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Abstract

Free choice and competitive neutrality are often assigned particular importance for successful market reform of public service. The aim of this article is to illuminate the practical work that goes into regulating free choice and competitive neutrality in a primary care market in a Swedish county council. The article asks: How is regulation of free choice and competitive neutrality in the primary care market carried out? Are there any particular challenges in working with this? If so, why? The article presents a qualitative case study and approaches the research questions with a market practice perspective. By studying how the work with a rulebook for authorization of care centers is carried out, detailed knowledge of the market regulatory process is gained. The result illustrates how purchaser officials frame the market with the rulebook. However, the ways free choice and competitive neutrality plays out in practice overflows the market frame. Overflows are caused by multiple, and conflicting, modes of calculations enacted by the rulebook. Therefore, free choice and competitive neutrality does not create the effects that policy-makers have expected in the primary care market.

Att designa fritt val och konkurrensneutralitet: Konstruktionen av en marknad för primärvård

Fritt val och konkurrensneutralitet anses ofta vara av särskild betydelse för lyckade marknadsreformer av offentlig sektor. Syftet med denna artikel är att belysa det praktiska arbetet med att reglera fritt val och konkurrensneutralitet för en primärvårdsmarknad i ett svenskt landsting. Artikeln frågar: Hur går reglering av fritt val och konkurrensneutralitet för primärvårdsmarknaden till? Finns det några särskilda utmaningar i detta arbete? Om så är fallet, varför? Artikeln presenterar en kvalitativ fallstudie och närmar sig frågeställningarna med ett praktikorienterat marknadsperspektiv. Genom att studera hur arbetet med en regelbok för godkännande av vårdcentraler bedrivs, har ingående kunskap om marknadens regleringsprocess skapats. Resultatet visar hur beställartjänstemän på landstinget ramar in marknaden med regelboken. Men sättet på vilket fritt val och konkurrensneutralitet fungerar i praktiken ifrågasätter marknadens ram. Ifrågasättanden orsakas av multipla, och motstridiga, sätt att beräkna som stipuleras av regelboken. Därför skapar fritt val och konkurrensneutralitet inte de effekter på primärvårdsmarknaden som politiska beslutsfattare förväntar sig.

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Introduction

‘Free choice’ and ‘competitive neutrality’ are said to be important qualities of public markets in general (Le Grand, 2007) and in primary care markets in particular (Anell & Paulsson, 2010). But how are these qualities attained in practical market regulation? This article presents a study of regulation of a public market for primary health care in a Swedish county council. Public markets bear with them an alleged promise of increasing quality and customer alignment of welfare service by combining free choice and competitive neutrality. In this spirit, the Swedish Government has decided that all county councils must organize their primary health care as a care choice system. The policy ambition is that free choice of primary care provider will create ‘competition that spur the actors in health care to improve quality and accessibility’ (Prop 2008/09:74: 23). But how is free choice of care provider to be established and regulated, and in what ways do they ‘create’ competition?

How to improve health care through marketization of public services has been occupying health economists and others for decades (at least since Arrow, 1963). But in practical reform, the challenges have proved to be immense. The practical and theoretical problems of health care markets have therefore continued to gain considerable attention. In quasi-market theory (eg Le Grand, 2007; Le Grand & Bartlett, 1993), proponents of marketization find a promising assertion of how health care markets could be designed. Applied to primary care, the idea of quasi-markets builds on combining free choice of care provider and competitive neutrality between providers. By each patient having an imaginary voucher, the patient is allowed to choose any one among the competing providers. The county council pays the providers for their service according to set prices of the voucher. Public as well as private actors compete with each other on the right to produce the service, but the public sector pays for the service and has the 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 previous research on the Swedish primary care market, the discussion has so far revolved much around the ‘reimbursement systems’ of different county councils (eg Anell, 2009, 2010; Anell & Paulsson, 2010; Paulsson, 2009). The big issue is whether reimbursement will be based on capitation, fee-for-service or performance (see Robinson, 2001) or a combination of them. Discussions have explicitly targeted how to make the voucher as fair and efficient as possible. But the focus is rather narrow on the design of the voucher in economic terms. Not enough attention has been paid to practical questions of how free choice and competitive neutrality stand in relation to a broader context of regulations of the primary care market.

To better inform this discussion, this article aims to illuminate the practical work that goes into regulating free choice and competitive neutrality in a primary care market in a Swedish county council. In the light of how free choice and competitive neutrality has been treated in policy-making and quasi-market theo-

ry, there is a need to understand more of their role in public markets of the real world. Taking into consideration what is known about the contingency and heterogeneity of markets in practice (see for example Kjellberg & Helgesson, 2007) there is a need to problematize the dynamics of markets beyond market theory. That also goes for the relation between free choice and competitive neutrality portrayed in quasi-market theory and taken up by policy makers. The article asks: How is regulation of free choice and competitive neutrality in the primary care market carried out? Are there any particular challenges in working with this? If so, why?

