



HEALTH, CULTURE and SOCIETY

The production of critical theories in Health Systems Research and Education

An epistemological approach to emancipating public research and education from private interests

Jean-Pierre Unger, Pierre De Paepe, Patrick Van Dessel, Alicia Stolkiner

Volume 1, No. 1 (2011) | ISSN 2161-6590(online)
DOI 10.5195/hcs.2011.50 | <http://hcs.pitt.edu>



This work is licensed under a Creative Commons Attribution-NonCommercial-No Derivative Works 3.0 United States License.



This journal is published by the [University Library System](#) of the [University of Pittsburgh](#) as part of its [D-Scribe Digital Publishing Program](#), and is cosponsored by the [University of Pittsburgh Press](#).

Abstract

This paper aims at offering alternative methodological perspectives in health systems research, to produce critical, theoretical knowledge in domains such as health policy and management of health care, organization of disease control, political economy of health and medical practice. We first examined the reasons to believe that worldwide economic agents have driven publicly funded schools of public health to adopt their preferred policies and to orient their priority research topics.

We then studied whether this hidden leadership has also contributed to shape research methodologies, which we contrasted with the epistemological consequences of a quest for intellectual independence, that is, the researcher's quest to critically understand the state of health systems and generalize results of related action-research. To do so, we applied concepts of what could be named the 'French School of Critical Sociology' to qualitative research methodologies in *descriptive* health systems research.

Keywords: *health systems research; qualitative research; research methodology; human sciences*

The production of critical theories in Health Systems Research and Education

An epistemological approach to emancipating public research and education from private interests

Jean-Pierre Unger, Pierre De Paepe, Patrick Van Dessel¹, Alicia Stolkiner²

I. Introduction

The human stakes of international health policies are immense: conservative estimates put the current avoidable death toll at about 20 million per year (if demographic coefficients from industrialised countries are applied to LMIC); and 150 million worldwide are yearly driven below the poverty line because of catastrophic health expenditure^{3, 4}. Poor or good policy also has huge economic and fiscal externalities: in 2007, the total expenditure on health as a proportion of GDP was 8.8 % in the European Region against 15.7 % in the USA . Given the size of this market-to-be, policy decisions are issues of fierce legal, financial and regulatory tactics, political influence and distortion of science⁵.

Evidence indicates that international policies were aligned on commercial interests and consequently overlooked universal access to individual care as an objective and as an evaluation criterion⁶. In LMIC, governments and international health agencies did not publish much data related to access to and quality of individual care. The

¹Jean-Pierre Unger, MD, MPH, PhD, Senior Lecturer in Public Health, Pierre De Paepe, MD, MPH, Research Assistant, and Patrick Van Dessel, MD, MPH, Research Assistant, are with: The Institute of Tropical Medicine Antwerp, Department of Public Health.

²Alicia Stolkiner is Lecturer and researcher in public health and mental health with: Universidad de Buenos Aires, Facultad de Psicología

³ Household health expenditure is said catastrophic when it reduces the household basic expenditures over a certain period of time in order to cope with the medical bills of one or more of their members.

⁴Xu, K., Evans, D.B., Carrin, G., Aguilar-Rivera, A.M., Musgrove, P., & Evans, T. 2007. Protecting Households From Catastrophic Health Spending. *Health Affairs*, 26, (4) 972-983 available from: <http://content.healthaffairs.org/content/26/4/972.full>.

⁵Stuckler, D., Basu, S., & McKee, M. 2011. Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed? *PLoS Medicine*, 8, (4) e1001020 available from: <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1001020>.

⁶Unger, J.-P., De Paepe, P., Sen, K., & Soors, W. 2010. *International Health and Aid Policies. The Need for Alternatives*, Cambridge University Press Medicine ed. Cambridge, Cambridge University Press.

WHO, for instance, requires member states to monitor the density of community health workers ⁷ but not hospital admission rates.

In theory, policies should be subject to scientific evidence on health systems but little is available and it often stands idle. Academics endowed with a social commitment have the responsibility to produce knowledge relevant to social actors striving for equitable health care systems. Accordingly, this paper aims at steering debates on health systems research (HSR) methodologies and content of health systems education ('-E') in domains such as health policy and management, organization of disease control programs, political economy of health and medical practice.

In the present paper, we examine the possibility that economic agents have driven publicly funded schools of public health to adopt their preferred policies and to neglect other research topics such as access to individual care in LMIC, overall health systems efficiency, psycho-social care, democratization of health sectors, effectiveness of universal health insurance coverage, international aid transaction costs, evaluation of private health care financing, non-managed care approaches to health care rationalization, etc. We then explore the epistemological consequences of a quest for intellectual independence from private interests in health systems research aimed at critically understanding the state of health systems (past and present) and at generalizing results of related action-research. Notice that we do not examine the methodological requirements of producing a body of professional, prescriptive (and descriptive) knowledge constructed to help introduce change in health care delivery and management.

We shall see that the objective of publicly funded HSR-E becoming independent from private interests does not only include the establishment of priority topics of research but also the methodologies to produce this knowledge while examining alternative options. Public health scientific knowledge largely builds upon bio-medical sciences in the domain of disease control and epidemiology. By contrast, the organization of individual health care services and health systems relies much more on human sciences. Clearly, schools of thought exist in these disciplines. To explore the methodological requirements of the qualitative research component of *descriptive* public health⁸, we deliberately concentrated on one such school, which could be named the French School of Critical Sociology. We chose to apply some of its key concepts to HSR because of its coherence across time (inter-generational dialogue of key authors, over 100 years⁹), its relevance to contemporary public health and health care organization issues and consistency with the values of a socially, not commercially, motivated approach to public health and HSR.

II. Why suspecting a capture of public research by private interests?

Public health and / or individual health care?

It has been shown that competition for funds and for international recognition pushes professionals towards vertical initiatives and that research practices contribute to the dominance of vertical strategies and limit the success

⁷ World Health Organization 2010b, World Health Statistics 2010, WHO Press, World Health Organization, Geneva, Switzerland, available from: http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf.

⁸ Another paper in preparation addresses the production of its prescriptive knowledge.

⁹ Therefore, each French social scientist playing a key role in the present essay is spelled with his/her first name.

of evidence based policymaking for strengthening health systems¹⁰. Given that contemporary vertical initiatives are part of a large scale move to privatize discretionary, individual health care in LMIC, it is important to examine the political economy of (public health) academic orientations, including historical factors, underpinning these individual researchers' preferences.

The historical role of public health in society, together with funding sources, has fundamentally influenced its modern operations. Public health can be traced back to the cholera epidemic deciphered by G. Snow in London in 1854.¹¹ For decades, public health mainly addressed infectious disease control. Before World War 2, European government-led policies gave to the poor "public health", large scale interventions designed to control some diseases and implemented by public services (Snow 1936) - while the upper classes were the only ones to access curative, individual care (delivered in the private for profit sector). The same pattern emerged in LMIC. Originally, disease control programs were created to protect the workforce (e.g. workers building the Matadi-Leopoldville railroad as a measure against malaria and those of the Panama Canal as a measure against yellow fever). Later, the so-called vertical programs expanded the range of beneficiaries to include all lower social classes and targeted more diseases (for instance trypanosomiasis and epidemic meningitis), some maternal and child conditions and included family planning in 'neo-Malthusian' programs¹². From an epistemological perspective tradition thus contributed to shape the borders of contemporary public health and to nest disease control in its hub while access to individual health care was neglected by the public health research community.

