

# THE DOMINANT ECONOMIC(S) PRISM IN HEALTH REFORMS: FROM ECONOMIC CONSTRAINT TO ECONOMIC PARADIGM

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**Abstract:** *With the economic and political crisis, economic standards are consistently emphasised in the literature on health systems. They are also emphasised by field actors when defining and implementing health policy. This study illustrates the impact of economic frameworks on the way health policy is designed and implemented.*

*An empirical investigation was conducted in a French region. We draw from eighty interviews with actors implementing health policy as well as direct observation of a range of meetings and working sessions.*


*Economic standards are a constraint for the actions of public health professionals: they force reforms, but they also determine the scope of reforms. Thus health policy is submitted to an economic prism that first affects the approach to public problems and second affects the forms of responses provided by actors. Beyond this cognitive and material constraint, the economic paradigm is so internalised that it becomes an integral part of health professionals' activity. Therefore the material constraints take on the appearance of economic policy, in the sense that both the instruments of action and the very motivations behind that action are driven economically.*

**Keywords:** *Health, economic crisis, economic paradigm, reform, public management*

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## From Economic Crisis to Economic Emphasis

The healthcare systems of industrialised countries are confronted with structural issues caused by financial stresses. Costs are rising due to population aging and progress in medical technology. At the same time, governments must deal with resurgent concerns about health inequalities. So, economic factors have resulted in a “prism”, a frame of reference that influences both debate and action at the levels of policy, organisational structure, and everyday activity. This economic prism is the topic of this article.

The aim is not to assess social or health consequences of health policy but rather to establish that normative and cognitive policy frameworks depend on economic constraints and rely increasingly on economic concepts which serve as tools and pathways to reform (health care expenditure, health care market, limits of resources, and optimum use of equipment). Economics provides policy instruments that are becoming the basis for designing efficient health care policies. It leads to a transformation of what is considered as a legitimate State intervention and what is considered as a “good” health policy. The Welfare State evolves by relying more and more on a system of reference that explicitly refers to the efficiency of market mechanisms.

The crisis is a key aspect of the way in which health issues are addressed politically. It is an image constantly referred to in the media, as well as in the discourse of both professionals and politicians, even though those actors do not necessarily explain what they actually mean by the expression. Some speak about the crisis of the health system, while others stress a crisis of the socialized model of funding and reimbursement in health care; for others, it is hospitals that are going through a period of crisis, or more generally, health care providers.

Although the crisis appears to be a subjective representation, the widespread use of this idea shows the strong emotional dimension of health issues and controversies (Tabuteau 2007). The phenomenon is reinforced by the way the media treat the topic, using scandal as a privileged form of information, as shown by high-profile cases of nosocomial infections or medical errors (Garrigou 2000).

Broad health concerns are not only discussed consistently as public health crises (the epidemic of bovine spongiform encephalopathy or mad-cow disease, the avian flu, and more recently the swine flu), but also public management crises, and obviously economic/fiscal crises. The latter two forms of crises are closely related: developed countries are experiencing a major economic crisis, which leads governments to implement new management methods in order to make health systems more efficient and competitive, while the current economic crisis exacerbates the crisis of health systems.

Public policy logics have been evolving in OECD countries to respond to the fiscal crises and to the lack of public sector efficiency. This transition is usually presented in terms of “new public management” (Osborne and Gaebler, 1993; Hood 1995; Murray 1975; Maarse 2004). It consists in adapting private management methods to the public sector, notably by promoting organizational autonomy and decentralization of management responsibilities, flexibility, efficiency, performance and cost control (Mattei 2007). Significantly, governments resort to normative references in terms of “governance” or “new governance” to describe their reforms<sup>1</sup>.

The economic crisis has actually triggered a reform movement and an evolution in the way reforms are designed and practically implemented. Governments must reconsider both the organization of their health systems and their models of public management. These dimensions are self-reinforcing, with the economic prism becoming central in the definition of problems to be solved and solutions to be proposed.

Additionally, health sector expenditure represents one of the largest items of public social spending in France as well as in all advanced economies. Financial strains are increasing in a context of constant medical progress and reinforcement of the global demand. More specifically, in the French health system based on a Bismarckian type of socialized financing, governments have to face a yawning deficit created by *Assurance maladie*, the French na-

1 In France, it had led to the implementation of “new governance of *Assurance maladie*” and “new hospital governance”, meaning a reorganization of the management in both institutions through several reforms. The “Hospital 2007 plan”, usually called “the hospital modernity pact” aimed at reducing hospitals’ external constraints, reviving investment and modernising internal management. The reform was based on four concrete points: activity-based pricing replacing global *ex ante* endowment; reorganisation of hospital services into strategic thematic “poles”; private-public partnership; and price convergence and competition with private structures. In relation to *Assurance maladie* offices, “new governance” means a redesign of management techniques and internal control mechanisms.

tional health insurer. The deficit is estimated at over 9 billion euros in 2009, with a decline in revenue caused by a global financial crisis related drop in employment. Thus, the impact of the current economic crisis on French health policies is twofold.

People’s living conditions are deteriorating, and consequently their health status, along with the share of their household budget that they are willing and able to spend on health. In addition, the deficit reduces state revenues and, in turn, the levers of intervention for public authorities. In short, the health of the economy has an impact on both population health and health economics.

Thus, in a context of widespread reforms of health systems in OECD countries, economic constraints have become a key dimension in understanding current changes in health policy as governments try to improve the economic efficiency of their services. They seem to have a central role in defining the principle of justice in health policy, i.e., what reforms are fair and what choices are legitimate.

The aim of the present analysis is to highlight the extent to which the economic prism can be seen in day-to-day activities and in the design of health policy, in the specific case of France. The central question is to determine how the economic(s) framing establishes a climate that is favourable to a new orientation in legitimizing health policy and then in the behaviours of field actors, namely administrators, doctors and agents of the *Assurance maladie*.

