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Medicine and Economic Knowledge: The Relevance of Career in the Study of Transformations in the Healthcare System

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Abstract: *»Medizin und Wirtschaftswissen: Die Relevanz der Karriere für das Studium der Transformationen im Gesundheitssystem«*. This contribution highlights the relevance of biographical research for the economic sociology of the healthcare system. In particular, the economy of conventions could be enriched by an approach that is suitable for studying the actors of economic coordination as well as for analyzing the significance of economic knowledge within the framework of specific conventions. This contribution is based on an exploratory study on the economization of the healthcare system in Switzerland. Biographical interviews were conducted with 14 influential experts and senior managers. The careers of four physicians with a strong vocation to influence the public healthcare system are presented. In the concluding discussion, the findings are compared with economic sociology research on the healthcare system in the US and France. The conclusion states that the biographical perspective brings additional aspects into light that are not taken into account by more traditional concepts and methods of economic sociology.

Keywords: Biographical Research, Career, Economic Sociology, Economization, Health Insurance, Healthcare System, Medical Profession.

1. Introduction

This paper is based on an exploratory investigation of transformations in the Swiss healthcare system. Different facets of this process were explored through biographical interviews with key persons, focusing on their occupational career (Streckeisen 2017). Selected findings are presented and discussed here from an economic sociology perspective. The following part explains the research perspective (section 2). Then the introduction of compulsory health insurance is placed in the context of economization (section 3), which is then followed by a sketch of four physicians' profes-

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sional careers (section 4). In the comparative discussion, the findings are related to selected publications on healthcare transformations in the US and France (section 5). The article concludes with a short plea to enrich economic sociology with biographical studies.

2. Career and the Study of Economization

Issue 22 of the 91st edition of the Swiss Medical Journal contains an impressive obituary of an exceptional physician. Hans Heinrich Brunner, former president of the Swiss Medical Association FMH and deputy director of the Federal Office of Public Health (FOPH), had passed away. The following sentences suggest that his was not a very ordinary existence:

> Thoughts of Hans Heinrich Brunner's life and death stretch the association to an ancient drama. Heroic figures involved in relentless battles, superhuman efforts, courage, anger, cunning and treachery, the quest for the absolute, mythical exaggerations and the confrontation with the unalterable truths of humanity: his life was filled with all of this. (Heuss 2010, 843)[1]

The obituary paints the picture of a man who was "a titan physically speaking. A rock of a man" (Heuss 2010, 843). As a politician and top civil servant, he had a decisive influence on the health care system, without ever leaving his beloved profession:

> He was a physician, body and soul. Both as FMH president and as FOPH deputy director, he retained a part-time position as senior physician in the emergency ward of the Inselspital [the leading public hospital in Berne, Switzerland]. He often had a superhuman workload: political negotiations during the day, working in the emergency ward at night, four hours of sleep in between, reading Heidegger to relax and a mountain tour at the weekend. (Heuss 2010, 845)

Brunner was driven by the goal of "maintaining and strengthening the independence and competence of the medical profession in the political arena" (Heuss 2010, 844). However, the signs of the times also led him to prescribe some unpopular medicine to his own profession, such as the introduction of the TARMED tariff [see note 5], which was intended to put the entire tariff system on a "rational, economic basis" (Heuss 2010, 844). The commitment of the deceased to TARMED, which is described in the obituary as Brunner's actual life's work, was not understood by many fellow physicians.

> The production, comparison and collection of data streams occasionally seemed to become an "idée fixe" that increasingly upset his environment. (Heuss 2010, 845)

[1] Quotations from Heuss 2010 have been translated by the author.

Brunner, however, did not let himself be put off.

> No, he wanted and searched for the whole thing. In a certain sense he was a late successor of the Enlightenment, who tried to make room for reason by trying to elicit a certainly not divine, but at least inner order from the confusing chaos of the health care system. Thus he immersed himself in the study and development of medical service, quality and care systems, examined medical decision making and completed a master's degree at the Harvard School of Public Health in the US in order to obtain the theoretical and academic foundation for his health economic visions. (Heuss 2010, 844-5)

The obituary quoted probably contains all the necessary elements to tell the story of the current transformations of the health care system based on the fate of the medical profession. Once again, the heroic figure of the physician appears as a lone fighter with superhuman performance in the daily routine of practice and hospital, and even more so in the political struggle for influence of the medical profession. At the same time, a new era is dawning in which the entire health system is put on an economic basis and the medical profession gets challenged by large data streams and rational models of medical decision making. Brunner embodied both, and for this reason he was both admired and misunderstood by fellow physicians.

Had Brunner not died in 2010, I would certainly have tried to interview him. The present contribution relies on biographical interviews with 14 persons who were, or still are, protagonists in the Swiss health care system. Mostly they have been working in this field for 30, 40, or even more years: senior managers in government departments, hospitals, or health insurance companies as well as well-known experts, consultants, or politicians (Streckeisen 2017). Their narratives shed light on different facets of the changes during the last decades. However, a uniform picture does not automatically emerge when they are collected and compared. While the obituary quoted above refers to the economic challenging of the medical profession, the story of the health fund director focuses the transformation of once non-profit insurance institutions into business enterprises. While the former deputy director of the Federal Social Insurance Office recalls how the first economists were hired in his department from the 1970s onwards, the now renowned health economist tells us that hardly anyone among the economists was interested in health care at that time. While the hospital director coming from the private sector claims that he was the first to call himself CEO far and wide, and that he was able to act as an entrepreneur like no other, his colleague from the university hospital recalls a revolt by the doctors that almost forced her to resign. And while the retired professor of health economics complains that necessary reforms in the health care system are still not being implemented, the president of the nurses' association reports on the drastic change in hospital operations, which is oriented towards economic rationalization and fundamentally undermines the professional ethics of nursing. This enumeration points out that the health care

system is a field in which actors refer to different conventions, i.e., frames of interpretation guiding their action and permitting coordination in the sense of economics of conventions.