However, such neglect has no scientific basis anymore: it is now believed that access to individual care is the key determinant of health status improvement. By 1994, the scientific community was convinced that the aggregate effect of medical care on life expectancy (LE) during the 20th century was roughly five years, with a further potential of two years¹³. Around 1996, conditions amenable to medical care (among others TB, appendicitis, asthma, etc.) and those that related to national health policies (liver cirrhosis, accidental death, etc.) were deemed to account for 11 and 19 % of total mortality¹⁴, respectively. Inadvertently demonstrating the consequences of the collapse of health systems, the rapid fall in ex-USSR life expectancy (LE) in the 1990s – before that social pathologies could unleash their disastrous effects - confirmed the importance of health care. In 2002, a study revisiting the 80's in East Germany showed that 50-60 % of the improvement in LE during that time (estimated by decomposing LE by age and cause, in particular unnecessary, untimely deaths) was attributable to declining mortality from conditions responsive to medical care. The authors concluded that the potential effect on mortality of reducing differences in effectiveness or quality of medical care was greater than had been assumed. Among women

¹⁰Behague, D.P. &Storeng, K.T. 2008.Collapsing the vertical-horizontal divide: An ethnographic study of evidence-based policymaking in maternal health. *American Journal of Public Health*, 98, (4) 644-649 available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2376990/>.

¹¹ Snow, J. 1936, "On the Mode of Communication of Cholera," In *Snow on Cholera: being a reprint of two papers by John Snow*, M.D., New York: The Commonwealth Fund; London: H. Milford, Oxford University Press, pp. 57-203.

¹² Such programs do not aim at reducing maternal mortality but at reducing fertility rate, which possibly drives them towards neglecting demands (e.g. of a woman with psychosocial problems) and needs of patients (say, a woman with C-section history).

¹³Bunker, J.P., Frazier, H.S., &Mosteller, F. 1994. Improving Health: Measuring Effects of Medical Care. *Milbank Quarterly*, 72, (2) 225-258 available from: <http://www.milbank.org/720203.html>.

¹⁴Albert, X., Bayo, A., Alfonso, J.L., Cortina, P., &Corella, D. 1996. The effectiveness of health systems in influencing avoidable mortality: a study in Valencia, Spain, 1975-90. *Journal of Epidemiology and Community Health*, 50, (3) 320-325 available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1060290/>.

in Poland, up to 80 % of premature deaths were related to conditions amenable to medical care¹⁵. Nowadays, some authors attribute up to 30 years LE gains to preventive and curative health services in the USA during the 20th century¹⁶. In industrialized countries, with improvements in public health (both environmental interventions and prevention) largely completed, medical care remains undisputedly the major determinant of life expectancy¹⁷. In short, there is a wealth of evidence to support placing access to versatile care (as provided by family medicine and general hospitals) at the core of (inter)national health policies and education.

Un-evidence based health policies and public health education

That access to care (in family medicine and general hospital settings) could save up to 20 million lives yearly, and that this could be achieved spending just 8 % of GDP (as in Europe) instead of 16 % (as in the USA) are dramatic facts simply overlooked both by: (1) international policy makers and, (2) health system researchers in most schools of public health worldwide.

1. In 1993, the World Bank¹⁸ dismissed access to care in LMIC as an objective for (inter)national policies and until recently, these followed suite. Although vertical programs have specific indications¹⁹, LMIC governments generalized them and financed access of the poor to family medicine and hospital care inadequately or not at all - despite the fact that their alleged cost was an invalid argument against them

20

At the end of the nineties, UN agencies started promoting community insurances, as a substitute for ailing public financing of private providers with an alleged public regulator²¹²²²³ After having promoted universal access to a limited number of health programs (defined by the MDGs), the United Nations made a U-turn and launched an all-

¹⁵Nolte, E., Scholz, R., Shkolnikov, V., & McKee, M. 2002. The contribution of medical care to changing life expectancy in Germany and Poland. *Social Science and Medicine*, 55, (11) 1905-1921 available from: http://www.demogr.mpg.de/publications/files/1257_1042711497_1_Avoid-Germ-Poland.pdf.

¹⁶ Shapiro, J.M. 01-Jan-2007. Jack Shapiro: Stunning Update -- U.S. Life Expectancy Gains Continuing to Erode. available from: <http://www.clickpress.com/releases/Detailed/1413005cp.shtml>.

¹⁷Bunker, J.P. 2001. The role of medical care in contributing to health improvements within societies. *International Journal of Epidemiology*, 30, (6) 1260-1263 available from: <http://ije.oxfordjournals.org/content/30/6/1260.full>.

¹⁸World Bank. 1993. *The World Development Report 1993: Investing in health*. Oxford University Press, Inc.

¹⁹Unger, J.-P.&Criel, B. 1995. Principles of health infrastructure planning in less developed countries. *International Journal of Health Planning and Management*, 10, (2) 113-128 available from: <http://www.ncbi.nlm.nih.gov/pubmed/10144230?dopt=Citation>.

²⁰Unger, J.-P.&Killingsworth, J.R. 1986. Selective primary health care: a critical review of methods and results. *Social Science & Medicine*, 22, (10) 1001-1013 available from: <http://www.ncbi.nlm.nih.gov/pubmed/3526564>.

²¹Arjona, R., Ladaique, M., & Pearson, M. 2001. Growth, Inequality and Social Protection. *OECD Labour Market and Social Policy Occasional Papers* (51) 1-80 available from: <http://www.oecd.org/dataoecd/58/44/34699478.pdf>.

²² Bennett, S., Creese, A., & Monasch, R. 1998, Health insurance schemes for people outside formal sector employment, Division of Analysis, Research and Assessment, World Health Organization, Geneva, Switzerland, ARA Paper number 16, WHO/ARA/CC/98.1, available from: http://whqlibdoc.who.int/hq/1998/WHO_ARA_CC_98.1.pdf.

²³ Bennett, S., Hanson, K., Kadama, P., & Montagu, D. 2005, Working with the Non-State Sector to achieve Public Health Goals, World Health Organization, Geneva, Switzerland, Making Health Systems Work: Working paper No. 2 (WHO/EIP/healthsystems/2005.2), available from: http://www.who.int/management/working_paper_2_en_opt.pdf.

out campaign for free care at the point of delivery²⁴ – as they began promoting public private mixes in health care financing - alongside health care commoditization.