The article approaches the research problem with a market practice perspective inspired by Michel Callon (eg Callon, 1998; Callon, Méadel & Rabeharisoa, 2002; Callon & Muniesa, 2005). With its help, the article shows that in regulating the primary care market, free choice and competitive neutrality stand in a very complex, and sometimes contradictory, relation to one another. The effect of free choice and competitive neutrality is not always one of mutually reinforcement, and does not necessarily create the effects that policy-makers have expected.

The article is outlined as follows. First comes a background chapter introducing the topic, with definitions of key concepts and previous research. Next, the theoretical framework and methodology of the study follow. The result is presented under the heading of 'The Case: Working With the Rulebook'. Under 'Discussion' the result is analyzed with the help of the theoretical framework. The article ends with the conclusions from the study.

Market Reforms in Public Service

'Free choice' and 'competitive neutrality' in public service are not new, but embedded in the 'new public management' reform agenda that has characterized European public administration for decades (Christensen & Lægreid, 2001; Pollitt & Bouckaert, 2004). 'Choice', defined in the broadest sense, could be made in several dimensions: where, who, what, when, and how (Le Grand, 2007). In markets choice is not 'free' in the definitive sense, but always conditioned. The prefix 'free' in this case rather speaks of the statutory right of the individual to choose service provider, as opposed to public authorities choosing a provider (Norén, 2003).

On 'competition' in public service 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 enjoy competitive advantages over their private competitors in public markets. The aim is a 'level playing field', where each provider might not have the same opportunities to succeed, but plays by the same rules (see Regeringskansliet, 2008a; 2008b).

Free choice and competitive neutrality are thus emphasized as vital features of functioning public markets: '[M]odels 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). And the voucher is supposed to be the mechanism that secures the effects. But who will regulate it in practice, and how?

Competition, Choice and The Purchaser-Provider Split

The purchaser-provider split developed strongly in Swedish county councils in the last decades (see for example Berlin, 2006; Berlin & Kastberg, 2011; Jacobsson, 2002; Siverbo, 2004). In ideal form, the purchaser-provider split aims to spur competition and imitate the procurement procedure that take place in business. The model is based on clear-cut roles and contractual management, in which the purchaser concentrates on specifying requirements, and the providers sell the service demanded (Nilsson, Bergman & Pyddoke, 2005). Procurement is a means of increasing competition between providers *for* the market (competition between providers at the level of tendering). This ideal is reflected in legislation of public procurement (for example in LOU 2007:1091).

Primary care is one of many sectors that have utilized procurement to increase competition. Yet, the current Swedish Government has not been satisfied with the extent to which patient choice *at* the market (competition between providers at the level of citizens) has spurred competition in public service. Ever since early 1990s, ideas of free choice of care provider and vouchers have been debated with an explicit focus on health care reform in Sweden (see Saltman, 1992; von Otter & Saltman, 1990). The purpose in moving from LOU to LOV (2008:962) is to empower the choice of the individual and improve competition at the level of citizens (Regeringskansliet, 2008a, 2008b). To ensure free choice and competitive neutrality at the market, LOV presupposes other conditions to be met than traditional procurement legislation. According to LOV, all tenderers that fulfill the contract specifications are eligible to set up their service to compete and attract patients on equal footing with all other providers. All providers are thus under the same contract.

The Difficult Purchaser Role

Even though LOV states that competition is to take place at the level of patients, purchasers work out procedures and tools to specify the service that is to be provided. Markets structured by vouchers and procurement is not the same thing, but both variants of public markets utilize an active purchaser function (see Anell, 2010; Forsell & Kostrzewa, 2009; Norén, 2003).

However, being a purchaser of public welfare is notoriously difficult (Forsell & Norén, 2004, 2006), even without free choice being part of the model. Previous studies indicate that there are many difficulties associated with realizing to the purchaser ideal. There is a 'principal-agent' problem, and the relation between purchasers and providers tend to rely on both formal contracts and other forms of trust (see Berlin, 2006; Kastberg & Siverbo, 2008; Siverbo, 2004;

Sundin, 2006; Walsh, 1995). It seems especially difficult to define what counts as quality (Norén, 2000) and what is the actual need that is to be satisfied by procuring the service (Fernler, 2004). The effect is that public market regulation tends to be unstable over time. Especially when vouchers are part of the market model (Forssell & Norén, 2006; Kastberg, 2005; Norén, 2001, 2003).

