with the way the 'third-party' insurance company is ensuring their interests (Schut 2009: 70). This encourages hospitals to target patients and their representatives more directly so that insurance companies are willing to broaden their definition of quality. This is exactly what the hospital studied here is doing. To frame the importance of quality improvement that is so hard to sell to insurers directly, this hospital has also chosen to address citizens and other parties by signing a 'contract with society', which includes announcements on highly specific care agreements per diagnosis in local newspapers and in the hospital's quality journal. As the quality manager explains:

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

However, a problem with this strategy is that it assumes that insurers can sell better quality at a higher cost to individual clients, while in practice they face reputation problems: insurance companies have a hard time purchasing quality that comes at a higher price, as it is difficult for them to convince insured parties that this prices goes into better quality care, rather than into higher profits. This is however not the only problem that insurers face: it is also not easy for them to actually negotiate with hospitals on quality care.

A HEALTH-CARE PURCHASING GUIDE AS A VALUATION DEVICE

One of the problems that insurers face when having to negotiate on quality with hospitals is that they could—in theory—negotiate on a very large number of DTCs, as initially around 30,000 such products were defined. This would require insurers to have an enormous and highly qualified staff with detailed knowledge of every instance of care delivered at hospitals—a daunting task

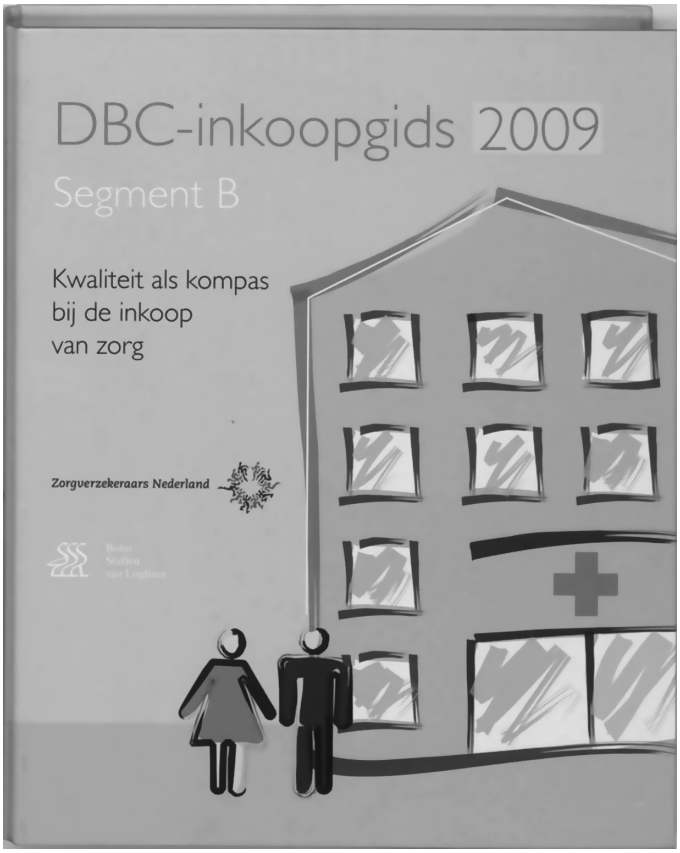

Figure 6.2. Dashboards for steering quality showing the average number of hospital visits in relation to the norm

that is obviously unfeasible. So one of their core activities in ensuring they can at least negotiate on some trajectories is to limit the number of DTCs on which they negotiate. As the purchaser of a large insurance company put it:

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

But if insurance companies were delegated the task of ensuring public values, the question becomes: what about the other DTCs? For those combinations that also allow for negotiation on price (the B segment), the Dutch Association of Insurers, the sector organization representing the providers of care insurance in the Netherlands, publishes an annual *DTC purchasing guide* (Figure 6.2), subtitled *Quality as a compass when purchasing care*.

The Dutch Association of Insurers compiles and publishes this commercially available guide for negotiations between health-care insurers and secondary care providers with various other actors, including scientific medical associations, and structures the profiles around available clinical practice guidelines. Furthermore, performance indicators developed on a national level are directly integrated and the opinions of patient associations on several diseases are taken into account.