2. In academia, research topics followed these international policy convolutions. For instance:

—The number of papers with the words “health”, “insurance”, “coverage” and “Africa” identified on Google scholar as key words multiplied by almost 10 between 1993 and 2010. Contrasting with this feverish activity, compulsory insurance systems never contributed much to overall health sector financing (always below 20 % in French speaking Africa²⁵). To assess the interest of authors in health care accessibility issues, we measured the same with two additional words: “access” and “care”. Between 1993 and 2010, their proportion increased from 31 % to 44 % only- while insurance coverage rate remained between 3 and 6 % of the French speaking Africa population (25Séry&Letourmy 2006, p. 204).

—The number of papers with the words “community”, “health”, “insurance” and “Africa” multiplied by 6.85 between 1993 and 2010, reaching 17,400 yearly. However, by 2003, although mutual aid associations already existed for many years²⁶, their members in 11 African French speaking countries represented 0.58 % only of the total population of these countries (26N'Diaye 2006, p. 326) (one published study / 170 affiliates!).

—In fact, public health researchers devoted many papers to describing mutual aid associations but 50 % of the 2010 papers identified with “community”, “health”, “insurance” and “Africa” did not include the word “evaluation”.

This lack of scientific interest in the effect of insurance on access to care contrasts with disturbing facts found in LMIC conditions:

—In Colombia, in spite of increased insurance coverage, access to care generally decreased, with exceptions in the subsidized system.²⁷²⁸

²⁴World Health Organization. 2010a. The World Health Report 2010: health systems financing: the path to universal coverage. World Health Organization available from: http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf.

²⁵Séry, J.-P. & Letourmy, A. 2006, "Chapitre 6 : Couverture du risque maladie en Afrique francophone : état des lieux, défis et perspectives," In *L'assurance maladie en Afrique francophone - Améliorer l'accès aux soins et lutter contre la pauvreté*, G. Dussault, P. Fournier, & A. Letourmy, eds., Washington, DC: La Banque Internationale pour la Reconstruction et le Développement/La Banque mondiale, pp. 197-225.

²⁶ N'Diaye, P. 2006, "Chapitre 10 : Le développement des mutuelles de santé en Afrique," In *L'assurance maladie en Afrique francophone - Améliorer l'accès aux soins et lutter contre la pauvreté*, G. Dussault, P. Fournier, & A. Letourmy, eds., Washington, DC: La Banque Internationale pour la Reconstruction et le Développement/La Banque mondiale, pp. 311-330.

²⁷Guarnizo-Herreño, C.C. & Agudelo, C. 2008. Equidad de Género en el Acceso a los Servicios de Salud en Colombia. *Revista de Salud Pública Colombia*, 10, (Sup (1)) 44-57 available from: http://www.scielo.org/scielo.php?script=sci_arttext&pid=S0124-00642008000600005.

—A similar paradox has been observed in Peru where the population who did not consult increased from 50.5 to 56 % between 2007 and 2008. At the same time, its Social Insurance coverage increased (from 26.6 to 44.7 in the population)²⁹.

—In Ghana, user fees increased from 9 to 11 % of total health expenditure between 2007 and 2009, in spite of insurance coverage increasing from 0 % in 2003 to 60 % at the end of 2009³⁰.

These examples and many others point to the existence of significant non-financial barriers to access to individual health care (at the side of financial ones) and ineffective protection provided by health insurances in LMIC - two facts conspicuously overlooked by the scientific literature and international organizations alike.

Notice that the repetitive, general failures of health insurance schemes in LMIC (see a few data above) are related to their focusing public financing on the poor. At first sight equitable, this principle leads to reducing rich / poor solidarity mechanisms. Targeting public funds to the poor leads middle classes purchasing health insurance on the market, rejecting taxes meant to finance health care and chronically under-financing of public health care for the poor. This focusing-on-lower-decile(s) principle is thus radically opposed to the grain of ‘traditional’ (since 1945) West-European health care systems.

In conclusion, criteria for assessing the products of health systems researchers paid with public funds should encompass the relevance of knowledge to policy makers and social actors involved in the quest for more equitable access to care, which assumes the capacity to criticize public decisions and to master the scientific tools and concepts needed to explore the determinants of health systems *failures* (and successes).

III. Reasons for extreme academic prudence

So why has the academic community been so little concerned with access to care, even while it was studying organizations meant to improve it? Basically, we contend, because universal access to individual care was not a priority theme of the main donors to schools of public health: the private sector (and in Latin America, the World Bank). Corporations have the will to orient public research to the best of their interest since they have a legally binding fiduciary duty to maximize shareholder profits. Since 1953 US law does not prohibit companies anymore from donating money to causes from which they do not directly make profit. However, companies indirectly use to their benefit donations to select the foundations’ CEOs and members of direction boards and to influence management of their endowments and grant making decisions.

²⁸ Zambrano, A., Ramírez, M., Yepes, F.J., Guerra, J.A., & Rivera, D. 2007. ¿Qué muestran las Encuestas de Calidad de Vida sobre el sistema de salud en Colombia? [In English: What do living standard surveys show about the health system in Colombia? *Cadernos de Saúde Pública*, 24, (1) 122-130 available from: http://www.scielo.br/scielo.php?pid=S0102-311X2008000100012&script=sci_arttext.

²⁹ Consorcio de Investigación Económica y Social. 2011. Investigaciones sobre salud. available from: <http://www.cies.org.pe/investigaciones/salud>.

³⁰ Andoh-Adjei, F.-X. 2010. Assessing the performance of district mutual health insurance schemes in Ghana. International course in health development (IChD) (46;2009/2010; Amsterdam) (Master in Public Health). Royal Tropical Institute, Amsterdam.

Corporations also have huge resources to commit to this endeavor. While there are more than 100,000 charity foundations in the USA, one of them, the Bill and Melinda Gates Foundation has an operating budget exceeding WHO funds³¹. Therefore, and because of the reduced government funding of public universities, an increasing share of public research has become privately funded, often exceeding public financing of the same by more than 50%³². Accordingly, public universities developed several mechanisms leading their scientists to abide by private interests:

1. Career and promotion, job stability and access to institutional resources became conditioned on the importance of grants attracted by researchers - that is on the extent to which their research accords with the charity foundations' agendas.
2. Careers began depending on publishing, which is measured by bibliometric indicators³³. High impact biomedical journals are often owned by shareholders investing in health care delivery, pharmaceuticals and health financing. This raises an issue of conflict of interest since these journals increasingly mix health policy papers with biomedical ones. They orient publications and thus research by selecting issues, authors, reviewers and methodologies – the latter being also influenced by those who pay for the studies³⁴. Professional associations also own scientific journals, which similarly generates a conflict of interest: if self-serving interests are recognized to dispel the myth of self-regulation³⁵³⁶³⁷³⁸, these interests are likely to bias scientific policies as well.
3. Ethical committees often expanded their mandate towards censorship of research protocols with a human sciences component.³⁹
4. Finally, critical academics were often barred or dismissed from universities⁴⁰.