A complicating factor in a process of marketization is that the primary care service is not easily defined and its content is constantly in flux (cf Krasnik & Paulsen, 2009). It has been suggested that such a service per se is unsuited for markets (Greener, 2003; Mol, 2008). Other authors suggest that rather than the nature of the service it is the risk of questioning that leads to instability of market regulation. The questioning often comes from discrepant political imperatives (Forssell & Norén, 2006; Kastberg, 2005; Kastberg & Siverbo, 2008; Norén, 2003), because regulation of public markets is formed in an environment of conflicting ideas and interests of public and private responsibility (Blomqvist, 2004). But interest-laden imperatives may also come from purchasers themselves. Either way, the ultimate effect is that purchasers are not broadminded enough to avoid 'blind spots' in the process of regulating public markets (Kastberg, 2008).

Being a purchaser seems to be difficult. Therefore, this article shares the view of Berlin (2006), who pleads for taking a particular interest in the work of purchaser officials (from hereon 'purchasers' and 'officials' are used interchangeably). Previous research give reason to believe the work of purchasers is key to market reform in practice. There is thus good reason to direct research towards purchaser discretion when working in great uncertainty making difficult judgments (cf Berlin, 2006) in public market regulation. Besides, as for purchasers working to regulate public markets according to LOV specifically, knowledge is very limited on how it is done in detail.

Theoretical Framework: Market as Practice

This article utilizes a theoretical approach that emphasizes how 'market' is not a generic organizing principle. Key in the market practice perspective is to analyze activities where rules of the market are set (Kjellberg & Helgesson, 2007). This article draws on the work by Michel Callon (Callon, 1998; Callon, et al., 2002; Callon & Muniesa, 2005) to describe the primary market regulatory practice.

What makes economic behavior 'work' in markets? Callon suggests it is the capacity to calculate. Calculating doesn't have to be numerical or mathematical. Rather, it means to establish distinctions of things and states of the world, and to map out possible courses of actions in relation to those states. Market actors with calculative agency are able to map out and prioritize between alternative actions, that is, they know what to do given the market setting in which they act. What distinguishes calculations from plain judgment is that calculations require certain arrangements; a calculative space (Callon & Muniesa, 2005).

It means calculating capacity is not the same in all settings and markets, but is entangled in the rules of specific markets. Framing of a market is a prerequi-

site for establishing the calculative space, and thus refers to the process where attempts are made to establish well-defined actors, rules and relations so that calculations and market transaction could take place (Callon, 1998). One part of framing is qualification. It means an 'object of exchange' have to be negotiated and specified. A specification of this object has to be established to become calculable within the market frame (Callon, et al., 2002).

But despite efforts to stabilize agency, objects, and relations in the market, framing could never be absolute. Framing efforts are constantly subject to overflowing, or what economists refer to as 'externalities'. An overflow is not calculable within the existing frame. What is an overflow, and what is its effect on an existing frame, is largely dependent on if the overflow could become calculable, and thus capable of being framed. Overflowing is a challenging imperative in the market that leads to changes in its framing and regulation (Callon, 1998).

This article adds to Callon's terminology something I call modes of calculativeness. By this, I claim that there are different regimes for how to calculate within the market frame, and these modes each claim their calculative space in relation to the others. Involved actors enact different theoretical and strategic versions of markets in their efforts to shape calculative spaces. The simultaneous efforts to shape markets gives multiplicity in market practice (Kjellberg & Helgesson, 2006). My usage of modes of calculativeness thus parallels Callon's usage of calculations, but modifies it to state that different versions of calculations can co-exist to create outcomes from the market. I thus challenge the idea that 'transactions' according to a fixed set of calculations (that is, the reimbursement system) is a precondition to understand the (market) behavior of actors in the primary care market.

The stance taken in this article is more open toward overflows than Callon's framework would suggest. The research task is to look into what modes of calculativeness there are, how they relate to each other, and under what circumstances overflows occur. In studying the practical work of purchaser officials in designing a rulebook (see below), this study illustrates the multiplicity of calculativeness that is enacted for care providers in the primary care market, and how it leads to overflows.

Method and Data Collection

This article is based on a case study of a Swedish county council conducted over three months in the spring of 2011. The research design was guided by an ethnographical approach, in which the research endeavor starts with an open-ended orientation to the field of interest and usage of a range of data sources (Hammersley & Atkinson, 2007). Given my interest in exploring the practical work that goes into regulating a primary care market, purchaser officials were chosen as access to the field. It seemed reasonable following the importance assigned to purchaser officials in previous research of public markets.

This strategy enabled collection of key data concerning relations, actions and interactions in the market regulation practice. As exploration progressed, it was evident that the main part of regulatory work was directed towards formulating contract and reimbursement specifications in a rulebook for care centers. The rulebook codifies what are the criteria for permission to open a care center in the county. All applicants that show the capacity to live up to the criteria are eligible to open a care center. The rulebook function as both invitation to tender and a contract. The idea is that no further contractual arrangements besides the rulebook are to be made between the purchaser and the provider (Kammarkollegiet, 2011a, 2011b). Through the course of the study, it was confirmed what decisive role the rulebook played for involved actors in the making of the primary care market. The actors of the market orient their action and attention to the rulebook; herein lies the reason to pay particular attention to the processes where the rulebook is designed.