The “economic prism” will be understood in two ways here. First it is linked to what has already been called the fiscal crisis: financial considerations are becoming increasingly important in public debate and policy tradeoffs. Reforms are taking place within a climate of fiscal crisis where, in France as elsewhere, the watchword is to curb spiralling healthcare, to reduce social expenditure. In short, through the notion of economic prism, what is analyzed is how the way economy is done affects health policy.

The second sense of the “economic prism” deals more with the constant influence of economics on health policy instruments and ideas. Indeed, current policy instruments for defining and evaluating health policies (activity-based pricing, health care expenditure and cost containment, or marketization of health care) stem from what economics defines as a “good” healthcare system. Fundamentally, the development of a new look on healthcare is in line with the recommendations of mainstream economic theory when seeking to define the conditions of establishing a healthcare market, or at least an efficient healthcare supply based on patient and physician responsibility and manager accountability.

In short, what is called here the “economic prism” echoes with the situation of an economy in crisis and with the representations of legitimate policies provided by economics.

Considering these two levels of the economic paradigm, the analysis straddles two fields of policy analysis: the field of instruments and the field of ideas and representations. The first step of the analysis is to show that what is deemed desirable, what is feasible and what is implemented appear to result from the economic environment. The second step would be to go deeper into the normative construction of the policy: indeed, the choice of strategies and instruments is channelled and shaped by ideas structuring a specific form of social order. Ideas about the legitimacy of certain claims over others, about priority objectives, in short, about the “good” health system to achieve, “all play a role in shaping the policy alternatives that emerge” (Fisher and al. 2007).

The analysis is based on reviewing the literature on public policy reforms and public health policy, not only concerning the French case but also different national systems. Thus, the French situation is apprehended from an international perspective. This theoretical approach is complemented and enriched by an ethnographic study, based on direct observations and interviews with field actors.

## A Macro View of Literature

Social science literature focusing on the financial dimension of health issues has developed a lot in recent years, while health economics has made key contributions to the development of health policy analysis (and health policy reforms). Several authors analyse the funding characteristics of health systems and their concrete organizational consequences (Simoens and Giuffrida 2004; Eggleston and Hsieh 2004; Forrest, Goetghebeur and Hay 2005). These authors show that physician payment methods, reimbursement practices, and more generally payment incentives for both providers and consumers, have an impact on levels of activity, on patterns of health service use and on the efficiency of the systems. Such an analysis shows that economic constraints and economically-oriented political decisions are a key dimension when analyzing health policy: economics provides theories of change and tools to act; it informs the redesigning of policy-making channels and changes the way needs are considered and met. By the way, many studies specifically address the problem of the economic crisis affecting national health systems and describe

the reforms implemented in order to deal with it (Musgrove 1987; Clark, McEl-downey 2000).

Some authors consider the relation between economics and policies from a different angle: they emphasize the link between economic theory and ethics and deal with the way economics and ethics may help policy makers and analysts when building and evaluating policies (Hausman, McPherson 1996; Wilber 1997). However, other authors provide a critical analysis of public policy decisions based on economics (Bellinger 2007). More specifically, some of them provide a methodological reflection on health and economics and question the consistency of economic tools regarding health issues (Hodgson 2009; Mooney 2009; Petrou and Gray 2005); others denounce an overemphasis on the economic dimension in the reforms (Vladeck 1984; Morelle 1994; Batifoulier and Gadreau 2004; Tabuteau 2007).

When considering these studies of the macro scale impacts, it seems vital to understand how the social actors in the public health system respond to economic constraints and take into account the economic dimension in their ways of thinking and acting. How does a gross economic trend impact on the practitioner, the administrator, and ultimately the patient in the waiting room?

## Methods

Field observation reveals that economic data and ideas are omnipresent and even overvalued in actors’ representations. To reveal the implications of such an emphasis, we present here a ‘thick description’ and analysis of local actors’ discourse on their daily activities.

The analysis is based on an empirical investigation, mainly centred on direct observations of various meetings and working sessions, and on a series of some eighty semi-structured interviews. The investigation was conducted in the Aquitaine region between April 2007 and May 2008. Data analysis was exclusively qualitative.

Two kinds of meetings were observed: first we attended professional workshops organized within an organization (a hospital or a State service) involving peers; we also attended multidisciplinary sessions bringing together different categories of actors, i.e., physicians and administrators or agents of both the State and the *Assurance maladie*. One of the objectives here was to confront professional discourses delivered to colleagues versus actors belonging to other institutions or other occupational categories.

Interviews were undertaken with actors working on the implementation of health policies, i.e., hospital practitioners and managers, and both regional and departmental state decentralized services agents. Interviews were long enough to enable people to familiarize themselves with the investigator and to feel more comfortable with both our approach and our mere presence. Some put themselves first in the posture of a professional who is assessed, thinking they would have to justify how they applied the rules and the way they met regulations and new standards for better health intervention. The goal of interviews lasting from 60 to 90 minutes was to allow time for respondents to give their thoughts and representations in a less formal manner, beyond official or formal discourses they have the reflex to deliver first.

To this end, the flow of topics discussed was thought of as follows: first the interviewee was asked to speak about himself, his job, his career. The aim was to start with questions he could answer without difficulty—and without having to address controversies immediately. Then we asked the interviewee to describe what were, in their opinion, the most important issues and challenges they had to deal with daily. This moment was an opportunity for them to drift from their personal cases to more general considerations about the health system. It was there that people usually mentioned economic issues and their centrality in constructing health related public problems and defining their solutions. In the final sequence of the interviews, actors were explicitly asked about particular reforms: how does this or that reform change their daily work? What is central in this reform? What is new and what remains the foundation of health policy?