³¹Stuckler, D., Basu, S., & McKee, M. 2011. Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed? *PLoS Medicine*, 8, (4) e1001020 available from: <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1001020>.

³²London School of Hygiene & Tropical Medicine. 2011. Financial Statements for the year ended on 31 July 2009. available from: http://www.lshtm.ac.uk/aboutus/annualreport/financial_statements_2008_09.pdf.

³³ Notice that evaluators are rarely compelled to make explicit qualitative comments on a paper in the context of an academic's assessment.

³⁴deSardan, J.-P.O. 2010. Anthropologie médicale et socio-anthropologie des actions publiques. Dispositifs de recherche, commanditaires, réformes... *Anthropologie & Santé*, 1, available from: <http://anthropologiesante.revues.org/86>.

³⁵Baldwin, R. & Cave, M. 1999. *Understanding regulation: theory, strategy and practice*, 1st ed. Oxford, UK, Oxford University Press.

³⁶ Bennett, S., Dakpallah, G., Garner, P., Gilson, L., Nittayaramphong, S., Zurita, B., & Zwi, A. 1994. Carrot and stick: state mechanisms to influence private provider behavior. *Health Policy and Planning*, 9, (1) 1-13 available from: <http://www.ncbi.nlm.nih.gov/pubmed/10133096>.

³⁷ Bennett, S. & Ngalande-Banda, E. 1994. Public and private roles in health: a review and analysis of experience in Sub-Saharan Africa, World Health Organization - Division of Analysis, Research and Assessment, WHO/ARA/CC/97.6, available from: http://whqlibdoc.who.int/hq/1997/WHO_ARA_CC_97.6.pdf.

³⁸Lagomarsino, G., Nachuk, S., and Singh Kundra, S. 07-Nov-2009. Public stewardship of mixed health systems. Synthesis report from the Rockefeller Foundation - Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries. Results for Development Institute (in collaboration with The Rockefeller Foundation)

³⁹ Becker, H.S. 01-Mar-2011. Quand les chercheurs n'osent plus chercher. *Le Monde Diplomatique* available from: <http://www.monde-diplomatique.fr/2011/03/BECKER/20226>.

As a result, conflicts of interest in public health research financed by charity foundations controlled by corporate manufacturers of food, tobacco and pharmaceutical goods have been shown to be paramount³¹ and with similar conflicts in Health Systems Research and Education (HSR-E). In public universities, private foundations often funded research into marketable devices (e.g. drugs, vaccines, and diagnostics)⁴¹ and participation in ‘global health initiatives’ - public-private partnerships intended to control diseases and to open outlets for products. Their interests span from jobs to capital return and from trade to consultancy. Besides funding this research, it appears that these private foundations also oriented topic selection in public research, disseminating pro-market messages in public universities, publishing papers, making presentations at scientific meetings, hosting conferences and workshops and paying scientists as spokespersons³¹ and by specializing research teams. There are thus reasons to suspect that private interests have managed to hijack publicly led *health systems research*, resulting in its neglect of medical and health care related knowledge (with the exception of managed care). This has not been done only by orienting priority research topics but also research methodologies.

IV. Epistemological requirements of an independent HSR-E

We now explore the methodological requirements for producing critical theories in HSR-E and contrast them with dominant practices. In public health, human sciences and qualitative research are well known for their ability to orient strategic management and contribute to managerial decision making. They also have a key role in assessing success conditions and determinants of health policies. To this end, Michel Foucault and Pierre Bourdieu proposed concepts particularly relevant to descriptive and interpretative HSR-E, which we now examine.

Foucault and the selection of research topics in the social sciences

Foucault studied the interface of human sciences with biology, economics and philology. Echoing Locke⁴², he explored their intellectual borders, which limit the domain of a science - the space within which the laws and language forms of a science are applicable and operationally effective. To qualify this border, Foucault used the concept of “representation possibility” – episteme, or the historical a priori that grounds knowledge and its discourses and thus represents the condition of its possibility within a particular, historical context.

The theoretical knowledge of HSR-E being partly descriptive (and partly prescriptive) and man being both its object and subject, virtually the entire domain of human sciences can find applications to it and contribute to marking the limits of its operational effectiveness. To the extent that research is publicly funded and HSR-E is an

⁴⁰Chomsky, N. 2003. *Understanding Power: the indispensable Noam Chomsky*, 1st ed. New York, Random House, Inc.

⁴¹Widdus, R. & White, K. 2004. *Combating Diseases Associated with Poverty: Financing product development and the potential role of public-private partnerships*, 1st ed. Geneva, Switzerland, The Initiative on Public-Private Partnerships for Health, Global Forum for Health Research.

⁴² Locke, J. 1999. *An Essay Concerning Human Understanding* (First Published 1690). The Pennsylvania State University available from: <http://www.dca.fee.unicamp.br/~gudwin/ftp/ia005/humanund.pdf>.

applied science, “relevance” to public interests should be a key criterion for defining its priorities. This requires making explicit the links of a particular theory to decision making and action (to improve the human condition).

The following example illustrates this problem of border definition with an issue key to quality of care: the survival of Hippocratic medicine. How can we convince doctors not to exploit the structural information asymmetry that characterizes their relationships with patients in LMIC settings (and makes health financing markets inefficient by definition⁴³)? While health care becomes increasingly commoditized, professional cultures become increasingly materialistic and regulation is not very effective to ease their effects in this context. Since motivation is at least partly an unconsciousness issue, the description of doctors’ ethos remains a borderline case study for the theoretical human sciences⁴⁴.

Foucault defined human sciences’ paradigms as historically evolving concepts. Man’s *functions* and their limits (norms) are debated at the interface of human sciences and biology (public health addresses death and disease but historically, it has neglected *bio-psychosocial suffering*). From an economic standpoint, people have needs and desires (e.g. those of patients, professionals, civil servants and investors) – interests and profits – that result in irreducible (social) *conflict* situations and require (political) *rules* to tame their effects. From a philological viewpoint, there are *systems of signs*. Contemporary health policy and administrative speeches, for instance, are by and large scientific in their expression, making them unquestionable by lay people and limiting the effectiveness of democratic mechanisms. Functions/norms, conflicts/rules and systems/signs together make up the study field of human sciences. Psychology mainly addresses the former, sociology explores conflicts and rules while their interpretation (signifying systems) is an issue of philology (language science) e.g. in literature and myths studies. The role of the concept of sense in philology is to show how a language can be the object of a representation. The (social, political, health) system study, instead stresses how a structure (say, a health system) precedes any sense (say, of patient-centered care, governance, transparency, accountability, etc.). Languages can be represented to the extent that both sign/sense and system are used.

Inter- or multi-disciplinarity? (Edgar Morin)

Economics and sociology, psychology, and philology are permanently intermingled at methodological (a theme further developed by E. Morin) and epistemological levels. In epidemiology, for instance, the study of the combined character of natural (disease) and cultural factors characterizes epidemiological research even when it explores the *primary* determinants of a disease.