The data consist of transcribed interviews and field notes (see appendix for a compilation) along with some documents for background data. The interviews were recorded and transcribed. In all other instances the method was observation. Data from these sources rest on field notes taken in real-time and corrected afterwards. Unstructured discussions were held with the informants in connection to interviews and observations. Notes on these discussions were taken afterwards.

There are essentially two important limitations in the chosen approach and empirical scope. First, officials working on a rulebook don't take into account everything that goes into the market regulation process and the article doesn't portray the entire list of possible overflows of this market. Instead, it highlights examples of framing efforts and overflows that are especially pressing in relation to free choice and competitive neutrality. Second, not all county councils have the same criteria in authorizing care providers. Their rulebooks show similarities, but they differ in some aspects of quality specifications and reimbursement (Konkurrensverket, 2010).

Taken together, the knowledge gained from this study is conditionally situated and the result of an inductive research approach. In one sense this is problematic, since recent literature reviews claim that one of the major problems of many public market studies is that they are not possible to generalize in a statistical manner (Hartman, 2011; Kastberg, 2010; Winblad, Isaksson & Bergman, 2012). Yet, the chosen approach is highly relevant as a point of analytic departure because of two reasons. First, the study adds detailed empirical understanding and advance knowledge of the role of purchaser officials in regulating public markets. Second, primary care as a 'difficult case' of a public market gives a solid ground for challenging and developing the market practice theoretical framework further.

The Case: Working With the Rulebook

The rulebook follows from a long development of market reforms, and the purchaser-provider split has long been prevalent in the studied county council. When the care choice system was launched on September 1st 2009, a rulebook for authorization of care providers had already been underway since 2006 (LiÖ, 2008b).

The specifications of the first rulebook drew on multiple sources for influence. For example, officials reviewed current primary care conventions and contracts in the county, and made an inventory of common denominators and areas for improvement. Quite early on, a consensus was worked out in the county council administration that the specifications of the rulebook should be based on the prevailing 'tradition' of primary care in the county, at the same time as it should be as general as possible to attract new market actors (source 1).

Table 1: Policy aims of the care choice system (LiÖ, 2008a).

Strengthen citizens' status as patients by free choice of care center.
Secure free choice by factual and accessible information for all, and ensure the free choice principle; ie the care provider must accept all who wish to enlist.
Provide opportunity to all 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 paid to the care needs of underprivileged patients.
Ensure quality of care through an authorization process in which the health care providers have the opportunity to develop their activities beyond a minimum level of quality.
Obtain increased patient needs alignment, with a possibility of care center specialization.
Ensure a balanced access to care through the county council (within legal grounds) controlling the geographic area where startups of care centers 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.

Looking at the policy aims (Table 1), free choice is definitely a goal in itself. Competitive neutrality is not mentioned, but according to the officials, it is so important to the system that it is essentially a goal too. Besides the intrinsic value of free choice, the officials express a belief that free choice and competition at the market leads to quality development and accomplishment of 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 place with each other. (Official, source 15)

Table 2: The reimbursement system. Adaption by the author from LiÖ (2010, 2011).

Basic	<i>Base</i> Dependent on number of listed patients. If more than one care center in a community, no payment. <i>Socio-economic</i> Areas with lowest 10 % of disposable income receive payment per listed patient. <i>Geography</i> For patients over the age of 75 living 11-25 or >25 km from care center.
Flexible	<i>Coverage</i> Payment for each patient up to coverage of 56 % of listed patients. <i>'Infidelity' visits</i> Payment for visits from unlisted patients. Deduction if listed patients go to other caregiver. <i>Pay-per-performance</i> Variable, but 2011: • Availability • Multimodal treatment • Diagnosis registration • Health promotion <i>Treatment pressure</i> DDD (defined daily dose): minimum level and comparison to county average.
Capitation	<i>Listed patients</i> Individual weights on age. <i>Medicine</i> Individual weights according to age and gender on both common drugs and focus drugs.
Special	For example patient fees, government grants, education grants

In the reimbursement system (Table 2), capitation makes up the bulk of payments to care centers. But the system is mixed and not significantly deviant from other county councils in level of detail and sophistication (cf Konkurrensverket, 2010).

Choice and competition are thus considered to be vital features of the care choice system. What does it take from purchasers to attain them in practice? As it turns out, a certain challenge is the mundane fact that care centers are located in certain places.

Duties and Rights in Local Areas

The notion of 'local areas' (Närområden) is used in the rulebook. That is a division of the total area of the county, where each care center has a certain responsibility for the area that is geographically closest to the care center. The rulebook states that there are both rights and duties for care providers related to the local area (see LiÖ, 2011).