As shown in the description of the general progress of interviews, interviewees were never asked directly whether economy or economics were important, in terms of concrete constraints or policy standards. It is actors themselves who have repeatedly pointed this dimension of health policy, and therefore, the object of research has been constructed inductively, according to what emerged of the ethnographic investigation.

We chose to study French actors insofar as economic efficiency is traditionally less central in the French policy discourse than in Anglo-Saxon countries. Yet, it is still a controversial dimension in matters of people's health. These observations may easily apply to other OECD countries; indeed, public deficits and financial efficiency are concerns shared by all governments. Domestic policies are affected by widespread processes that cross national borders.

The initial objective of the present study is to explain how economic issues are a key variable orienting policy reforms. We shall then discuss how that health

policy is defined and implemented by individual actors working under economic constraints. Additionally, we propose to analyze how those actors employ economics as a prism to consider health policy, illustrating how economic efficiency is a goal constantly invoked when developing reforms as well as a legitimating language for designing, selecting and discussing projects. We conclude that economics itself represents a paradigm of action.

## Health Policy Under Economic Constraints

In a context marked by increasing public deficits and a willingness to “modernize” administration, public policy is characterized by a rise in managerial logics, combining effective public intervention with efficient use of resources.

The Organic Law on Finance Laws of August 1, 2001 (*Loi organique relative aux lois de finance, Lolf*) which determines the legal framework of finance laws encapsulates this evolution of the French public policy paradigm. We can note here a reversal of the old logic that had prevailed since 1959, notably because the budget process is reorganized according to a performance goal.

The state general budget used to be defined by each ministry, through limited budgets. On the contrary, the *Lolf* introduces a result-oriented logic, including reinforced accountability at all levels of the administrative hierarchy. The budget is therefore divided into 34 missions and 103 programs that lead to “program operational budgets”. On that basis, the administration has to give accounts annually on its goals and its strategies, which are then evaluated.

## Implementation of Health Policy by Administrators, Insurance Agents, and Doctors According to Economic Frameworks

This new way of considering public policy obviously affects health policy. The agents of the state decentralized services describe the magnitude of changes in their daily work. A public health medical inspector underlines how methods are significantly changing in his administration: “We work for performance. That is to say we work through goals, with the resources that go with them. Gone are the days when we had operating budgets. We work through projects. And projects mean performance: did we employ sufficient means to achieve the objectives? Have the objectives been achieved? Are our indicators satisfactory or not? Those of my generation have seen this change. It is an important aspect.”

Administrative agents similarly contend that the framing of their action and priorities stems more from the implementation of the *Lolf* than the goals defined by health legislation, notably the 2004 Public Health Act.

Some agents of the *Assurance maladie* also describe the new orientation of their missions, redefined in terms of “risk management”, that is to say not only financing health but also regulating spending, controlling medical expenditures, favouring prevention programs and fighting against fraud.

Some social partner representatives denounce this focus on a purely monetary logic. The president of an *Assurance maladie* office notably highlights that managers are timid about investing in innovative projects, such as healthcare networks, because their long-term advantages are not directly visible in the annual performance evaluation of each office.

Similarly, many doctors I have interviewed note that governments want above all “to save money”, which leads to reforms which, according to them, do not take into account the reality of medical practice. For instance a private practitioner asserts that “nowadays, it is accounts rather than field work that matters most”. One of his counterparts finally compares politicians to so many “Scrooges”. A public health medical inspector also denounces the fact that economic issues “are put forward. I do not say that there weren’t things to do to save money. But I think the vision is too focused on accounting.”

So the centrality of the financial factor is clearly noticeable in local actors’ representations and problem prioritizations. Most of my respondents point to financial matters first when they are to define the major issues that their own structures or the health system as a whole have to face. These concerns are typically centred on social security financing or new economic burdens on institutions.

These are recurrent themes throughout my interviews. For the administrator of a health network, “money is the first issue”. A hospital doctor asserts that “there is an issue which is significant and which explains everything else: that is, the financial issue. From the moment we no longer have enough money, and people live longer and longer and drugs are expensive, there is an extraordinarily important economic environment that leads or that forces us...” A public health medical inspector also insists on the predominant aspect of financial frameworks in recent reforms, far stronger than the “territorialisation” process and “health democracy” requirements often put forward. According to him, what really changes health policy, and more specifically the hospital environ-

ment, is above all new governance dynamics: “the debate is polluted by activity-based pricing. For hospitals, with all this story of activity-based pricing, the economic issue now prevails”.

Such local observations clearly show that a plurality of actors emphasise that economic constraints are a key dimension in the implementation of health policy. As suggested by the quotations above dealing with hospitals, similar representations are also noticeable in the design of hospitals’ internal management.

### Implementation in the Hospital: Centrality of Finance

It is in the hospital world that financial concerns are the strongest. For example a manager states that “difficulties are mainly related to financial aspects. I mean, taking charge of people’s health is expensive and we are in a situation where *Assurance maladie* is not in a flourishing situation, financially speaking, and where there is necessarily a saving logic”.

One of his colleagues argues that the only real issue is “the implementation of new governance and the financial reform. The rest of it is not for real. Care accreditation and quality assessment is a permanent theme but it is mere vanishing. New governance and budget reform are going to be the real political issues.”

All hospital managers I have interviewed express deep concern over the impact of this “financial constraint”, which influences the internal management of their structures. They are notably worried about the maintenance of specific public service tasks, “General Interest Missions”, including teaching, research and innovation. These roles are part of the identity of public hospitals and, as members of staff argue, they cannot be evaluated strictly on the basis of economic criteria. For instance, “we might have an important challenge: the specific funding we obtain for those missions will no longer be flat-rate funding but linked to performance indicators. We will have to produce and evaluate, not only from a scientific and academic point of view, but also considering financial results. Today it is done more or less unconsciously; but tomorrow, evaluation and optimization of medico-economic performance will represent even more of a constraint.” One hospital manager explains that the grip of financial questions is “the real difficulty”. Indeed, “we are in an activity-based pricing logic. But health cannot be a profitable world. [...] We are in a financial dilemma which weighs heavily on our management. I said that the issue was to reconcile economic efficiency with quality of care. Today, we focus essentially

on the first item and not much on the second one. Financial analysis is really the dominant prism.”