Biographical research provides instruments to interpret such narratives in a methodically controlled way. In particular, it is important to distinguish experiencing, remembering, and telling (Rosenthal 2010) and to analyze the production of biographical illusions (Bourdieu 2004), which induce persons to tell their lives as a coherent story or to simply explain important events as the result of chance or (bad) luck. In addition, it is of course necessary to supplement the interviews by policy, media, and document analyses in order to gain further information that is helpful for the interpretation of the interviews and allows the statements of interviewees to be relativized or questioned. If people surely are living their lives themselves, their biographical agency heavily depends on social structures and institutions, and their biographical decisions are shaped by norms prevailing in the society they live in. Hence, like the economics of conventions, biographical research transcends the opposition between methodological individualism and methodological holism. Moreover, it can also be interpreted as an example of methodological situationalism (see Diaz-Bone 2011, 49), because biographical narratives always describe a series of crucial situations in the life course that must be investigated by the researcher. Hence, situations are an important unit of analysis in biographical research, and actors mobilize resources (like norms, conventions, and knowledge) that are social and distributed rather than primarily individual.

Apart from these epistemological considerations, the question also arises as to whether the different narratives mentioned above have anything in common that would allow us to interpret them as different facets of the same process. This contribution is based on the assumption that a common denominator can be defined by the concept of economization. Following Foucault's (2008) investigations into the relationship between power and knowledge, governmentality studies have developed as an independent research approach (Bröckling 2012). In this perspective, economization can be defined as a process in the course of which economic forms of knowledge gain importance in the prevailing power dispositives. This can be seen, for example, in an expansion of the field of economic expertise, as a result of which economic knowledge becomes relevant in fields of action in which it has not had a significant influence in the past. This phenomenon, also known as economic imperialism (Radnitzky and Bernholz 1987), can be well observed in healthcare today. As a deeper matter, economization also means processes that constitutes things, actions, or relations as economic phenomena, for example by transforming objects into goods, allowing people to act as economic actors or turning organizations into companies. In this perspective, Çaliskan and Callon (2010, 5) differentiate

five "types of framing" in the production of markets: pacifying goods, marketing agencies, market encounters, price setting, and market design and maintenance.

Biographical studies[2] offer a potential for analyzing economization processes that have hardly been exploited to date. They offer insights into action-guiding forms of knowledge acquired particularly in the course of vocational training and/or studies. It can be assumed that this secondary socialization, which builds on the primary socialization in the family, also produces emotional, physical, and habitual imprints beyond professional knowledge and skills, which are expressed, for example, in certain forms of perception and communication as well as in the differentiation of lifestyles. Finally, such interviews are suitable for finding out what drives the interviewees in their professional activities and what goals they are aiming for. This is especially the case with people who are in leading positions and/or in the public limelight – where a strong vocation is often discovered – aimed at helping a certain view of the world to break through. A pioneering analysis of the relationship between education and vocation can be found in Bourdieu's (1996) study of French elite schools.

If the aim here is to examine the increasing importance of economic forms of knowledge, the analysis need not be limited to economists. As Callon (2007) emphasizes with the concept of "economics at large," economic knowledge becomes particularly effective in the cooperation between specialists and laypersons, in the exchange between researchers and practitioners, between economists and members of other professions and disciplines, and ultimately also in the everyday practice of the most diverse social groups. In this sense, economization must be understood as a far-reaching process involving many different actors, who may pursue very different goals. In the present study, the role of economic experts in the health care system as well as the acquisition and use of economic knowledge by other actors were of interest. Following a nominalistic logic, I define economic knowledge as the totality of all forms of knowledge that originate in economic science. Of course, this is not a homogeneous field. Economic studies are divided into sub-disciplines, most notably economics and business administration. Economic thinking encompasses different theoretical and methodological approaches, even if this pluralism may be smaller than in other social science disciplines. Thus, economization does not necessarily mean that the plurality of conventions that guide action decreases or even disappears; rather, the term refers to an increase in the importance of economic knowledge.

[2] For research methods in biographical studies, see Chamberlayne, Bornat, and Wengraf 2000.

Before sketching four physician's biographies as was announced previously, a brief contextualization of the field of investigation with regard to the Swiss Health Insurance Act of 1994 is outlined in the following section.

3. Compulsory Health Insurance in the Context of Economization

The introduction of general compulsory insurance has a long history in Switzerland. As early as the end of the 19th century, a health and accident insurance law was drafted, which provided for an obligation for working class people. However, this law, known as the Lex Forrer, was rejected in a referendum in 1900. Subsequently, the government presented a new law that still covered the two risks of accident and illness together, but with quite different regulations. In 1918, the compulsory accident insurance was established, which is still administered today by a central state fund, the Swiss National Accident Insurance Fund (SUVA). Health insurance, on the other hand, remained voluntary and continued to be offered by the existing health funds. However, the state began to support these funds with subsidies, and some cities and cantons set up their own public health insurance. In the course of the 20th century, several attempts to bring about compulsory health insurance failed. This only succeeded with the new Health Insurance Act of 1994.