One of the duties in local areas is exercise of public authority by issuing of attestats, relating to matters such as death certificates and custodial care. Attestats aren't very popular among the care centers, especially when they involve coercion, suicides or violent deaths. However, from a societal perspective it must be done. How does this duty relate to free choice? According to the officials, it is problematic. A similar concern resides in relation to health promotion aimed at the population where the care center is located; by many medical professionals considered to be an important function of primary care. Says one official:

It's a contradiction. As for [Care Center X]: their listed population is not from their local area. If they are to do population-oriented work: where do they even start? That is based on an out-of-date thinking about how we divide our communities - if individuals have their own choices or if we put them in pigeonholes. (Official, source 15)

Not all care centers have their listed patients in the neighborhood: why is it that they should have to issue attestats or target health promotion to others than their listed patients? The officials think that the idea of population health promotion collides with the idea of choice, and must thus be given up; otherwise it wouldn't be fair to providers. What is left in the rulebook in the future in terms of duties is kept to a minimum: 'So, now we have really just left local areas [in the rulebook] where we absolutely must have it, when people go crazy on the street and all that...' (Official, source 15). Because of the inherent problem between local areas and free choice, there is an underlying ambition from the officials that duties in local areas will not be dealt with in the rulebook, but somewhere else in the county council organization.

Yet, local areas play a role in passive enlistment of people not making an active choice of care provider, newborns and people moving to the county. Passive listing is considered an important function of local areas, and especially for the welfare of newborns, it is overwhelmingly important to establish an early contact with a child welfare center. This function could become problematic when a new care center opens, because the opening brings forth a revision of the borders of the local areas. Sometimes, if the revision affects areas with many sheltered housings or families with children, there could be a substantial effect on passive

enlistment of one care center. With sheltered housing come heavy patients and a great workload; with children comes an opportunity for easy money and less work. Passive listing is therefore considered both as a duty and a right for care centers, depending on the composition and health of the population in the area. This could become a great source of discontent among different care centers (source 2; 6; 15).

For example, a new care center opened in one of the major cities in the county. Because of revised local area borders, a public care center that used to have a big proportion of newborns was suddenly given only a few. A way of leveling out this effect of ‘un-fair competition’ was for the Head Manager of the public care centers (that is, from the provider organization in the county) to arrange for special deals between the care centers in distributing passive enlistments of newborns (source 8; 15). On the behalf of the purchasers, they generally have nothing to remonstrate at this. But they also express concern over these types of arrangement in relation to competitive neutrality:

The law on care choice is of course very clear about it, first of all, that it should be competitively neutral. A care center 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 the disadvantages. (Official, source 1)

What they consider to be most problematic about this case was that they didn’t learn about the new border deal until very late in the process. What they did was to embrace the idea of revision of borders as such in the rulebook, with an amendment that the provider ‘shall notify the purchaser of changes in the division of local areas’ (LiÖ, 2011: 6). Whether care centers will be able to get along remains to be seen.

Care Centers in Rural Areas

Before starting the care choice system, there was an underlying fear from politicians and officials that no private establishments would be made in the rural areas of the county. This fear has been realized. Today, only public care centers run its business in rural areas of the county. And according to the officials, there is no legal possibility in LOV to fulfill the political ambition of having one care center in each municipality, or to steer where new care centers are to be established. An important principle of the care choice system is the free right to establishment of care centers, which means that it is ‘not possible to force private care centers to expand or open where they do not want to’ (Official, source 11).

As for care centers managers, they claim that the practical conditions of running care centers differ substantially between urban and rural areas. One problem is that there is drainage of passively listed patients from the local areas in the countryside. This manifests itself in the able-bodied and young residents (that is, the most profitable patients) from the local area choose to go to other care centers. They tend to choose care centers in the vicinity of their workplace, which is often located in the cities (where there are more private care centers). This

means it is mainly old and very sick people (that is, the most costly) remaining at the rural (public) care centers (source 8; 9).

The officials recognize the problems of rural care centers. On top of the providers' distress, officials are also concerned with the patient choice perspective: if there is only one care center in a village or municipality, 'free choice' is nothing but a chimera. They however feel that the principle of 'same rules for all' is a strong imperative. But there are situations in which the imperative of competitive neutrality could be compromised:

... [If one care center] gets lots of listings and others fewer listings, well, then it is the citizens that control. This is a very explicit system for that. Our mission is to be entirely neutral in this context. Except perhaps if some municipality get a problem with its care center and cannot handle its task, and there is no one else there. Then, there is another thing. (Official, source 1)

The officials speak of the ambition of having one care center in each municipality as an invalid claim in relation to LOV – in principle. However, in the name of promoting free choice in practice, it is possible to deviate from the principle of competitive neutrality. There are ways to help rural care centers. One has been to design additional reimbursement for them, which is visible in the outline of the reimbursement system. Another possible solution is to set up separate contracts with rural care centers, outside of the rulebook. But these types of 'supplementary assignments' are difficult to get in place. Separate contracts outside of the rulebook are only conceivable if 'the market' has shown it to be necessary (Official, source 9). If a care center manager claims it is not worthwhile or possible to run a care center on the terms of the rulebook, it has to be put up for sale before any supplementary assignment could come into question. Though, a somewhat less drastic solution would be to make a normal procurement of the care center. Patients are then offered to choose that care center in the care choice system. In this way the officials would save choice, but they recognize that it would be to side-step competitive neutrality (Official, source 1).