The purchasing guide was developed as an immediate response to the new role insurers play when negotiating with hospitals on the content and price of care. This purchasing guide frames to a large extent what negotiations focus on. It is an interesting market device for several reasons. First, it seems indispensable in reducing the enormous work of health-care insurance companies to doable proportions. Second, though this framing is crucial for a pragmatically functioning hospital care market, the idea that public values are delegated to insurance companies, who act on behalf of their insured, seems in need of revision. With its hybrid forum of doctors, patients, and guidelines, this hot potato of composing quality in relation to cost seems to have landed on the Dutch Association of Insurers' plate rather than with individual insurers. This raises questions about the form and place where public values are indeed shaped and what is taken into this de facto national framing of quality of care. Because of this, the framing of the guide warrants further scrutiny.

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

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

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

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

In this quest for doability, DTCs are increasingly selected and combined in clusters. A relatively small number of 'baskets' thus covers a large percentage of delivered care, especially in certain types of treatment such as eye care. Thereby, the purchasing guide assumes that a smaller number of DTCs can be used in negotiations, all the while still pursuing quality on a larger scale:

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

This assumption is highly understandable in the light of the creation of a doable health-care market, but quality improvement researchers have observed that improvement to one stream of care is often at the expense of other patient groups. This phenomenon, generally referred to as 'carve out' (Silvester et al. 2004), has been particularly noted in eye care where the dominance of cataract often leads to well-organized treatment pathways that are completely isolated from other forms of eye care.

These problems do however not stop this negotiation infrastructure from at times being highly consequential. As the associations' respondent told us, the purchasing guide is not only an instrument for insurers, but also for hospital directors:

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

In this sense the purchasing guide sets a de facto norm, even though it was supposed to be a 'mere' negotiation aid. Apparently, the threat of future negotiation combined with a standard created partly by doctors themselves can produce results—and possibly—quality gains without the need for actual negotiation.

As we have shown in this section, the hospital has had to do much work to create valuemeters that shape public values in the market for hospital care. The challenge for insurers seems no less daunting, and the results for the relation between markets and public values seem equally ambiguous; this despite the valuemeters the sector organization of health-care insurance companies developed in the form of the purchasing guide. Having analysed some of the work various actors carry out in the market for hospital care, let us now return to the question of which values are produced.

The composition of public values in the Dutch market for hospital care

One aspect of the health-care market that has come explicitly to the fore is that all public values, not merely affordability, tend to get framed in the light of financial devices. Quality improves through the market devices we encountered, but generally only the quality that comes at a lower cost. Interestingly, all actors, whether based in hospitals, insurance companies, or agencies like the Dutch Association of Insurers, grant an ontologically privileged status to the price mechanism to ensure public values. One of the clearest indicators for this is that for those aspects of care not included in the DTC B segment, there is no purchasing guide. Insurers indicate that quality is only quality if it includes efficiency gains and hospitals point out that quality not associated with a financial advantage cannot be sold.

As a consequence of this situation it is harder to sell good quality than to divest expensive care—a policy that respondents referred to as 'managing bleeders and feeders'. This shows that, whereas the aim of the market policy was to get health-care organizations to compete for the favour of the insurance companies on the basis of differential quality, in fact they were becoming more similar due to the market devices that were developed to meet this aim.

Negotiations on quality do seem to have started, which most certainly is a major gain for hospitals, patients, insurers, and policymakers alike, in comparison to earlier times where discussions between insurers and hospitals only focused on volume and money. But according to the respondents, through the central positioning of price mechanisms, these negotiations shape the definition of quality as positively related to cost reduction, despite the wide range of valuemeters being developed by many actors to countervail this definition of the public value of quality of care.

Conclusions: Critical composition of value practices

As we hope to have shown, the market practices under study have complex relations to public values. What 'the market' is and what 'public values' are, is never clear in any fixed or static sense. Our approach to studying this process of the composition of public values through market practices has allowed us to analyse the *work* that many actors need to do to produce such effects. It also opens up the study of markets as 'political issues' (Barry and Slater 2002: 287) as it allows us to analyse how markets and public values shape each other. If market devices shape public values in specific ways, rather than merely implementing predefined values, the development of market practices is a

highly relevant empirical domain. Government agents as well as market researchers will want to understand how this occurs, with what consequences, and possible alternatives to remedy bad value-composition.