The almost hundred-year period between the Lex Forrer and this new law was repeatedly regarded in history and political science as a typical example of Switzerland being a laggard in welfare state development. However, such a perspective can prove misleading in two respects. On the one hand, a certain welfare state model is set as the norm by which the various countries are measured, as if it were a matter of course that all countries should actually converge towards this very model. On the other hand, there is the danger of extrapolating a specific social policy problem to a far later period, overlooking the fact that the whole context has changed. For instance, despite voluntary insurance, practically the entire Swiss population had health insurance around 1990; according to the Federal Social Insurance Office (FSIO 1996, Table A.01), insurance density had reached one hundred percent. It was therefore no longer a matter of insurance expansion, as was the case a century earlier. In the meantime, a complex and state-subsidized insurance system had developed, which had grown strongly, especially after the Second World War. But from the 1970s onwards, a new discourse became dominant in health policy, which was characterized by two main problems: the containment of rising costs and the introduction of new care

models, such as managed care or HMO.[3] Two events marked the arrival of this discourse: the establishment of the Swiss Society for Health Policy in 1976, which was to become the most important platform for reform-oriented forces for a long time, and the National Cost-Saving Conference in 1982, where funders, service providers, and experts met at the invitation of the government to discuss solutions to stop rising health care costs.

The 1994 law was therefore not about the introduction of a new social security system, as has often been claimed, but rather about changing the political regulation of a mature, largely saturated system. The introduction of compulsory insurance gave the state greater legitimacy to regulate the system comprehensively. The decisive factor was the change from a subsidy regime to a model of regulated competition: the state stopped subsidizing health insurance companies and set up a system of premium reductions for households with modest incomes instead. Health funds were not allowed to set higher insurance premiums for women and older people any longer. It became easier for insured persons to change insurers, which was intended to foster competition. In order to prevent "good risks hunting", a risk equalization scheme was set up between the insurers. Another central element was the distinction between basic and supplementary insurance: a mandatory catalogue of benefits was defined which all health funds must offer; in addition they can sell other benefit packages (e.g., costs for dental treatment are not included in basic insurance). The financing of health insurance through per capita premiums was retained after earlier attempts to introduce compulsory insurance failed due to resistance to wage deductions with equal employee and employer contributions. The new law laid down requirements for uniform tariffs at the Swiss level for ambulatory and hospital care, which were implemented in the 2000s: The physicians' tariff TARMED[4] was introduced in 2004, and the Swiss DRG hospital tariff[5] in 2012.

The cost containment orientation as well as the new competition model have produced an omnipresence of economic terms and data that characterize the health care system in Switzerland today. The new law laid the political and legal foundations for the development of comprehensive electronic data systems comparing the costs, benefits, and quality of medical services. While FOPH is pressing ahead with quality indicators (initially mainly in the hospital sector; BAG 2019), cost control has largely been delegated to Santésuisse, the leading association of health funds. Both the monitoring of health insurance costs reported since 1997 and the cost-effectiveness audit

[3] Managed Care is a health care system that restricts the patient's free choice of physicians in favor of planned treatment procedures. This model is based on integrated service providers that cover various dimensions or the entire spectrum of medical services, also known as HMO (Health Maintenance Organization).

[4] TARMED is a single service tariff for ambulatory medical treatment.

[5] Swiss DRG is a system for financing hospital services based on diagnosis related groups (DRG).

of ambulatory services are now performed by Santésuisse and its subsidiaries. The use of statistical methods makes it possible to identify statistically conspicuous physicians who must respond to questions regarding their charging practices; if they cannot justify the cost structure of their practice, they are required to change it, otherwise health funds can stop covering their costs. So far, only a few cases of conflict have come to light in which the parties have taken legal action; Santésuisse assumes that these audits have a mainly preventive effect, i.e., they educate physicians to cost consciousness (Santésuisse 2019). The general public is also experiencing an unprecedented diffusion of economic knowledge on healthcare. The rise of health insurance premiums is staged and dramatized every year as a mass media event. Information service providers such as Comparis[6] offer price-performance comparisons and invite the insured to choose the best offer: Stimulating competition is their very business model. Compulsory health insurance also provides strong monetary incentives for the insured to subject their use of healthcare services and the choice of healthcare schemes to economic calculations (Streckeisen 2013; see also section 4.3 of this article). Some health funds also have developed mobile phone applications that allow the insured persons to measure their own health behavior; however, premium reduction for healthy behavior is not permitted up to date.

Since the enactment of the 1994 law, however, costs have continued to rise. This observation easily leads to the misunderstanding that the permanent political discourse on cost containment and reforms has evaporated without any effect. In reality, this discourse has made a decisive contribution to transforming the health care system into a market, and medical services into economic goods whose value can be calculated and whose quality can be statistically compared. In this sense, the economic tribunal (Foucault 2008) has increasingly subjected health care to its jurisdiction. In the following section, I will discuss how physicians with a particularly strong vocation to healthcare reform act in this field, sketching four professional careers as empirical examples for that.

4. Four Physicians between Medicine and Economy

Four of the 14 people interviewed in the present study have studied medicine. In this section, the argument relies on their narratives. In view of the

[6] Today, Comparis is the leading Swiss provider of information services on the insurance sector. Founded in 1996 by an economist and a computer scientist, Comparis took up the idea of regulated competition, which is anchored in the 1994 health insurance law, and tried to encourage the insured to choose the most favorable health insurance company. In the meantime, Comparis offers many other services, including a physicians directory and a hospital comparison.

fact that the medical profession is represented by a majority of all other interviewees as the most important force preventing reforms in the healthcare system, it is particularly interesting to examine the views of physicians. More than 50 years ago, Kocher (1967) already described the medical profession as a force whose ideology aimed at preventing unwelcome innovations (back then health funds were attacked as socialist organizations). Against this background, the question arises as to whether economization simply bounces off the resistance of physicians, or whether it initiates a transformation of the medical profession. It is also a question of finding out whether economization confronts the medical profession exclusively from the outside, or whether this process has taken root in its own field. The four physicians mentioned below are not representative of the entire medical profession, of course. What unites them, despite all their differences, is their vocation to contribute actively to shaping the reforms of the health care system. Therefore, they do not to focus their professional activity on their medical surgery or the clinic anymore. How difficult such a decision can be for a physician was mentioned at the beginning of this contribution with reference to the obituary of Hans Heinrich Brunner, who went on practicing as president of the FMH and as FOPH deputy director.