A public health medical inspector expresses the same idea. He underlines how difficult it is to submit all the activities of public hospitals to profitability and performance standards. Indeed these standards could jeopardize general interest missions specifically pursued by public hospitals: “some activities depend solely on public hospitals and they are not profitable. If they are not valued by public authorities, it might cause difficulties; because those missions are not profitable but at the same time they cost money and staff. How could hospitals reconcile them with the economic logic?”

So, health policy as a whole and, more specifically, hospital policy seem to be designed with primary reliance on economic frameworks. The financial constraint appears as a key concern for all categories of actors, from *Assurance maladie* and administration agents to practitioners. They all consider economic issues as the basis of their daily work. Therefore, the financial prism constitutes a cognitive but also an organizational constraint.

### Rigidity and “Lock-ins”

The idea of a lock-in comes from economics and historical studies. It is used to illustrate the way initial choices prevent actors from changing their ways of doing, even though the choices they first made turn out counterproductive or inefficient (Arthur 1989; David 1985). An initial decision might restrain future choices, so that inefficiencies may become locked in, notably because of “switching costs” and “network externalities”. Such a path dependence phenomenon can be useful when analysing the French health system: the “dominant prism” of economics tends to create a path that determines the scope of legitimate interventions. It participates in the perpetuation of old models and channels of action.

Beyond the imposition of a framework for action and evaluation, the “dominant prism” of finance determines the scope of reforms and the opportunities for their implementation. This dimension is the basis of controversies; it is a factor perpetuating divisions between actors and between public problems that should be addressed in an integrated way.

Local actors express the idea that the financial factor ultimately prevents any real change in practices and it limits the implementation of a profound reform

of public health policy. Notably, they affirm that the persistent dominance of caring for the sick (known as “health care”) over prevention and public health programs in the concrete functioning of the global system –an historical characteristic of the French system—is due to the financial environment.

The director of a state decentralized service admits that some ideas are evolving, but he recalls that budgets dedicated to public health actions remain very modest compared to those dedicated to medical care activities; he consequently doubts that the former could prevail. Similarly, an agent explains that the Public Health Regional Group<sup>2</sup> deals with important themes but “it is epsilon in terms of budgets.” Thus, the creation of this new public health body is a positive step forward in matters of common reflection and institutionalization of practices, “but without great power, or more exactly, without a great issue. It is always better when there is no huge issue behind, notably a financial issue.” The head of a local association for health education logically shares this view: he considers that limited and non-permanent funding dedicated to public health projects leads to a persistence of “the centralism of health care”.

Finally, several general practitioners mention that most medical procedures dedicated to prevention are not covered by *Assurance maladie*<sup>3</sup>: “For instance for a medical certificate for sports”, explains one of them, “a twelve-year-old child comes because he wants to play football: if I do my job properly, I take time to examine him, to ask questions, to do many things. Well normally, such a procedure is not covered. It means, clearly, that *Assurance maladie* tells us that they only reimburse curative acts; prevention is not important.”

Private practitioners often mention that fee-for-service limits the development of prevention consultations, notably for patients with chronic pain or addictions, which tend to require lengthy consultations. According to them, “Fee-for-service puts an important pressure on us when running our medical practices, so we are a bit stuck”; “You can imagine that a doctor that would only do such consultations would not earn a crust. It would be nice if there was financial recognition for those lengthy consultations, if they were recognized at their fair value”.

2 Those groups were created in each region in 2004, gathering all actors involved in public health programs in order to implement public health policies in each region and rationalise public policy.

3 Actually, practitioners report these acts as other medical procedures, so that they get paid and patients are reimbursed on the basis of the price of medical consultations.

Hospital managers also tackle this issue for their own organizations, arguing that the method of payment established by the “new governance” reform hampers prevention: “activity-based pricing does not pay for prevention”, explains one of them, “it means that doctors can address prevention within their consultations, but pure prevention, a prevention policy, we are not paid for it. There is a bias in the system here.”

Thus, our interviews with health professionals suggest that unless budget allocation and payment evolve, the general organization for health service provision might remain unchanged.

Moreover, most actors underline that some partitions between funds, between budget lines, tend to make relations more rigid and public policy restructuring more difficult.

Actors logically denounce the administrative division between Hospital Regional Agencies financing hospital care, and *Assurance maladie* financing private practitioners’ outpatient care. Such a split is described as “counterproductive” and eventually “expensive”.

Additionally, some cross-cutting projects, combining social and medical care, or hospital and home care, are on decline or are not even carried out, not because of professional resistance but because “the resistance is financial”, in the words of a departmental agent.

A hospital manager also describes successful attempts to organize coordinated care, which however suffer from funding compartmentalization: “We work things out but it is a bit complicated because in the background, there are underlying funding problems”. Roughly speaking, a hospital can only invest in health care programs, while local authorities can finance social or medical-social devices, so that “it is always complicated at the boundaries, at the point of demarcation of boundaries”. Similarly, a doctor stresses that “a system of separate funds might add a division where we really do not need it”. He describes at length what he calls a “weird” case: as a hospital doctor, he had to intervene to help implement a network project lead by private practitioners that sought specific funding dedicated to the quality of private care. However, “as a hospital practitioner, I have been criticized for eating on private practitioners’ plates. And I thought then that something was going wrong.”