One supplementary assignment that is actually in place is Primary Care Affiliated Home Care (PAH: *primärvårdsansluten hemsjukvård*). PAH means home care is performed in rural areas beyond the range of the rulebook. It is, because of tradition, regulated in a separate contract. In the light of the care choice system, PAH looks like a real puzzle. But so far it has been treated as the provider's business alone. The purchaser officials are very reluctant and don't want to handle it in the rulebook. Because of its problematic character in relation to the care choice system, they want to keep it as an issue for the providers to handle. According to one official, PAH is such a quandary that it 'should not even be mentioned loud in a care choice context' (Official, source 8).

Discussion

The first research question took interest in: How is regulation of free choice and competitive neutrality in the primary care market carried out? Both free choice and competitive neutrality are supposed to be key aspects of the market regulation because a) they are statutory in LOV; and b) they are the basis for the incentive structure of the reimbursement system to work as intended.

The article describes how free choice and competitive neutrality are discussed and handled by market actors and translated into writings in a rulebook. The rulebook is the instrument to define the quality and need of care within the primary care market. In that way, the rulebook could be said to frame the primary care market, with officials working to design the rulebook itself.

Framing Free Choice and Competitive Neutrality

The officials work to fit the regulation of the market within one rulebook, which is to function as the market frame. In this frame, free choice of care provider and competitive neutrality between providers are supposed to secure the function of the market. Regarding free choice, the rulebook secures the patient right to enlist with a care center of one's own choice. The aim is to strengthen the status of the individual patient. The choice is conditioned to choice of care center. All care centers must accept the choices of patients and take them on their lists.

‘Competitive neutrality’ means all eligible care providers have the same right to open care centers and compete for patients in accordance with the specifications of the rulebook. The rules for running care centers should be exactly the same for all providers, and are supposed to ‘level the playing field’, regardless of ownership.

In contrast to public procurement, competition on the primary care market is to take place *at* the market (the level of citizens). The ‘voucher’ is a theoretical construct of the rulebook, and is operationalized through the reimbursement system. The reimbursement system is supposed to provide a mechanism to develop and improve service at the primary care market by combining free choice and competitive neutrality. The reimbursement system is fairly complex as it is designed to be an economic representation of many different activities performed in primary care. Because reimbursement follows patients, the rulebook frames the economic agency of care providers and enacts care providers as market actors who pursue economic interests by attracting patients. Thereby, the rulebook is developed to frame primary care as a ‘fair’ market and to control the behavior of care providers.

However, by looking into the market practice the study shows that there are certain aspects of the market frame that are problematic; these problems can be understood as overflows. This finding leads to the other research questions: Are there any particular challenges in working with [regulation of free choice and competitive neutrality in the primary care market]? If so, why?

Overflows and Conflicting Modes of Calculativeness

The article portrays how the primary care market practice leads to questionings between market actors, regulatory incoherencies, and difficulties to develop 'fair' reimbursement. These problems could be understood as overflows of the market frame. The discussion below will argue that there are multiple, and sometimes conflicting, modes of calculativeness stipulated and enacted by the market frame. It means that for different reasons, as explained below, care providers perform different types of calculations at the same time, even though they are to operate under one market frame. And these calculations could be conflicting.

The overflows portrayed in this study relate to the mundane verity that care centers are located somewhere. The examples of care center activity in this article – exercise of public authority by attests, health promotion, passive listing, care provision in rural areas – are all considered to be very motivated activities for primary care. That is why they are in, or considered, for the rulebook. But they complicate the framing of the market inasmuch as they enact different modes of calculativeness. This, in turn, complicates the market mechanism between free choice and competitive neutrality intended by the rulebook.

An example is 'local areas', where the rulebook enacts (at least) two modes of calculativeness for care providers at the same time. First mode: reimbursement comes from the voucher. The mode of calculativeness related to the voucher implies that the 'incentive for care providers' (cf Le Grand, 2007) is to calculate how to attract certain types of patients. What matters for the market behavior of care providers in this mode of calculativeness is thus the number and structure of enlisted patients. The incentive is 'internal' in the sense that the rulebook doesn't enforce any rules on the number of listed patients. There is no force behind reimbursement, it is instead supposed to spur care providers to improve their service to attract more patients.