4.1 The Public Health Pioneer

Born at the end of the 1940s, the public health pioneer stems from a family of teachers. Despite his strong philosophical and humanistic interests, he decided to study medicine. During a study visit to Southeast Asia, "the scales fell from his eyes": health cannot be understood as a purely individual phenomenon, but must be examined in the context of social conditions. In contrast to some contemporaries who specialized in so-called tropical medicine, he set himself the goal of applying this insight to the Western countries. From this point on, the (would-be) public health pioneer was fascinated by the question of how the individual and collective aspects of health are interrelated and what would be necessary to promote public health. On his own initiative, he gained notice of the Master's degree at the Harvard School of Public Health. He was one of the first Swiss physicians to obtain such a degree in the US. Although fascinated by the US academic world, he returned to Switzerland in the second half of the 1970s, where he played a leading role in a pioneering study on cardiovascular disease prevention as part of the Swiss National Science Foundation's first National Research Programme. This seemed much more desirable to him than a well-paid occupation in the pharmaceutical industry, which he was offered at the time. After completing his habilitation thesis, his academic career led him to successively become director of two uni-

versity institutes for preventive medicine. In the 1980s, he also headed the country's first health economics research program, which focused on the effectiveness and efficiency of the health care system. He became known to a broad public through health prevention programs and a liberal drug policy. Politically active for many years already, he was elected to the Federal Parliament at the end of the 1990s, where he was one of the rare physicians for more than 15 years. In addition to his academic and political activities, the public health pioneer held a considerable number of board mandates in various economic sectors, for which he was sometimes criticized in public but also by colleagues.

In the narratives of the public health pioneer, a strong vocation to open up medicine in an interdisciplinary way and to establish public health as an independent medical discipline is articulated. In addition, he was committed to healthcare reforms outside the academic world, for example by serving for many years as president of the Swiss Society for Health Policy. He describes the 1970s and 1980s as a time of a new era in healthcare, when concepts such as managed care were invented and important discussions were initiated. In the physicians' community, his commitment often met with skepticism and a lack of understanding: numerous physicians opposed the introduction of social science and economic concepts in the health care system. They were by no means inclined to make not only health and illness, but also the healthcare system itself and the medical profession, the object of scientific research. However, he immediately got on well with colleagues from other professions and disciplines who advocated healthcare reforms. Among his natural allies were, in particular, some of the first health economists in Switzerland. The public health pioneer sees the economic way of thinking as a fascinating and indispensable perspective for today's healthcare system. Unfortunately, however, most physicians would never think of problems such as the scarcity of resources, economic efficiency, political regulation, or the interplay of supply and demand. During his time in the US, the public health pioneer attended various economic courses, not exclusively on health economics, but also general questions of economic theory and research, which he found very enriching.

4.2 The Healthcare Expert

The healthcare expert came to Switzerland at the end of the 1960s with his parents, both of whom were chemists. He studied medicine because he could not decide for anything else. During his studies he was attracted by the craftsmanship elements of the profession: He was not fond of the over-headed medicine of internists, but surgical operations were fun. He worked in the surgical department of the hospital for a few years, but he increasingly found the working hours too difficult to reconcile with family

life. When the opportunity arose to work for a large health insurance company in setting up family doctor networks and managed care models, he left clinical work. This company was one of the first in Switzerland to experiment with the models known from the US. Among other things, it looked for physicians who would be able to convince other physicians of these models. At this point, the (prospective) healthcare expert enjoyed a great deal of freedom and was able to delve deeper into conceptual issues. He completed a Master of Public Health degree and began to take a particular interest in hospital financing through flat rates for diagnosis-related groups (DRG). At the end of his master's degree he published a book on this topic. In the mid-2000s, the healthcare expert was appointed to FOPH, where he served for almost five years as deputy director responsible for compulsory health insurance. Today he is head of healthcare in a canton that is considered innovative in terms of health policy. He sees himself as one of the fathers of DRG hospital financing in Switzerland. The healthcare expert also describes himself as a health economist. He is still one of the few who understand both the language of medicine and that of economics.

Regarding the focus of his professional commitment, the healthcare expert answers with a saying from his boy scout days, according to which it is the task of everyone to leave the world in a better state than he found it. The conversation reveals a strong vocation to improve healthcare as a whole through intelligent regulation. Ultimately, he is concerned with questions of social balance and social peace, to which a just system can contribute a great deal. The healthcare expert sees his strengths particularly in analytical thinking, which allows him to break down the challenges into their individual aspects - similar to the craftsman or the surgeon who (re)assembles the parts correctly. In addition, he sees himself as a team worker who does not want to be the best specialist, but supports his colleagues in their professional development. In this way, he clearly departs from the traditional figure of the medical lone wolf. As an autodidact, the healthcare expert has taught himself economic knowledge, especially regarding insurance. Whenever he considered taking part in training courses on financial and economic topics, he came to the conclusion that he already had a good command of the subject matter. Although he has a Master's degree in Public Health, he does consider himself rather as an insurance expert and as a specialist in healthcare systems regulation. In his view, economic knowledge is obviously of central importance. At the same time, however, he emphasizes that most health economists lack understanding of the medical perspective and are therefore not respected by physicians. The healthcare expert calls himself the "last physician in the Federal Office of Public Health." Since his departure, not a single person with medical training has been represented on the FOPH's management board – a fact he finds

extremely problematic. A look at the office's history, which goes back over a hundred years, also reveals that in 2010, a director without medical training was appointed for the very first time.