Doctors emphasise another constraint linked to the compartmentalization of funding, that is to say the difficulties they encounter when they seek funding for their projects. Most of them explain that they struggle to find the right in-

terlocutor and to adapt to budget lines that seem unclear and not always appropriate. Those involved in local networks often mention the time they spend seeking funding and applying to meet different institutions’ procedures. What is criticized here is the division between potential funders, which leads to an obstacle course for professionals who are not specialized in administrative and management methods.

Doctors stress out that they are “not accountants”. They thus have difficulties dealing with financial issues and evaluation frameworks. For instance, a hospital practitioner describes that “in terms of compartmentalization between institutions, it is crazy! I mean, sometimes we have a budget given by an institution, but they eventually say ‘I cannot give you the budget anymore, go see such and such institution’. But the latter says ‘no, this is not our responsibility’. So we go see another one, etc.” One of his colleagues considers that “some financial arrangements are unbelievable! Some health networks have twenty budget sources. This is completely crazy. Without even considering the time the coordinator spends to verify, to fetch an envelope of a thousand or two thousand euros per year... this is stupid. It requires enormous human energy expenditure!”

The actors’ discourse reflects how often economic questions and arrangements affect their possibilities and patterns of action. Interestingly, it also shows that they do their best to adapt to these constraints, revising their strategies. Actors appear locked in, as they must conform to established institutional models. The “dominant prism” of finance limits change because it triggers switching costs for field actors and, beyond that, it prevents them from establishing new decision-making channels and mechanisms.

### Changing Strategies

In such a context, actors eventually reverse their *modus operandi*. Some assert that they used to define a project and then present it to potential funders, “and we got the money or not”. Now, some say that they proceed the other way around, that is to say they directly adapt their projects according to funding opportunities they know about. The coordinator of a health network considers that “previously, our medical project prevailed, we got money to do something nice”, whereas now, he and others explain, networks must adapt services they provide to the funding envelopes available.

In that sense, funding processes encourage local actors’ conformity, rather than their creativity. A project must appear “fundable” in order to progress beyond

the initial stage of evoking ideas. Some of its originality may be lost along the way, though, which entails a risk of demobilization or loss of motivation among the actors concerned.

Practitioners also feel there is not enough advertising about available funds; information mostly circulates by word-of-mouth, so professionals cannot always benefit. Such opacity boils down to a problem of lack of rationality in the global management of local health initiatives. Professionals consider financial constraints as one of the major pitfalls preventing relevant collective action. Both funds and funders appear far too fragmented for professionals to be truly responsive and adaptable.

Thus, throughout dominant local representations, public health policy proves to be submitted to a “dominant prism”—an economic/financial one—that affects the approach to public problems and consequently the forms of responses actors intend—or are able—to provide. In such a context, we can consider that public health policy takes on the appearance of an economic policy: beyond a mere constraint, the financial paradigm is so internalised by actors—and institutions—that it tends to be an integral part of health policy.

## Health Policy Turns into Economic Policy

Economy is not only a constraint that must be integrated into public policy, but a central factor in the evolution of ideas and action frameworks. It does not only imply technical/financial consequences but it also influences the very principle of justice in health action.

### The Impact of Economics: Field Actors Resort to Economic Tools

In times of budget restrictions it seems logical that actors should try to reorganize in order to generate long-term savings at both the macro and the micro levels. But when considering the situation in France, through local discourse sampled and government announcements analysed, we can observe that intervention tools and the very reason to act are of an economic type. Several actors express the idea that the reforms that are proposed at both national and local levels are dictated primarily by prospects of better economic management of health. They have the feeling that reforms are just meant to save money, and not necessarily to improve the efficiency and effectiveness of health care.

For instance, a hospital practitioner considers that Public Health Regional Groups are intended to “seat around the table people interested in public health, to contribute money rather than to discuss. It is often said that money is the sinew of war, but it’s more than that: it is the brain of war. So it is the only thing people are interested in.” Similarly a state decentralized service agent interprets the creation of Hospital Regional Agencies and Public Health Regional Groups as a way of making multiple partners finance health actions, insofar as the state budget is “in great pain”. Notably, the challenge would be to make local authorities get involved in health financing as much as possible, even though they do not have the legal competence.

Thus, local actors’ representations illustrate Fassin’s analysis dealing with the first French health care networks (Fassin 2000). According to Fassin, such networks were part of a more general movement that questioned the traditional order prevailing in public health policy, an order based on two central institutions: hospitals and private medicine. At the same time, the institutionalization of these networks by state administrations seemed aimed primarily to reduce costs. The objective of cost containment, though, only partially met the goals of the network initiators who mainly wanted to improve health care protocols.

Similarly, economic mechanisms represent the current instruments of public health policy. One of the most recent reports on the reorganization of the health system, the Ritter report, presented in January 2008 by the minister of Health, Roselyne Bachelot, is underpinned by an explicit logic of strengthening economic efficiency. Thus, future Health Regional Agencies—which are to be created in November 2009—turn out to be financial management tools, even before being instruments for rationalized regulation of the health system. One can also mention the introduction of user fees in hospitals the scaling down of medicine reimbursement, or the establishment of health insurance “deductibles” in 2008, which have triggered outcry<sup>4</sup>.

Regarding health issues, local observations as well as documentary evidence reveal that policy instruments are nothing but thinly veiled economic tools and devices. On that basis, the very sense of public policy becomes economically focused.

<sup>4</sup> This instauration of deductibles consists of making patients pay a lump sum for each medical consultation and each drug prescription, up to a certain annual amount. This mechanism has been denounced by the opposition parties, but also by some practitioners and patient organizations, considering that this reform means that the sick will pay, which is contrary to the French tradition of socialized payment.