We feel there are two reasons why this should not lead to a re-politicization of the development of market devices through increased democratic control and debate over their development processes. First, as we indicated in the introduction, political debates on the role of markets in health care are generally caught in the question as to whether health care really is or is not a market, making it highly unlikely that such re-politicization would be productive. Second, bringing markets back into the political forum implies that the composition of public values could somehow be brought back under democratic control through discursive action. We would rather propose to accept that public values are shaped in practice and that therefore the relationship between policy aims and consequences can never quite be captured through the logic of implementation. For this the process is too unpredictable and the consequences too unforeseen. Such dynamic unpredictability is better explored through an experimental role for policymakers. They would see market devices not as an operationalization of policy aims, but as experimental practices in which the aim is a good composition of public values. Without such a shift, health economists and policymakers may always have the promise of a better market future but never a prospect for achieving it (Latour 2010: 486). Abandoning the idea that a market can implement public values is a key requirement for composition, for how could one 'assemble anything properly *while not looking at it*! . . . It is impossible to compose without attending firmly to the task at hand' (Latour 2010: 487, emphasis in the original). And such 'attending firmly' is precisely undone by the logic of implementation.

Our analysis shows that market devices can shape specific public values in rather unexpected ways. Though the policy aim in the Dutch hospital market was to increase choice for both clients and insurance companies and thereby provide incentives for quality improvement through diversification of hospitals, ironically, DTCs are producing the very opposite result of a national standard for quality of care. These market devices therefore seem to undo the very aspects that, according to the policy aims, they were supposed to strengthen. Market devices have often been regarded as shaping the setting in line with the policy aims and assumptions under which they are expected to operate—generally captured under the heading of 'performative' market mechanisms (MacKenzie 2004; MacKenzie et al. 2007). However, the market devices we studied made the practices within which they were supposed to operate less favourable to the policy aims—a phenomenon that has been called 'counterperformativity' (MacKenzie 2007).

Furthermore, the market devices studied here lead to specific compositions of the public value of quality that is shaped predominantly in financial terms. Quality is easily defined as directly related to cost savings, which leads to

substantial gains in the affordability of care and reduction of length of stay in most hospitals. This is a substantial improvement, given that each unnecessary day in a hospital is both a societal cost and a risk for patients. Yet this specific definition of quality sits uncomfortably with notions of quality that do *not* involve cost savings. Given the extensive efforts to develop valuemeters for such non-financial definitions of quality, the fact that quality has come to be defined in terms of cost-saving is not merely a consequence of a lack of quality information and/or 'information asymmetry'.

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

The point therefore is not that that these new market devices have made an issue of price or money. Nor do we want to pose it as problematic that public values are shaped in the practice of operationalizing them in market devices: means always change and translate the aims they are supposed to ensure (Latour 1999b). Interestingly in this study however, we noticed that the redefinition of public values in terms of price is not in the absence of, but despite the wide availability of a range of valuemeters that precisely aim at the broader notion of 'metrology' that Latour and Lépinay (2009) propose. The strategy of preventing such narrow definitions of public values through the development of a wider range of valuemeters therefore seems not only to neatly match initiatives by health economists and other actors who have been developing such meters for decades; it also seems unworkable in practice.

This crucially shifts the focus from the *development* of valuemeters to a study of valuemeters *at work* and points to tentative ways of exploring experimental grounds for the task of composing rather than implementing public values.[3] Such explorations would need to be pursued not merely

[3] In this light, it would e.g. be interesting to experiment with market developments that do not ascribe a privileged status to financial devices and price mechanism, for which experimenters could draw upon the existing economic literature about non-price competition (Gaynor and Vogt 1999; Hammer 1999; Pope 1989). Rather than developing more valuemeters that have to *compete* with the measurement of price, the DTCs with fixed prices (the DTC A segment) may be precisely one of the most promising domains for exploring competition on other public values such as quality. Experiences within the British NHS with the 2006 reform of fixing prices and giving patients the choice of at least five hospitals seem promising in this regard (Gaynor et al. 2010).

through developing valuemeters that would make actors' value judgements 'visible and readable' (Latour and Lépinay 2009: 16), but also by *disarticulating* certain values to allow other values to be more powerfully articulated. Latour's definition of composition, of having to put things together while retaining their heterogeneity, also implies that, when such heterogeneity is lost through the dominance of one value defining the others, a somewhat more antagonistic process of excluding certain aspects—in this case price—may be warranted. If composition is to substantially change existing practices of market development, rather than mirroring a health economic promise of a future with symmetrical treatment of heterogeneous values once the correct information is available, scholarly critiques of the workings of existing market arrangements may not be opposed to composition, as Latour proposed, but may well be dearly needed for the very process of composing public values. When such critiques are not aimed at debunking 'the market' in order to unveil sociological complexity, but are geared towards differentiating between poor and better composition of a heterogeneity of public values—in other words, if critique shifts from being predicated on sociological realism to finding a firm footing in immanence—composition becomes *critical* composition. Wouldn't that be a prospect for social studies of value practices?

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