4.3 The Medical Data Specialist

Born at the end of the 1960s, the medical data specialist is the only one of the four physicians who did not study medicine in Switzerland, but in Germany. He realized early on that he was not that interested in practicing medicine. A keen interest in mathematics and statistics led him into the field of medical informatics. His participation in a comparative oncology study at a German university enabled him to gain initial experience in working with computer scientists. Subsequently, he specialized in medical informatics and wrote his habilitation thesis in this field. At the same time he completed a distance learning course in business administration. A mandate for the Swiss Hospital Association H+ took him to Switzerland for the first time for professional reasons. This association subsequently hired him as head of the informatics and statistics department. Over time, his work increasingly included economic issues. Finally, in the beginning of the 2000s, he became a delegate of the hospitals in the process that led to the development of the new system of hospital financing system based on diagnosis-related groups. Currently, the medical data specialist acts as the director of the non-profit company, which is entrusted with the maintenance and improvement of the current hospital tariff system. He sees his company primarily as a technical support to service providers and funders in the healthcare system. Since its foundation in 2005, he also participates in the Swiss Society for Medical Controlling, which gathers data specialists from hospitals (medical controlling, quality management, business administration), health funds (auditing), and cantons (provision planning, contract management).

In the interview, the medical data specialist was keen to keep the technical and political sides of the tariff system apart. On the one hand, data quality, description of services, and transparent calculation models are at stake; on the other hand, economic interests, regional differences, or special features of the different hospitals are at stake. He regards the technical maintenance and improvement of the system as a prerequisite for the fair settlement of political issues. This requires a set of tariff rules that are negotiated jointly by service providers and funders and that clarify the most important questions of tariff application. For example, the medical data specialist warns against overly aggressive benchmarking, which would lead to unsustainable business practices and ruinous price competition between hospitals. On the other hand, the new tariff system, in conjunction with a clever set of rules, offers great potential for getting hospitals to behave more entrepreneurially

according to him. Making a primarily technical contribution to this is the central vocation of the medical data specialist, who is firmly convinced that entrepreneurial behavior will lead to an improvement in the quality of services and to a more customer-friendly range of products. This requires hospitals, for example, to specialize more in those services that they can provide particularly well and efficiently, and to discontinue other treatments or to provide them only in cooperation with other hospitals. The medical data specialist plays down the importance of his economic studies for his current job. In the same way, he says it would also be possible to fill the current position without medical training. Nevertheless, the medical data specialist emphasizes that it is a great advantage that he can meet physicians on an equal footing because of his studies. All in all, his narrative expresses the ethos of a technician with a strong vocation to serve the general public, who wants to conduct a factual discussion with all stakeholders involved on the basis of differentiated and diverse specialist knowledge in medicine, informatics, and economics.

4.4 The Medical Lobbyist

The medical lobbyist was born in the early 1950s as the son of a physician. He initially decided against studying medicine because the length of study and social expectations regarding the permanent availability of a physician had put him off. After a diploma in commerce, he first worked for a bank and an airline for several years. His fascination with the medical profession, which had always been present, led him to study medicine as his second professional training. He specialized in surgery and worked as a senior physician in a regional hospital, whose management he had to take over from one day to the next, as he says, after the two senior physicians had been dismissed and one of them had even taken his own life. In the mid-1990s he opened a practice for visceral surgery with a partner. He was still working in this practice at the time of the interview, albeit with a reduced workload due to his successively expanded political commitment. From the beginning of the 2000s, he got involved in the Cantonal Medical Society, which he was soon to chair. One of his main achievements was the creation of the Conference of Cantonal Medical Societies (KKA), which was intended to give the medical profession more political clout at the federal level. The KKA had emerged from a body charged with introducing the TARMED tariff in a cost-neutral manner: the so-called cost-neutrality office. In 2012, the medical lobbyist joined the central board of the Swiss Medical Association (FMH). After the sudden death of a vice-president, he inherited the tariff department a few years later and was in charge of the (unsuccessful) recent attempts to renew TARMED. In addition, he chairs the board of directors of two companies founded by FMH; one company

specializes in the secure communication of health data, while the other provides economic expertise for the medical profession based on a medical data pool.