The domain of human sciences applied to HSR-E is not defined by what cannot be explored by biomedical sciences. Rather, to the extent that applied sciences are geared towards decision making and action, HSR-E requests ad hoc combinations of theoretical, practical and empirical knowledge, yielded by blends of managerial, biomedical and human sciences methods. According to Edgar Morin, scientific assessment and representation should be inter-rather than multi-disciplinary in essence – meaning that instead of mere parallel use of disciplines to address a problem or a question (which is multi-disciplinarity), each discipline should influence the methods used by the other disciplines – which characterizes inter-disciplinarity. As Morin puts it, “*The issue is to question the principle of*

⁴³The World Bank. 1997. Health, Nutrition, & Population Sector Strategy. The World Bank Group available from: <http://go.worldbank.org/1BO4F9LL30>.

⁴⁴ Professionals’ motivation can be studied by action-research, which is an issue of professional, partly prescriptive knowledge, while the present paper addresses scientific knowledge only.

*disciplines which divide up a complex object, made of numerous interrelations, interactions, interferences, complementarities, oppositions between constitutive entities, a principle whereby everybody is prisoner of a particular discipline.*⁴⁵

Topics and issues at the interface of HSR and human sciences

Foucault observed that the history of human sciences has been one of changes in the interaction of the three biological, economical and philological binomials. During the 20th century, he said, human sciences reduced their preoccupation for functions, conflicts and meanings and increased their concern for norms, rules and systems.

In this incipient 21st century, HSR-E lacks concern for and interpretation of conflicts, human functions and meaning while norms, rules and political structures (systems) are (over-?)emphasized. Biological norms are increasingly used to define rules for taming economic conflicts appearing in the health sector. The MDGs, for instance, conspicuously overlook access to family medicine and hospital care. People's demand for individual health care has been replaced by bureaucratically defined "health needs" (⁶Unger, De Paepe, Sen, & Soors 2010, p. 160) – universal access to disease control programs. These 'needs' are a norm in public health speeches and, not by chance, a rule fixed by international trade agreements⁴⁶.

As opposed to what happened in the 70's and 80's, health care services are no longer studied as the product of social, political and economic conflicts. Possibly because public research is increasingly financed by private interests, health care is increasingly studied as an issue of rules justified on alleged health systems functionality⁴⁷. In schools of public health, signifiers and non-signifiers are no longer viewed as characteristics of human behavior. With the closer alignment of bioscience and policy, non-signifiers are progressively overlooked. QALYs and DALYs indicators have become quite popular in scientific publications⁴⁸, although they are not capable of apprehending (biopsychosocial) suffering (and they are not used much in real health planning practice). Specifically, their use has been ideological: to contribute to justifying a bias in health planning of public services towards disease control.

In conclusion, life, need and language are thus mirrored in the world of human sciences by function (e.g. explored by psychology), conflict (e.g. studied by sociology) and meaning (e.g. represented by philology). These categories have corollaries – norms, rules and systems of signs, respectively – which are transparent ('not given') to consciousness⁴⁹ (not easily objectifiable) but can be easily represented. This facility, together with the ideological and political functions of conservative HSR, probably explains the long lasting predominance of this public health paradigm. For instance, responsiveness, transparency, and rule of law are values often used in contemporary policy speeches. These terms rubbed off on scientific studies although they were deemed invalid and unverifiable criteria⁵⁰.

⁴⁵ Morin, E. 1979. p.227, *Le paradigme perdu: la nature humaine*, Paris, France, Editions du Seuil.

⁴⁶Unger, J.-P., De Paepe, P., Ghilbert, P., & De Groote, T. 2004. Public health implications of world trade negotiations [Letter]. *Lancet*, 363, (9402) 83 available from: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(03\)15191-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)15191-4/fulltext).

⁴⁷ Disease control programs in LMIC public services – probably the largest bureaucracy ever invented by mankind – were not questioned on their economical function (to prevent a subsidized public sector to compete with private interests in the domain of health care delivery) and rarely on their biological mass effectiveness.

⁴⁸but not in real world policies, which reveals the mere ideological function of these indicators.

⁴⁹ Foucault, M. 2004. *Philosophie : anthologie*, Collection Folio essais (No 443) ed. Les Editions Gallimard.

⁵⁰Grindle, M.S. 2011. Good Enough Governance Revisited. *Development Policy Review*, 29, s199-s221 available from: <http://dx.doi.org/10.1111/j.1467-7679.2011.00526.x>.

Other concepts were systematically misused, as is the case of allocative efficiency often mistaken for technical efficiency.⁵¹ Only the underlying conflicts (health care privatization, restrictions on public services functions to avoid subsidized competition with the private sector) allow deciphering of this paradox.

Norms, rules and systems represent a border of human sciences. Knowledge and exploration of these borders is an issue of human sciences⁵². However, scientists cannot study norms, rules and systems without concurrently studying functions, conflicts and meaning. Consider the following examples:

- The role of mental health services cannot be studied without defining norms in mental health and in behavioral deviance;
- Health services management cannot be studied without scrutinizing the underlying social, political, geo-strategic and economic conflicts;
- And governance and stewardship, for instance, cannot be researched without clarifying the semantic ambiguities and ideological valence of its florid terminologies.

In HSR-E, the absence of such balance not only reveals the traditional but acknowledgedly variable dominance of biomedical sciences upon human sciences. It also reveals the scientists' internalization of dominant policy discourses and the continued dependence of public research in applied sciences to private funds and interests. To detect and limit the consequences of this material dependence, the "Praxeology" concept of Bourdieu opens an interesting avenue to those academics who are keen to remain relatively free to search and teach.

V. Bourdieu's praxeology applied to HSR-E

The epistemological architecture of public health schools: a mirror of the social world?

Implicit theories of practice⁵³, says Bourdieu, are correlative of neglecting the social conditions that permitted the theory to exist. In the case of ethnology, researchers are interpreters in essence, leading them to privilege communication relations and symbolic exchange relationships. In the 70's, several authors belonging to the French school of ethnology (Robert Jaulin⁵⁴, Georges Balandier⁵⁵, Pierre Clastres⁵⁶ and others) questioned the

⁵¹Segall, M.M. 2003. District health systems in a neoliberal world: a review of five key policy areas. *International Journal of Health Planning and Management*, 18, (Suppl 1) S5-S26 available from: <http://www.ncbi.nlm.nih.gov/pubmed/14661938>.

⁵²the sciences which are the last to host the concept of representation, the field of episteme: "On dira donc qu'il y a "science humaine" non pas partout où il est question de l'homme, mais partout où on analyse, dans la dimension propre à l'inconscient, des normes, des règles, des ensembles signifiants qui dévoilent à la conscience les conditions de ses formes et de ses contenus ». Michel Foucault. *Philosophie : Anthologie*. Collection Folio essais (No 443), Paris: Les Editions Gallimard, 2004 (p. 288).

⁵³ Examples of theories of practice in public health are those related to the regulation of health care delivery, the process of policy making, the design of disease control programs, the motivation of health care providers with pay-for-performance, etc. They almost always are part of the social practice of a complex set of institutions.