### A Macro Level Analysis: From Economic Tools to Economic Models

The predominance of debates and measures that are essentially economic goes further, even beyond public policy instruments, with health policy as a whole being restricted to an economic regulation policy. In the case of health, politics and economics are so close that they tend to merge. The former boils down to the latter. The move towards a “dominant prism” of finance stems from a proactive policy of public authorities: in a context of scarce resources and limited funding opportunities, health policy is designed to save money and at the same time to reorganize supply and reform organizations. Thus, economy remains a constraint for reforms but, more fundamentally, economics provide a set of references and standards that contribute to build the image of what is a “good” or efficient health system.

Such a strategic and paradigmatic influence of the “economic prism” observed in the specific case of the French health system is in line with Callon’s conclusions on the performative character of economics (Callon 2007; Callon, Muniesa 2007). With the concept of performativity, Callon shows that economic theory contributes towards enacting the realities that it describes: economics is not only a scientific knowledge that depicts a state of things or describes an existing situation, but fundamentally a set of representations, instruments and practices that contribute modifying and even constructing the situations studied. In Callon’s words, economics “performs, shapes and formats the economy, rather than observing how it functions”. The specific case analyzed here allows extending his conclusions: in a way, economics shapes and formats the health system. Indeed, the latter can be considered a specific field of economic activity, some say a market. Anyway it is a specific field of public policy which brings into play economic variables and considerations. In that sense, the health system constitutes an illustration of the performative character of economic theories: at the basic level it is shaped and designed taking into account the state of economy which is itself shaped and constructed by economics.

Many analyses point to the prevalence of financial standards, and even market standards, within the conceptions of health related public problems. For example, Morelle (1996: 297) considers that health security issues have traditionally had difficulties to prevail in France because of the “financial prism”. With the advent of the welfare state, health has gradually become “a package of benefits, in kind or cash, to be funded”. The financial issue totally “overshadowed any other vision and sterilized any debate” (Morelle 1996: 298). Morelle illus-

trates this phenomenon by describing interdepartmental meetings where the goals and representations of the Ministry of Finance take precedence over public health arguments.

My findings extend Morelle’s analysis by giving evidence that the “financial prism” he highlighted persists today. They also bring to light the fact that the “financial prism” has specific manifestations at the local level. Morelle shows that the financial paradigm imprints its trace on public health choices at the national level, mainly at the time of the French scandal over contaminated blood due to the distribution of AIDS-tainted blood products to hemophiliacs in 1985. Field observation gives further insight into the French situation: not only health security issues but also health policy as a whole are underpinned by economically-focused questions. The national decision-making process as well as the micro-level representations and devices appear to be framed by the financial “prism”, as stressed by local actors.

Such a “market trajectory” of public choices is also underlined by Batifoulier, Domin and Gadreau (2006) who explain how the financial paradigm delineates the scope of problems considered important as well as possible solutions, so that spending restrictions become a central goal and the basis of structural reforms. Under supranational pressure, notably exerted by the European Union and its convergence criteria, and because of the influence of health economics, public policies and field actors’ representations are imbued with mercantile principles<sup>5</sup>. In that sense, the financial argument will “format the problem to be solved” (Batifoulier, Domin, Gadreau 2006: 4): the health system must comply with the imperatives of competitiveness, competition and local accountability. This is reinforced by “new public management” criteria that tend to permeate public policy, through private management tools, chiefly benchmarking or competition as a source of efficiency. Such measures form the basis for establishing activity-based pricing in public hospitals or the “new governance” reforms in both hospitals and *Assurance maladie* offices.

The management and financial paradigm leaves its mark on public health policy because public problems are focused on the question of the status of public accounts, notably the well-known deficit of *Assurance maladie*. In 1981, Nicole Questiaux, Minister of National Solidarity, already declared that she refused

5 European convergence criteria aim to assure a sustainable convergence required for the achievement of the economic and monetary union. The European Treaty sets four criteria which must be met by each Member State before it can adopt the Euro. Chiefly, the ratio of annual government deficit to GDP must not exceed 3% and the ratio of government debt to GDP must not exceed 60%.

to be a “minister of accounts”. But Pierre Bérégovoy succeeded her the following year under pressure from the Prime Minister, “with the mission of counting” (Gibier 1993). The balance of accounts was the explicit central objective of his ministry as well as that of his successors’ ministries, including leftist ones. Thus, all recent *Assurance maladie* reforms have shared the same objective of financial restructuring.

It is as though the instrument had become the issue of public policy itself, the means replaced the ends, with the control of health spending *per se* becoming the health policy (Tabuteau 2007). Significantly, French media cover health related public problems mostly by focusing on the issue of “the Social Security hole”, which was called a “myth” by Duval (2007)—a somewhat hackneyed story in the press when dealing with the successive reforms.

Considering that economics provides instruments, goals and the very legitimacy of health policy, it should come as no surprise that field actors should feel compelled to incorporate the necessity of economic calculations into their daily actions.

### A Micro Level Analysis: Actors Internalize the Financial Paradigm

The modification of the rules of the game creates new institutional arrangements that shape the sense of justice in the health system. Consequently, economically-focused rules of the game affect field actors’ behaviours. The new rules that are underpinned by the “financial prism” impose a new institutional framework on actors, a framework that also provides them with the cognitive resources on which to base their behaviours and strategies. Economics has a strong influence on collective and individual representations by specifying the problems deemed to be important, defining the boundaries of solutions and the regime of “good ideas”, or indicating the relevant resources. It leads to the diffusion of an economic frame of reference which individuals use increasingly to interpret rules and environments.

The interviewees perfectly describe how they have to comply with a policy that is primarily underpinned by an economic logic. Some of them strongly denounce such an environment. For example, a private practitioner mentions that politicians are only “accountants” and that administration is spending its time “counting peas” while neglecting substantive debates. But others describe a movement that seems inevitable, a movement everyone must join in order to carry out their missions.