Much more than the other three careers, the one of the medical lobbyist thus bears a resemblance to the life of the extraordinary physician Hans Heinrich Brunner, who was the subject of the first section of this contribution. This applies not only to the combination of political commitment and practical medical activity, but also to those almost heroic moments when, twice after the sudden death of a colleague, he was forced to take over herculean tasks as it were overnight. During the conversation, the politician also expressed his admiration for Brunner, whom he knew personally of course. He thinks of him as one of the few physicians who had succeeded in combining medicine and economy in a meaningful way. In particular, Brunner had anticipated the importance of internet and e-health. He understood that the future lay in numbers, and that the medical profession needed its own data systems and evidence-based expertise in order to fight for its interests in collective bargaining and political disputes on healthcare reforms. This is why he took the initiative to create companies by the FMH, two of which the medical lobbyist is now chairing. Like Brunner, he sees his vocation in the defense of the liberal medical profession. He is convinced that patients are only well off if physicians love their profession and get the opportunity to practice in good conditions. At the same time, he is quite critical of his own profession. He is annoyed by the fact that physicians instinctively reject anything new, and he rebukes them for their lacking interest in economic and political issues. Without economic knowledge, he says, one lost today. He himself has repeatedly benefited from his commercial training in the context of collective bargaining. Above all, however, the medical lobbyist pleads for new training curricula: in contrast to law studies, for example, medicine still offers graduates hardly any opportunities to specialize in different directions beyond the medical disciplines. Anyone who decides to stop practicing medicine and to specialize in hospital management or medical informatics, for example, is smiled at by his colleagues; behind closed doors they say that he or she has simply not succeeded as a physician. Thus, between the lines of his telling, one can see the image of a medicine which, both as a knowledge system and as a professional ethic, is all too closed and rigid to meet the current challenges of the health care system.

4.5 Interlude

The portraits of the four physicians show different examples of how medical and economic knowledge can be combined to shape the development of the healthcare system. The public health pioneer uses economic

knowledge to open up medicine in an interdisciplinary way and to establish public health as a separate field of expertise. For the healthcare expert, economic knowledge serves to regulate the healthcare system. The medical data specialist relies on the combination of economic and medical knowledge to create the data infrastructure for hospital financing, while the medical lobbyist has recognized that the medical profession must have its own data and economic analyses in order to have a say in healthcare politics today. Of course, these examples do not exhaust all the possibilities of combining medicine and economic knowledge. In the interviews, for instance, another still quite rare figure is mentioned: the hospital director with a degree in medicine and further training in economics, preferably a Master of Business Administration (MBA). Neither of the two hospital directors I interviewed had medical training. While the authority of the female director was openly challenged by head physicians, the male director was more successful in persuading them to cooperate, using economic incentives as rewards for entrepreneurial behavior.

This exploratory study did not deal with the experiences and views of the vast majority of practicing physicians without influential position or higher calling. This would undoubtedly be another fruitful field for biographical studies that could reveal different connections between medicine and economic knowledge. Here I would only like to mention two developments, which have significantly changed the everyday working life of physicians. The move from medical history as a paper document to electronic patient files is part of the development of comprehensive data systems (e-health), which are of central importance for the economization of the health system. In this context, the individual practice is directly integrated into the accounting systems of the health funds, which are charged by the state, among other things, to check the economic efficiency of medical services. In the same way, future research could focus on the increasing frequency of group practices. In these institutions, the physician becomes either an employee or an entrepreneur. It is true that the medical profession in Switzerland has a long political tradition of liberalism, which has always thought of the physician as an entrepreneur too. However, it must not be overlooked that practicing in a liberal profession and being an entrepreneur is by no means simply the same. Furthermore, the traditional individual practice sets quite narrow limits to entrepreneurial activity, especially with regard to the possibilities of economic growth and expansion by mergers and acquisitions.

As mentioned in the second section of this contribution, the physicians' careers are not creations *ex nihilo*, by no means. They are heavily dependent on social structures and institutions, on the distribution of economic and educational resources, and so on. One could say that the four physicians mentioned above have seized the opportunities offered by the economiza-

tion of health care in order to build their respective careers. In the meantime, they were among the very protagonists of this whole economization process in Switzerland. For sociological research, both perspectives are therefore necessary and promising: to shed light on individual careers by analyzing political, economic, and societal transformations; and to use biographical studies in order to question research on this kind of macro or general processes. In the following section, I will now turn to this second analytical perspective.

5. Discussion from an Economic Sociology Perspective

This section breaks away from the individual biographies and uses selected findings of the exploratory study in order to discuss inspiring research on the health care system in the US and France.

5.1 Profession, Government, and Management as Institutional Logics

Scott (2004) describes the development of the US healthcare system using the concept of institutional logics. According to him, in the course of the 20th century, a gradual replacement of professional logic by state logic, and then of state logic by management logic, can be observed. Every institutional logic is a belief system shaping the self-concept of the actors and guides their actions. At the same time, every logic is based on the predominance of specific organizations: In the case of professional logic, it is the professional organization, i.e., the organized medical profession; in the case of state logic, it is the bureaucratic organization; and in the case of management logic, it is the company. The rise of state logic in the US was linked to the establishment of Medicare and Medicaid, which led to the federal government becoming the largest purchaser of medical services virtually overnight in the 1960s (ibid., 278). No state intervention like that has ever taken place in the history of the Swiss healthcare system. Having the analysis of the 1994 Swiss healthcare act outlined above in mind, one would not speak of a replacement of state intervention by management logic, but rather of an increasing intertwining of these two logics, which is expressed in the concept of regulated competition. The strengthening of the management logic in hospitals and health insurance companies is clearly visible; in ambulatory practices, the growth of group practices could point in the same direction. However, the rise of management is by no means at the expense of state regulation, but rather encouraged by it.

Furthermore, investigating economization with biographical interviews further questions Scott's approach. In particular, it becomes clear that pro-

fession, state, and management are not uniform realities whose logic or essence could be fixed once and for all. Instead, they are in a state of flux, and this can be seen, for example, in the fact that economic knowledge today has gained importance in all three areas, albeit in a specific way. At health funds and hospitals, for example, it was not a case of strengthening a management that had always existed; rather, real management structures and management systems were only established in the context of the most recent transformations of the healthcare system. In the past, a hospital director was not a CEO who managed the hospital like a company; instead, he held an administrative and representative function, while the hospital's chief physicians were directly subordinated to political decision-makers (Streckeisen 2017, 8-10). Moreover, comparisons between the state and management and between bureaucratic organization and companies can prove misleading. Today, there are managers in state hospitals, and every larger company is a bureaucratic organization. Interestingly, numerous studies, including this one, clearly suggest that economization is essentially driven by state authorities and leads to a significant increase in bureaucratic structures and processes.