⁵⁴Jaulin, R. 1970. *La Paix blanche - Introduction à l'ethnocide*, Paris, Éditions du Seuil (Combats).

⁵⁵Balandier, G. 1967. *Anthropologie politique*, 1re ed. Evry, France, Presses Universitaires de France.

⁵⁶Clastres, P. 1974. *La société contre l'État*, Paris, Les éditions de minuit.

political function of ethno-science. By contrast, questioning of the social conditions and function of public health and medical sciences, however, emerged only occasionally^{57,58,59} - perhaps because of their high economic weight of the health sector (up to 16 % of GDP in the USA) hampered truly contextualized research and to prevent journalists' findings to feed descriptive HSR.

How did pro-market health policies and their determinants impact on HSR-E knowledge? In the academic world, these social and political factors made their mark on two sciences that barely interact, namely medicine and public health. Medicine responds mainly to individual demand for care; Public health responds to collective necessities or needs defined by professionals. The quasi absence of interactions between these sciences meant that individual health care delivery did not have to echo preoccupations for collective health and consequently, public health did not have to address individual care delivery – in spite of the wealth of evidence pleading for the opposite (mentioned above). To address collective health problems, the disciplines allied to traditional public health were generally mobilized in a standard pattern. This recurring epistemological architecture had already been described in 1965⁶⁰ in terms of the following sequence:

1. Initially, economists determine the orientation of the projects. In general, they choose vertical programs, because they are considered efficient⁶¹;
2. Epidemiologists then choose priority diseases to be controlled;
3. Medical doctors define the technical interventions of the program (this is their sole contribution to the process);
4. Sociological surveys are set up to determine how to improve the population's compliance⁶²;
5. Field work is done by LMIC auxiliary health workers. In theory, their performance would be an issue of economics and behavioral psychology;
6. Finally, economists, demographers and epidemiologists carry out the evaluations.

When public health researchers examined LMIC health systems and policies, several hermeneutic representations appeared influenced by these traditional functions. For instance, the economists' influence led to focus health systems analysis on their financing (pooling, funding,...) while other issues key to universal access to care were overlooked, e.g. the relationships between health system structure and care coordination; the organizational requirements of reflexive medical practice and multidisciplinary teams; the integration of disease control in individual, discretionary health care delivery; the multiple dimensions of care accessibility; the

⁵⁷ Illich, I. 1981. *Némésis médicale. L'expropriation de la santé*, Paris, Editions du Seuil.

⁵⁸ Polack, J.-C. 1971. *La médecine du capital*, Paris, Editions François Maspero.

⁵⁹ Wilson, A., Robertson, J., McElduff, P., Jones, A., & Henry, D. 2010. Does It Matter Who Writes Medical News Stories? *PLoS Medicine*, 7, (9) e1000323 available from: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000323>.

⁶⁰ Pan American Health Organization 1965, *Health planning: Problems of concept and method*, Pan American Health Organization, Washington, DC, Scientific Publication 111.

⁶¹ Mann, J. 1998. Public health: ethics and human rights. *Sante Publique*, 10, (3) 239-250 available from: <http://www.ncbi.nlm.nih.gov/pubmed/9881024?dopt=Citation>.

⁶² Banerji, D. 1986. *Social Science and Health Service Development in India. Sociology of Formation of Alternative Paradigm*, 1st ed. New Delhi, LokPaksh Publishers.

professional identity of health professionals and its influence upon motivation; and the management of integrated services networks.

In conclusion, the social conditions of public health theory production deterred many researchers from questioning the traditional epistemological functions in public health, although the underlying policies were shown to be unable to achieve their limited disease control objectives in LMICs. What other route could they have taken?

VI. Acquiring a critical, theoretical knowledge relevant to HSR-E

In this section, we examine:

- why HSR-E needs to take as its object the relations between internalized (linguistic, ideological, behavioral) conditions of social system reproducibility and its (economic, social, institutional and political) structures;
- why such a study needs a reflexive concern for the possibility conditions of for the research itself, as a surrogate for a quality check.

How can methodological concerns make human sciences amenable to yielding critical concepts relevant to HSR-E and help some scientists evade the determinism described above? Bourdieu proposes a typology of approaches to theoretical knowledge production in human sciences:

1. The phenomenological approach to knowledge

Historically, the phenomenological methodologies overcame difficulties linked to the application to human sciences of a positivist approach typifying the natural sciences – which excluded all methods not solely reliant on sensory observations. Phenomenological methods, empirical in essence, acknowledged the validity of psychological experience – and were thus the first in introducing a reflexive concern in science. Notice that phenomenology admits modes of enquiry in sociology but also history and economics. This approach makes explicit the truth of a direct, social experience (interviews, observations), as was the case with early ethnological studies and is now with most epidemiological research into social determinants of health. The phenomenological approach to qualitative research does not require that the conditions making this knowledge possible be made explicit. It does not rule out triangulation of informant sources to improve qualitative data validity. Together these sources are often deemed sufficient to derive knowledge of social process and of the role of actors. Although phenomenology admits modes of enquiry in different disciplines, mono-disciplinarity has often been historically and logically attached to phenomenological approaches to the social sciences.

Bourdieu criticized the validity of direct, social experience on the notion that belief are independent of the will of an individual and are rather collective (cultural, ideological, linguistic) phenomena. Notice that two other French sociologists explored this concept:

- In political sciences, Gilles Deleuze and Felix Guattari⁶³ offered an original concept of pluralism whereby the individual is not conceived as the basis of any social organization. Social subjectivities are above individuals, and they structure and dismantle any collectivity.
- In social psychology, the existence of a collective dimension in perception had also been studied on experimental design by Pierre Moscovici.⁶⁴

How does this apply to HSR-E, e.g. in policy assessment? These collective phenomena materialize:

- in the social strategy of the interviewee, limiting his/her sincerity,
- his/her organization rationale, affecting his/her identity,
- the country or region's degree of freedom of expression, shaping his/her thoughts and expression, and
- his/her limited access to information.

Finally, the lack of a priori knowledge used in interviews limits the relevance of the interviewer's questions; the researcher's false ingenuity limits any complicity with interviewees; and it permits avoiding important but politically sensitive issues. This explains why so few policy research published in 'scientific' health and medical journals are contextualized and it so often fail to refer to key government and administration features: because it is phenomenological in essence.

2. The objectivist / structuralist approach to knowledge

Beliefs (opinions, statements, discourses) as detected in qualitative research are objects of interpretations and explanations that attempt to understand their economic, symbolic, and linguistic environments, which structures the actors' practices and representations. Therefore, objectivist scientists stress the need for distance between researcher and interviewee. Some even plead that a relative a priori ignorance of the environment's features optimizes the researcher's distance and therefore objectivity.