Second mode: the rulebook states that all care providers have the same duties in local areas. The qualification for the service to be done in local areas (for example issuing of attests) builds on a mode of calculativeness that is, strictly speaking, competitively neutral. Every provider has the same rights and obligations. It builds on a 'common good' to be achieved, motivated by a tradition of what it means to provide primary care in a community. There is little room for competition at the market to take place, since there are no patients who make a choice in relation to the service performed in local areas. In one way, this mode resembles traditional health care governance; the principal provides a budget and directs the agent how to perform (Hallin & Siverbo, 2003). Taking care providers 'incentives' into consideration, the calculations involved in performing the duties in local areas has little to do with attracting patients. The motivation is 'external' inasmuch as care providers must adhere to the rulebook, ultimately with their authorization at stake. However, there is an incentive for care providers to embrace the rights of local areas (passive listings of healthy patients). This enacts a mode of calculativeness where there is an interest among care providers

to negotiate the borders of the local areas in a favorable manner in relation to passive listings.

All in all, the rulebook sets up multiple calculative spaces at the same time. The modes of calculativeness of these spaces expect, or stipulate, different types of behavior on the behalf of care providers. Apart from the intentions of market regulators, there is no 'one incentive' following the market frame. It is not disciplining market behavior of care providers coherently. This finding is something else from market actors accepting or not accepting 'the rules of the game', or whether purchasers and providers act as principal and agent trying to maximize their outcome (cf Rees, 1985a, 1985b); they do not even map out alternatives and priorities in the same conceptual regime. One explanation of the 'blind spots' found in previous research of the market regulation process (cf Kastberg, 2008) could actually be overflows between conflicting calculative spaces.

Market Regulation Instability: The Purchaser-Provider Split Revisited

The above discussion has implications for previous research that suggests voucher market regulation tends to be unstable (cf Kastberg, 2005; Norén, 2003). Some authors propose that one reason for instability is that there is a 'nature' to the primary care service itself, which makes it unsuitable for marketization. This argument stresses that good care as such should disqualify market behavior: since the voucher poorly depicts what traditionally counts as good care, marketization is bound to destroy it (Greener, 2003; Mol, 2008). The argument makes some sense in the case of this article as well. (Traditionally good) primary care should, for example, be provided to both individuals and population in a local neighborhood. There are some aspects of this in the rulebook. And as shown, these aspects are not always aligned with the mode of calculativeness implied by the voucher.

However, what is 'the nature' of the primary care is not established once and for all. Interestingly, in the efforts to qualify the need (cf Fernler, 2004) and quality (cf Norén, 2000) of the service that is to be provided, it is the rulebook that actually enacts different calculative spaces and stipulates different types of behavior on the behalf of care providers. How to qualify the primary care 'object of exchange' is precisely what is up for grabs in the market framing efforts. This finding is in line with Norén (2003), who claims that rather than the nature of the service, it is the risk of questioning of the market frame that creates instability. He further suggests that one source of questioning could be that there are profound conflicts and ambiguities between ways of calculating within the market frame. This condition is clearly visible in this study as well.

Still, it is far from clear where different modes of calculativeness come from. The overflows portrayed in this study differ in several aspects, and they do not all have the same consequences for the efforts to (re)frame the market. It is evident that Callon's theoretical framework is helpful when it comes to describing how and why overflows occur in relation to the regulation of a market. But it is insufficient to explain the difference between overflows, and why the primary

care market is obviously in place, care is being provided and reimbursements are made despite regulatory instability and market actors' inability to map out and prioritize between alternative actions in the same mode of calculativeness. Instead, a possible explanation of this could be found by looking into previous reform of the primary care market.

The market that current market regulators are trying to establish operates in a setting shaped by earlier market practices. Market regulation previously invested in the history of primary care has created a 'form of the probable' (Zuiderent-Jerak, 2009) that market actors have to face. And, I would like to add; this also affects the content of the probable. The form and content of older reforms of primary care have strong repercussions in the current primary care market practice. Key in this respect is the purchaser-provider split. By this reform, the intention was to create competition for the market, by enacting a calculative space based on tendering and public procurement. Two types of actors were created for that market: one purchaser and several (competing) providers. Regardless of ambiguous results in terms of costs and efficiency of the split (cf Kastberg & Siverbo, 2008; Siverbo, 2004), it created a calculative space that allowed these actors to perform calculations according to a contract and reimbursement specification. However, since there was no free choice of care provider, there was no need for competitive neutrality in the ultimate sense of 'same contract for all'. Therefore, contracts could differ in relation to the specific conditions of each care center. The result was that in the actual provision of care, calculations were performed in different ways, depending on the content of the contracts.