5.2 Solidarity-based Institutions and the Welfare State

Batifoulier, Da Silva, and Vahabi (2019) use the French example to illustrate the complicated relationship between solidarity-based institutions created on the initiative of citizens ("citizen welfare") and the modern welfare state. They argue that welfare state institutions arose from the demands of the war economy in the course of the 20th century. According to them, the welfare state was an integral part of the predatory state that led European nations into two world wars, acting in the narrow interests of national elites. In particular, the state's social policy aimed at increasing and strengthening the population forces as a decisive military factor in the concept of total warfare. In contrast, solidarity-based institutions for mutual support and insurance emerged before the welfare state, in France especially at the time of the Paris Commune. They experienced a renaissance after the Second World War when the comprehensive "Régime General de la Sécurité sociale" was created and administered not by the state but by social forces, above all the trade unions. According to the authors, this is the special feature of the French development: World War II did not bring about an immediate expansion of the welfare state, but rather a revival of "citizen welfare." In the following, they describe how the French state gradually subjugated these solidarity-based institutions and undermined the foundations of self-government.

At first glance, it is difficult to see parallels between the French history and the development of the Swiss healthcare system. Switzerland did not

participate militarily in the world wars and therefore total warfare never reached a comparable scale to France. After the Second World War, the welfare state was to a certain extent expanded with the introduction of old-age and survivors' insurance; health insurance and health policy, however, did not undergo any fundamental changes at that time (Lengwiler 2009). However, it is interesting to keep hold of the fact that solidarity-based insurance schemes existed before the emergence of the welfare state in Switzerland as well. Even today, compulsory health insurance is covered by health funds whose historical roots often go back to the time of mostly local solidarity-based institutions created by labor movements or philanthropic and religious circles. This ancient world of health funds has suffered dramatic change in the course of economization (Streckeisen 2017, 6-8). Only 50 out of approximately 1,000 health funds of the 1960s are left today. This was not only a concentration process through bankruptcies, mergers, and takeovers, but also a double qualitative transformation. The health funds were wrested away from their historical roots in the local milieu, which can be described in economic sociology terms as an example of disembedding; and the funds changed their organizational structures and their legal form in order to become insurance companies in the true sense of the word. The 1994 health insurance act forwarded this process by changing from a subsidy regime to a competitive order that no longer required health funds to be non-profit organizations. Thus contrary to France, in the Swiss healthcare system it was not a matter of subjugating solidary institutions to the welfare state, but rather of transforming them into insurance companies, that is, making enterprises out of mostly local solidarity-based organizations.

5.3 Empowering Patients through the Market

Batifoulier, Domin, and Gadreau (2011) examine the connections between measures to strengthen patients' rights and the implementation of market mechanisms in the French healthcare system. There were two legal amendments at the beginning of the 2000s, one protecting the fundamental rights of patients and the other empowering the patients as consumers, i.e., as economic actors in the healthcare market. The authors reconstruct the economic rationale behind the second of these amendments: In order for the health care system to function as a market, the one-sided dependence of patients on physicians must be challenged. This calls, on the one hand, for reducing the information asymmetry by providing patients with more and better information they can access themselves (including information about physicians and other service providers). On the other hand, patients must be given real choices because there is no *homo economicus* if persons cannot make decisions based on rational calculations. With the amendment mentioned above, patients have thus been given the

opportunity to choose between a treatment pathway or free choice of physician. Furthermore, they can also opt for or against supplementary insurance. This empowerment of health consumers goes hand in hand with greater cost-sharing by patients. At the same time, economic incentives for choosing the treatment pathway model were created.

International comparison shows that Swiss healthcare is characterized, among other things, by a high level of cost-sharing by the insured: At 25.1 percent in 2012, this was twice as high as in Germany and the US and more than three times as high as in France (Streckeisen 2013, 39). In addition to the instruments mentioned above for France (treatment pathway and optional supplementary insurance), the Swiss system has a general cost-sharing scheme and a free amount up to which the insurance does not cover any costs (it is free for the insurer, not for the insured). By choosing a higher level of this so-called franchise, insured persons can reduce the fee (and vice versa). The empowerment of patients through the market thus proves to be not only an obligation to a higher participation in costs, but also an education in the rational handling of health risks. It is not only about the figure of the consumer, but about becoming an economic actor in a comprehensive sense who invests in his/her health and thus saves costs for him/herself and the general public. This perfectly conforms to the reinvention of the social analyzed by Lessenich (2008). Nevertheless, it would be wrong to examine the strengthening of patient rights solely from the perspective of their market rationality. In the biographical interviews, it became clear that most healthcare reform protagonists considered the economic instruments only as a means to an end, useful in order to strengthen the rights of patients, improve the quality of services, or promote larger social and political concerns. Health policy debates of the 1970s were influenced by social movements of the 1968 era. Attacking the power of physicians was linked to a general criticism of traditional forms of authority. Having this in mind, it makes sense to use Boltanski and Chiapello's (2007) analytics of the "new capitalist spirit" for investigations into healthcare. In the same way as the new management models in the private sector have integrated and adapted notions of critique, the economization of healthcare system is partly based on demands of social movements and critique in the post-1968 era. Higher cost-sharing for insured persons, and the education of patients to perform rational economic behavior, turns out to be the price that the system demands for a partial limitation of the "Gods in White" power.