This approach addresses the objective relationships which structure praxis and actors' representation of praxis, at the cost of some rupture with the truth of the direct social experience. Only when these underlying relationships are explored, can objectivist knowledge organize the features of the social world. However, the objectivist approach, says Bourdieu, stresses the message structure (for instance the structure of a health policy, of a hospital organization, of a regulation) to the detriment of its function. Speech merely treated as a product of language leads to decoding studies that favor sign structures – the relations they have amongst themselves – over their practical functions (which never vanish). To the contrary, these practical functions (which are the key concerns of public health and HSR - more than of ethnology) are at the core of the praxeological study of health systems and policies, which Bourdieu introduces (see below).

The objectivist analysis denies that symbolic forces and relationships depend on political ones. Such analysis does not recognize that the knowledge of a code (say, of a control procedure) only imperfectly permits understanding the relevant interactions. At the end of the day, it does not oppose the phenomenological analysis in that both establish the postulate that immediate comprehension – an unconscious decoding process – is possible. The

⁶³ Deleuze, G. & Guattari, F. 1980. *Mille plateaux*, Paris, Editions de Minuit.

⁶⁴ Moscovici, S. 2003. *Psychologie Sociale*, 1st ed. Paris, Presses Universitaires de France.

objectivist knowledge differs from the phenomenological in the type of envisaged reflexivity. Phenomenologists are compelled to observe their psychology while objectivists limit the domain of validity of their research with assumptions related to the similarity in experience of observer and observed: such similar social and cultural experiences would be a requisite to interpret peoples' representation and their determinants. But, concludes Bourdieu, if one ignores all the other important possibility conditions of any science, one then studies bodies of practice merely as symbolic facts (and is thus liable to personal opinions).

The acquaintance of HSR-E with biomedical sciences led many public health researchers to rely heavily on repertoires of representations. Unfortunately, these hardly capture the ('idiosyncratic') practices of social interaction's symbolism. These repertoires are theories of theories (e.g. theory of good governance, of staff motivation with managed care techniques, disease specific programs selection with cost-effectiveness analysis,...), which closely mirror those used by health bureaucracies worldwide. The material conditions of the study often lead researchers to turn a blind eye to their key political function and neglect other options. Furthermore, predetermined programs of discourses and actions are adapted to some 'cultures' but not to others. The difficulty in translating into Arabic or Asian languages concepts such as 'transparency', 'accountability', 'rule of law', simply reveals that local social hierarchies use different concepts to reproduce themselves ('European values', 'European way of living together'⁶⁵, the Chinese government led 'person-centered policy' and 'quest of social harmony', etc.).

In conclusion, the objectivist approach introduced a distance between the observer and the social world but persistently failed to recognize that researchers remain part of it in spite of these efforts. Consequently, they rarely felt compelled to assume the ethical and logical consequences of this belonging, namely that researchers have a responsibility to:

- improve the state and conditions of their study objects;
- learn from the successes, failures and conditions of this experience; and
- make explicit their underlying philosophical and political position as well as the study conditions (e.g. the researchers' status and funds origin).

Only such a reflective effort would put readers in a position to appraise their topic and methods selection, their results and interpretation.

3. The praxeological approach to knowledge

Praxeological knowledge thus introduces a rupture with objectivist knowledge by scrutinizing the dialectic relationships between the economic, linguistic, social, institutional, political structures – and the internal, individual features (habitus, representations, ways of doing) that permit institutions such as health systems to reproduce themselves. As seen above, the two-sided, interwoven nature of these relationships often justifies the use of interdisciplinary methods to study them.

⁶⁵ Halimi, S. 2011. Ne rougissez pas de vouloir la lune. Le Monde Diplomatique available from: <http://www.monde-diplomatique.fr/2011/07/HALIMI/20760>.

Praxeology thus aims at studying, beyond statistics, one such relationship: the production modes of practices, the dialectic of practices and their conditions. To avert any structure realism and reification of concepts such as social classes and parenthood structures, says Bourdieu, there is a need to move from statistical regularity to the production principle of the observed order. Unlike phenomenological approaches, both objectivist and praxeological knowledge view the object of science as possibly being captured by a construct, against the evidence of common sense and pre-established classifications (and official definitions). For instance, in the health sector, the public health discourse has a practical impact on health care practice, which researchers should deconstruct (in the terms of Derrida) instead of elaborating it. The question is: how?

In HSR-E, ‘praxeologist’ scientists can access primary and secondary data on the impact (output and outcome) of health policies on health care delivery and management, and on peoples’ health status and access to care. They can also access discourses of decision makers, health professionals and bureaucrats with interviews and focus groups. The key contribution of the praxeology approach to such qualitative research is that it assumes that somehow, social, political, economic and linguistic structures featuring the prevailing social hierarchy are mirrored in structures internalized by people. These internal features are the conditions of social structures and hierarchy reproducibility.

Bourdieu names these internal features: habitus, ways of doing and being, and representations. Social structures determine these internal features with education, information, propaganda, advertisement, organized in markets which all convey a symbolic capital. These ‘substrates’ convey discourses which were deciphered by Guy Debord and Roland Barthes⁶⁶, who both studied the implicit objects discourses and their social functions. Likewise, Jean Baudrillard studied how consumption objects and their exhibition contribute to structure modern social relationships. This is how objects acquire a social symbolic function largely exceeding their usage value⁶⁷.

In conclusion, an insight into the actors’ representations, habitus and ways of doing can shed a light on how the social structure (e.g. health systems) tends to reproduce itself - with which symbolic, organizational and cultural mechanisms. This study object is key to produce a critical theory on health systems while adopting a praxeological approach to qualitative research. However, this is not sufficient per se: quantitative and qualitative technical evidences on health care delivery, services and systems are needed to cross check and prompt opinions.

VII. Contributions of biomedical and human sciences to HSR-E

“Feuerbach does not see that the “religious feeling” (public health, medicine) is a social product and that the individual (the health system, the individual patient) under scrutiny belong(s) to a specific social type.” K. Marx, 7th thesis on Feuerbach, German Ideology⁶⁸ (parentheses are of the authors).

Deeds of actors import as much as thoughts to ‘praxeologist’ researchers, as well as their mutual, dialectic adjustment. To detect deeds, in HSR-E, quantitative studies of - and nested qualitative research into - disease and care distribution, allow assessment of their effects, while singling out undesirable effects, contrasts between

⁶⁶ Barthes, R. 1957. *Mythologies*, 1st ed. Paris, Editions du Seuil.

⁶⁷ Baudrillard, J. 1972. *Pour une critique de l'économie politique du signe*, Paris, Les Editions Gallimard.

⁶⁸ Marx, K. & Engels, F. 1972. *L'idéologie allemande*, Paris, Editions Sociales.

achievements and failures, successes and problems in health system outputs and outcomes. System failures, deliberate lack of relevant information, and sustained ineffectiveness provide verifiable evidence in the study of mechanisms whereby infrastructure (e.g. economic and linguistic) and superstructure (political and social) factors influence each other while determining the features of the health system.