The data suggest that many actors internalize the economic paradigm. Indeed, they offer arguments conforming to this paradigm and justify this perspective by asserting that such an approach to health problems is the most “realistic” or “responsible”. One can see that, at the micro level of daily activities, actors use economic patterns of justification and economic ways of thinking and evaluating with a view to praise a particular device or legitimize their practices. In that sense they appropriate the economic framework and use it to evaluate their own and others’ actions.

For instance, the coordinator of a network focused on respiratory rehabilitation explains that the team has modified its *modus operandi* for “more effective and even efficient” services, “riding the wave of patient therapeutic education and disease management”. He justifies such a choice by stressing out that such services combine high efficiency and lower costs. The description of its activities is clearly based on financial arguments. He notably explains that one euro spent for respiratory rehabilitation means five euros saved for the health care system. He also explains that although his network is expensive, it is in fact “a profitable long-term investment”.

In general, practitioners involved in patient therapeutic education programs use economic arguments to legitimize their practice. They underline both the low cost per day of their education programs and the overall savings they provide by reducing the use of health care services and improving the use of treatments by educated patients. Thus, a health economics perspective coupled with the benefits expected for patients through therapeutic education makes it possible to demonstrate that patient therapeutic education “is worth it”, both economically and medically—in chronic disease management. In addition, the results are said to be worth the additional cost of operating the networks that implement it.

In the same way, the manager of another network dedicated to nephrology insists on the added value of his network in terms of health economics. He argues for funding renewal on the basis of a comparison between the high cost of dialysis and the very low cost of running the network. He contends that the network provides complete epidemiological data: “Compared with a hundred million euros [for dialysis], giving a hundred thousand euros [for the network] is nothing. It represents two years of dialysis [for one patient]!”

Therefore, among arguments that local actors invoke to legitimize their actions, the economic paradigm predominates as a justification and evaluation framework. Admittedly, budget limitations represent a constraint for actors but, more deeply, health projects and policies appear to be based predomi-

nantly on economic instruments and ideas, rather than on health care protocols or medical arguments. Economy defines the right representations of problems and directs the interpretation of texts. It then determines which professional behaviours are legitimate. Thus, the definition of justice in health policy boils down to the definition of what is economically right.

Indeed, especially in the hospital, the interviewees clearly express the strength of the economic paradigm which provides not only instruments for health care reforms but also the cognitive framework of public policy. A hospital manager, talking about activity-based pricing, mentions “a radical paradigm shift”, “a macro model change”; another one speaks of “deep cultural resonance”, given that not only the way to obtain resources but also the organization of the entire hospital system has changed. Changes in financing seem to have initiated change in the historical identity of hospitals.

Our findings concerning the impact of economic models on both representations and behaviours in the region of Aquitaine are consistent with the results provided by the economics of conventions (Batifoulier and Gadreau 2006; Orléan 1994). This French school of thought reconsiders the concept of “convention” developed by Weber, i.e., a rule of social conduct voluntarily and collectively accepted whose breach entails collective disapproval and social sanctions (Weber 1978).

According to the conventionalist research program, conventions refer to values, rules and representations incorporated into institutions and public policies that influence expectations and behaviours, i.e., individual choices. They are constructed frameworks of social realities forming the basis of individuals’ coordination, given that each individual considers that his own beliefs and conceptions of what is legitimate are consistent with others’ (other individuals considering the same in return). A convention, as a common knowledge and as a shared assessment regime, is to coordinate people’s expectations in social interactions. Individuals living in a complex social environment use rules and interdependencies to forward their own interests: actors consider those rules to be shared by others, so that interdependencies are backed by common beliefs and common regimes of justification.

Considering these definitions, what we call the economic prism appears to be a convention in the health system, as it provides frameworks for action, but also for public justification and evaluation. It helps shape both macro public policy and micro individual choices concerning health intervention, determining what is considered as fair in the health system.

These insights of the French health system allow us to extrapolate that, with the focus on the economic prism, health and medical ethics eventually

changes (Batifoulier and Gadreau 2006). Economically-oriented public policy tends to influence representations and assessment criteria and, in turn, they influence the definition of behaviours that are considered as complying with norms, including ethical standards. Eventually, with the affirmation of economic constraints and paradigms, the model of public intervention on health issues is evolving. With it, the very conception of what legitimate action is changes. The economic prism turns out to be the fundamental convention of public health policies. It shapes actors’ behaviours and common models of evaluation and forms the basis on which controversies emerge and agreements are reached.

## Conclusions

The empirical study of local actors in the French health system reveals a close link between the economic crisis, as a fact but also as a widespread representation, and the way and pace in which reforms are set up.

The “crisis” appears to play a central role in the reform process, its impact being both material and cognitive. On the one hand, the current economic crisis affecting public finance triggers public management reforms. More fundamentally, it is synonymous with public policy change. Indeed, the economic crisis turns some issues into public problems or, in other words, they become issues that public authorities have to deal with. Chiefly, health care suppliers have to reorganize themselves, something that is still on the agenda, as shown in the bill on “Hospital, patients, health, territories” that was passed on July 21 2009<sup>6</sup>. It is a key public policy issue precisely because *Assurance maladie* can no longer afford to finance the health care system as it is currently organized.

Territorialisation, multidisciplinary, cooperation or supplier accountability have become new policy standards, largely developed in political speeches and systematically included in health reforms. They appear to be underpinned by the need to reform a system that has become too expensive. The idea here is not to assert that these public policy standards are only rhetorical tools aiming to hide real political motivations. Rather, our observation of the way health policies are actually defined and implemented shows that a generalized scarcity principle determines the range of possibilities. In other words, scarce

6 This new reform aims to restructure hospitals’ internal management as well as their territorial organization and cooperation. It is also to establish a new supervisory authority with extensive powers, the Regional Health Agency, in order to rationalize regulation and global management.

funding determines the extent to which those objectives of territorialisation, cooperation or institutional reorganization can be concretely pursued, what type of tools are available—and with what time horizon—as clearly exemplified in the interviews we have conducted.