Before primary care became the object of exchange at the market, it was thus qualified in different contracts. And care providers of today are actually used to accomplish these contract specifications. They were assigned to perform care that was considered to be good, but different for all. Moreover, it would seem as this form/content of the probable of earlier contracts seem to affect market actors' tendency to question the current market frame. It might be that the rulebook (as an invitation to tender and contract) actually is more suited as a tool to regulate competition for the market than at the market.

By introducing free choice at the market in the name of patient empowerment, there have certainly been efforts to alter the incentives and probable repertoire of care provider behavior. The mode of calculativeness of contract following has now been added an element: the incentive to attract patients. However, rather than the new reform sweeping away the older reform, they tend to overlap and mix in new ways (cf Hallin & Siverbo, 2003). And the interaction effect of reforms is often not possible to predict beforehand. This study shows that this overlap of reforms creates overflows, inasmuch as multiple and conflicting modes of calculativeness are brought to the same market frame.

Conclusion

The aim of this article was to illuminate the practical work to handle free choice and competitive neutrality in regulating the primary care market. The article first

asked: How is regulation of free choice and competitive neutrality in the primary care market carried out? The research design was inductive, and in search of an answer to this question the rulebook was found. The article utilizes a Callonian framework to describe how the rulebook is the instrument to define the quality and need of care within the primary care market. That way, the rulebook could be said to frame the primary care market, with officials working to design the rulebook itself. It should not be ruled out that other forms of regulation play a role in the market regulation. But the rulebook matters as a framing device as it is by design intended to collect all market regulation in one place.

As for free choice and competitive neutrality specifically, they are also discussed and translated into writings of the rulebook. For free choice, the rulebook secures the patient right to enlist with a care center of one's own choice. The choice is conditioned to choice of care center. For competitive neutrality, the rulebook sets up the specifications for opening a care center. The rules for running care centers should be exactly the same for all providers. The 'voucher' connects free choice and competitive neutrality through reimbursement; all care providers are reimbursed through the rules stipulated by the rulebook and follows patient choice.

Second, the article asked if there are any particular challenges in working with this regulation? And if so, why? The officials have struggled to frame the market to make free choice and competitive neutrality create the desirable effects of the primary care market reform. But free choice and competitive neutrality are difficult to attain in practice. The study has shown that the rulebook actually enacts different calculative spaces and multiple modes of calculativeness at the same time. It means that the rulebook stipulates different types of behavior of care providers. Interestingly, these are often conflicting. This leads to problems for market actors to calculate in a coherent manner. These problems could be understood as overflows. This poses a challenge to market regulators, and the study has described how these are handled. It appears as the rulebook is more suited as a tool to regulate competition for the market than at the market.

The article has advanced knowledge into public markets through the perspective of overflows. This approach enables an informed understanding of why public market regulation could be unstable, and why public markets often have unintended consequences. This article shows that incoherencies in public markets could even exist between such market key notions as free choice and competitive neutrality. The effect of advancing free choice and competitive neutrality is not always one of mutually reinforcement. Because of the 'incentives' of the market being incoherent, care providers are stipulated to behave in conflicting ways. Free choice and competitive neutrality does not necessarily create the effects that policy-makers have expected.

This finding generates as many questions as it delivers answers: Do other public markets show similarities with the overflows in the primary care market? How do purchasers work to frame them? For future public reform, the lesson from primary care should be to take overflows and incoherencies seriously. An

informed public discussion of regulating public markets ought to include more aspects than just reimbursement. This article helps in understanding why.

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Appendix: Compilation of Data Sources

	Activity	Place	Informant	Date
1	Group interview	County council HQ, Linköping	Project managers, county council officials	2011-02-23
2	Observation	Private care center, Linköping	County council officials, care center management	2011-03-08
3	Observation	Private care center, Linköping	County council officials, care center management	2011-03-08
4	Observation	County council HQ, Linköping	County council officials	2011-03-10
5	Observation	Private care center, Norrköping	County council officials, care center management	2011-03-14
6	Observation	Private care center, Norrköping	County council officials, care center management, corporate group officials	2011-03-14
7	Interview	Respondent's office	Former county council project manager	2011-03-15
8	Observation	Conference room, US, Linköping	County council officials, care center management	2011-03-15
9	Observation	Conference room, Vrinnevisjukhuset, Norrköping	County council officials, public care center management	2011-03-16
10	Participant	Swedish Association	Managers of	2011-03-22

	observation	of Local Authorities and Regions HQ, Stockholm	Vårdval from all county councils in Sweden	
11	Observation	County council HQ	County council officials and economists, care center management	2011-03-24
12	Interview	County council HQ, Linköping	County council economist	2011-04-12
13	Observation/ interview	County council HQ, Linköping	County council officials, politicians	2011-05-10
14	Observations	County council HQ, Linköping	County council economists	2011-05-11
15	Group Interview	County council HQ, Linköping	County council officials	2011-05-16