5.4 Industrialization of Medicine

Da Silva (2018) examines changes in the French health care system from a conventionalist perspective. He opposes the term rationalization, which is

often used to describe these transformations. In his eyes, they are not a matter of rationalization, but of changing from one economic convention to another. Whereas the practice of the medical profession was previously subject to professional self-regulation, today we can observe an increasing submission to state regulation. According to Da Silva, liberal medicine in its traditional form is a connection between the convention of inspiration and the convention of the house. The uniqueness and complexity of the cases physicians deal with were emphasized; against this background, it seemed appropriate to offer them almost unlimited competence concerning medical treatment and not to delegate quality control to any external bodies. At the same time, the proximity and familiarity between physicians and patients was emphasized, which would inevitably be disturbed by the intervention of third parties. Today, in contrast, the author observes an industrialization of medicine, i.e., the implementation of an industrial convention that leads to the standardization of treatments and sees quality control as a state task, which in France is carried out by the Haute Autorité de Santé (HAS), founded in 2004. Control is based on evidence-based medicine, which understands disease as a phenomenon that can be objectified and separated from individual patients. Therefore, statistical comparison can and must be made regarding the quality and effectiveness of services.

Da Silva's analysis coincides in many respects with the results of the present study on the Swiss healthcare system. The standardization of services seems to be particularly strong in the hospital sector. This corresponds to the new financing scheme with flat rates based on diagnosis-related groups (Swiss DRG) as well as to systems for measuring nursing performance. In Switzerland, however, there is no central quality institute like in France. The cantons are responsible for quality control in the hospital sector, and the health funds have this mandate for ambulatory care. In accordance with the 1994 law, they must also check the cost-effectiveness of medical services and can request sanctions from cantonal courts of arbitration. Half a century after doctors have definitely lost the battle for their freedom to settle accounts without a fixed tariff and without the health funds interfering in their patient relationships (Kocher 1967), we indeed observe a further loss of professional autonomy. But the industrialization of liberal medicine analyzed by Da Silva is linked to further transformations, which could also be analyzed with a conventionalist stance. For example, the domestic convention has long been a dominant feature of health insurance, but this has completely changed as health insurers have been detached from their local milieu. In public hospitals, there are clear indications of a decline of the civic convention in favor of the market convention. And the emergence of managers and entrepreneurially active physicians points to the fact that the project-based convention of the new capitalist spirit (Boltanski and Chiapel-

lo 2007) has now also gained a foothold in the healthcare system: they are displacing the heroic figure of the lone warrior doctor, which was once again prominently featured at the beginning of this article using the example of the Hans Heinrich Brunner's obituary. Hence, the concept of economization designates a plurality of transformations, all of which are connected with the industrialization of medicine. But economization cannot be reduced to this one process alone.

6. Conclusion: Career and Convention in Economic Sociology

This contribution presents selected findings based on career studies on the economization of the Swiss healthcare system. The exploratory study indicates that economic knowledge has gained considerably in importance in this field of activity in recent decades. For empirical research on economization in the broader sense, i.e., with a view to the constitution of economic phenomena in the sense of Çaliskan and Callon (2010), in-depth studies in specific areas of the healthcare system would be necessary. At any rate, the reality effects of knowledge cannot be investigated without examining concrete actions of people. Such actions, however, do not only take place in the interactions of everyday life, but also over longer periods of time, during which people create their own biographies and attach biographical significance to individual experiences and decisions. From this perspective, biographical studies can make a specific contribution to the analysis of transformation processes. They allow researchers to accompany the interviewees during several decades on their way through the object of research, pausing occasionally to deepen selected aspects or establish links with narratives of other interviewees or with documentary analysis. The interpretative instruments of biographical research, the comparison of different narratives as well as the increasingly in-depth knowledge of the field of investigation – also gained by studying supplementary sources – can be used to separate the rather individual aspects of biographies from dimensions that may be characteristic of a whole generation, or of a specific field of action.

Max Weber, one of the founding fathers of economic sociology, was very interested in analyzing which economic subjects capitalism produces. In the renaissance of economic sociology since the 1980s, this focus has faded into the background in favor of networks, institutions, or economic cultures. The economy of conventions also contributed to this fading away of the economic subject. It focuses on processes of economic coordination, but has little interest in the actors "in the flesh and blood" who coordinate economic

activities. Biographical studies could prove to be a valuable addition, as they make acting people empirically tangible and produce insights into the possibility and probability of different ways of interpreting situations and acting accordingly. If conventions are interpretative frameworks developed and handled by actors in order to be able to carry out the evaluation of situations and the coordination of action (Diaz-Bone and Thévenot 2010, 4), this presupposes the appropriation of cognitive instruments that can be analyzed in biographical context and related to socialization and vocation. The biographical perspective is also particularly well suited to examining economization because the actors have an idea of what it means to do a commercial apprenticeship or to study economics, and in their narratives they link concrete experiences and meanings with the various stages of their training and professional careers. The findings presented in this contribution confirm that there is a plurality of economic rationality, and that economization therefore does not necessarily equal the triumph of one single form of economic knowledge. Enriching the economics of convention by biographical research in the study of economization could therefore prove a promising endeavor. In order to explore this perspective, the concept of methodological situationalism (Diaz-Bone 2011) might offer a common ground between both approaches. Biographical situations are not the same as situations of economic coordination, of course. But there is no reason for an a priori statement against the combined analysis of both kinds of situations.

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