Therefore, economic standards are also the origin of power relations and actors' more or less favourable positions. They can be both a driving force for action and a barrier to deep upheavals.

The lack of money challenges organizational practices and operating habits. It can impel reconsideration of the logic behind action by inviting questioning of interests or convictions (for example, the belief that the emphasis on public health programs might be less expensive for the health care system in the long term). The existing financial framework may also prevent massive restructuring and local innovation.

Whichever vision we adopt, both of them appear in local actors' discourse. They testify to the deep impact of the financial paradigm as the basis of representations and configurations we view.

On that basis, one question is left unanswered by my research. The conclusions drawn from the insights of the French health system leave aside the issue of the strategic use of economic arguments.

The constraint imposed by the economic logic can be used strategically by actors who overexpose and exploit this rationale. Indeed, the weight of financial constraints on health action can be employed by local elected officials or, to a lesser extent, local administrative agents, who systematically associate health issues with their financial dimension in a context of public finance crisis. This can represent an argument for them not to become involved in specific programs or projects considered as too expensive.

This dimension is perceptible in several interviews but it has not been completely investigated. This point may deserve further research attention in order to determine to what extent field actors make a conscious use of the financial paradigm. Findings presented here reveal that economics provides tools for action but also a well-rooted cognitive framework for health policy. Further ethnographic work could reveal to what extent economics provides a justification discourse for political involvement—or non-involvement.

Being both a constraint for concrete action and a strong cognitive framework, the economic paradigm imprints a lasting trace on actors' representations and actions. Our findings illustrate the conclusions of the conventionalist literature: the concept of convention offers a means of capturing ethical rules in health in-

tervention, whether macro decision-making or micro medical intervention. The analysis of health policy in France eventually contributes to the interpretative approach to ethics, revealing how rules as normative references are capable of influencing the sense of justice prevailing in society that is reflected in individual behaviours and policy-making.

This leads us to a last dimension that has not been fully explored in the paper but would deserve further analysis: in the light of the insights presented here it would be relevant to wonder about the very existence of an alternative to the economically-focused health policy discourse. As we have highlighted the predominance of the "economic prism", we wonder if there could be a competing principle, an alternative "convention" to the one provided by economics.<sup>7</sup>

Indeed, as shown by the economics of conventions, a plurality of forms of justification—in other words, a plurality of conventions—may exist simultaneously (Boltanski and Thévenot 1991). In health policy as in other policies, there are always many drivers of the reforms, underpinned by a plurality of possible representations of problems and legitimate solutions. The way we have studied the impact of the economic paradigm does not mean that the latter is the only frame of reference and values present in collective and individual choices. If the paper—following field actors' discourse—attributes changes to a financial prism, other drivers may exist that also help shape what is a fair health policy and what is expected to be socially and economically efficient. Other conventional constructions should be considered in this regard, notably the idea of social justice or the notions of service quality and safety. Indeed our results do not allow asserting the observed economic prism as the origin of all structures of meaning and legitimacy shaping health policy.

In this regard, one point must be mentioned that reveals that the economic prism is not the only one shaping medical ethics and, maybe surprisingly, it is not rooted primarily in the economically liberal branch of the French medicine.

In France, outpatient care is traditionally provided by private practitioners and based on fee-for-service. The private practitioner receives a certain amount per consultation, negotiated by medical unions and *Assurance maladie*<sup>8</sup>.

7 Many thanks to William Rifkin, Director of the Science Communication Program at University of New South Wales, and to Jean-François Allafort, Professor at the *Institut d'étude politique* of Bordeaux, whose comments and edits were very useful and rewarding.

8 On that basis, *Assurance maladie* pays most medical bills, not patients. Nevertheless most patients have to pay for their consultations and are then reimbursed by *Assurance maladie*. This historical system has been reformed recently in order to restrict "medical nomadism" but the

As shown earlier, many private practitioners—notably general practitioners—criticize the fee-for-service system, considering that it deters them from doing the best medicine possible. Therefore, unions and *Assurance maladie* are currently negotiating in order to amend the system: parallel to fee-for-service, *Assurance maladie* develops several systems of additional lump sum payments for specific acts and protocols which require special monitoring and lengthy consultations (chronic disease, obesity and nutrition problems). Thus, fee-for-service has shown obvious limitations that have led to changes in the funding system.

Agreeing to be paid partly with lump sums by public authorities in order to make fewer medical consultations and to find time to take better care of patients, private practitioners depart from a pillar of their historical professional identity. They demonstrate that their daily work must be based on terms that are different from the economic calculation. They notably put forward the ideas of patient well-being, quality of doctor-patient relationship, but also an appeased practice of their art detached from financial considerations.


What is surprising then, is that a system that is being amended for private medicine is at the same time being set for hospitals. Indeed, activity-based pricing gradually introduced since 2005 in hospitals is nothing but a fee-for-service system applied to organizations. This might lead to a change in hospital practitioners' relationships with money and behaviours. For instance, a "good" hospital doctor will be both a good medical practitioner and a professional who brings money to the hospital. So, this movement raises questions about the future of hospital physicians' professional identity that should be analyzed further.

This example shows that a market-based frame of reference which was traditionally associated with private practitioners is actually leaving its mark on hospital management and changing the legitimate identity of French hospitals, while its influence is, in some respects, getting weaker in the world of private medicine. This confirms that the economic prism is pervading all parts of the medical world, but it also prevents to consider *a priori* the economic prism as the only normative and cognitive frame shaping representations of what justice means when it comes to health.

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principle remains unchanged. In that sense, the situation of private medicine is quite paradoxical in France: it was historically built on the defence of its liberal dimension (meant to preserve both professional autonomy and patient freedom), but it is largely financed by public funds which guarantee the price of medical consultations and a large clientele for practitioners by ensuring the solvency of the majority of the population regarding health care.

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