These nested studies/evaluations require technical (health) benchmarks - analytical criteria and indicators, which are specific to ethical and political principles. For instance, specific criteria have been formulated for not for-profit (socially motivated, publicly oriented) health care delivery and services management⁶⁹, disease specific programs⁷⁰, health planning⁷¹ and policy⁷². Related indicators belong to a large array, e.g.:

- they measure access to and quality of care (notice that they are different according to whether assessed care is multifunction such as family medicine or monovalent, as in the case of a disease control program);
- they permit assessing the degree of services integration within a system; and
- they reveal how resources are used. (Of course, these criteria are different when the organization's mission is to maximize capital return).

Again, this confirms that interdisciplinary studies are needed to question common sense and official policies classifications - unlike any theory of theory, accounts of accounts and constructs of constructs (made by the actors on the social scene)⁷³, objectionable because such knowledge relies on symbolic interactions while symbols are independent of the agents' will⁷⁴. We have seen that contemporary HSR-E studies focus much more on procedures and processes than on the social construction of health systems and policies (in Foucault's terms: on rules rather than on conflicts). This is because, it is often alleged, the representation of the latter is subject to the authors' political biases – as if:

- the study of processes (e.g. managed care techniques) would be immune to them; and
- rules would merely be rooted in (hard, biomedical) science.

⁶⁹Unger, J.-P., Marchal, B., & Green, A.T. 2003b. Quality standards for health care delivery and management in publicly oriented health services. *International Journal of Health Planning and Management*, 18, (Suppl. 1) S79-S88 available from: <http://onlinelibrary.wiley.com/doi/10.1002/hpm.722/pdf>.

⁷⁰Unger, J.-P., De Paepe, P., & Green, A.T. 2003. A code of best practice for disease control programmes to avoid damaging health care services in developing countries. *International Journal of Health Planning and Management*, 18, S27-S39 available from: <http://onlinelibrary.wiley.com/doi/10.1002/hpm.723/pdf>.

⁷¹Unger, J.-P., Criel, B., & Mercenier, P. 1998, "L'approche verticale: une méthodologie d'identification des priorités stratégiques du contrôle des maladies tropicales," In *Intégration et recherche*, W. Van Lerberghe & X. de Béthune, eds., Antwerpen: ITG Press, pp. 17-43.

⁷²Unger, J.-P., De Paepe, P., Ghilbert, P., Soors, W., & Green, A.T. 2006. Integrated care: a fresh perspective for international health policies in low and middle-income countries. *International Journal of Integrated Care*, 6, (15) 1-10 available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1570879/>.

⁷³Schutz, A. 1972. *Collected Papers I. The Problem of Social Reality (Phaenomenologica)*, 1st ed. Springer Publishers.

⁷⁴Bourdieu, P. 2000. *Esquisse d'une théorie de la pratique (précédé de trois études d'ethnologie kabyle)*, Paris, Les Editions du Seuil.

In HSR-E, we contend that health systems should be studied as social constructions. Their representations (which are thought objects) should not, therefore, *automatically* be treated as the cause of praxis. Objective structures (e.g. the system's productivity, its efficiency and people's access to quality health care) should be determined (and possibly measured) before studying the mechanisms linking them to praxis (and praxis representation)⁷⁵. Such nested biomedical (and other quantitative) studies will yield paradoxical observations ('problem based research'), which are a prerequisite for exploration of the social, political and economic determinants of health policies and systems, a precondition that allows questioning of official speeches aimed at justifying policies, that is, self-apologetic discourses based on alleged functionality and contributing thereby to the system reproducibility. For instance, since it has been shown that Costa Rica spent nine times less on health care per capita than the USA and scored as well on access to quality care and on epidemiological and demographic indicators⁷⁶, economic and political factors (and not alleged health benefits) can now be seen as key determinants of the promotion of the US health system model by multilateral agencies⁷⁷.

Comparisons of health policies which disentangle their effects from other health systems determinants permit plausible representation of the regularity conditions of poor policies design – their determinants. This is why HSR-E, like any applied science, cannot be treated as being *exclusively* a human science.

VIII. Conclusion

The relevance of the knowledge acquired in the realm of HSR-E lies in its subsequent use e.g. equipping all social actors aiming at equity in health in policy decisions, from mutual aid associations to a MoH general director, with relevant and good quality knowledge. HSR-E knowledge can roughly be categorized as scientific or professional, with an accent respectively put on description and prescription. While this paper did not address the latter, professional knowledge should also be an object of research and teaching in public health academic institutions⁷⁸. Unlike the WHO 'building blocks', HSR-E should treat medical care and access as key components for strengthening health systems as they address *the* key determinant of health status and are powerful political pacifiers. Therefore, access as defined here could usefully become a new MDG in health.

Researchers in publicly funded institutions should make explicit how their HSR are linked to decision making and action to make them, in Popperian terms, 'prone to validation'. Those making theories of practices should specify which groups authorize the language they use and give it authority if they do not want to merely contribute to the existing social and symbolic order. In other words, one way of explaining how a study possibly contributes to decision making is by requiring that it makes explicit how it attempts to:

⁷⁵Ibid, p. 237

⁷⁶Unger, J.-P., De Paepe, P., Buitron, R., & Soors, W. 2008. Costa Rica: Achievements of a Heterodox Health Policy. American Journal of Public Health, 98, (4) 636-643 available from: <http://ajph.aphapublications.org/cgi/reprint/AJPH.2006.099598v1>.

⁷⁷ In this kind of study, the technical challenge consists in attributing epidemiological and demographical features of a country to the health services characteristics and to disentangle them from the impact of other determinants – confounding factors.

⁷⁸ Notice that while Walter Benjamin criticized the exclusion of science from those faculties where professional knowledge was taught (W. Benjamin. Oeuvres 1. La vie des étudiants. Collection Folio Essais. Paris: Les Editions Gallimard, 2000, p. 126), symmetrically, it is regrettable that professional knowledge has often been barred from public health faculties and publications.

- improve decision making;
- reveal the social functions of decision makers discourse, deeds, policies and health system structures – while contrasting them with field achievements;
- understand its host social structure and how it determines health systems features and actors behaviors.

By contrast, phenomenological knowledge does not question the research possibility conditions of the experience it attempts to explain. Therefore, it universalizes an experience of the social world, while producing a doxa, a corpus of concepts associated with a given set of social and economic conditions (e.g. the expansion of health markets in LMIC) and their reproduction conditions (e.g. pro-market health policies and their “scientific” ground). If one considers that the opinion addresses what is explicitly questionable, says Bourdieu, than it is in the interest of the oppressed social classes to shrink the doxa domain. In HSR-E, as in other applied sciences, phenomenological knowledge has a conservative function in that it prevents questioning the doxa⁷⁹ – the dominant policy and its methodological alibis.

Research methodologies in human and consequently in applied sciences do thus have a political valence. If HSR-E were unambiguously recognized as an applied science with a human sciences component, and if the related research were entitled to question the established order, scientists would examine the relationships between culture and language, between social order and policy discourse, between politics and health system evaluation. It is not and it does not, or does so only rarely. The praxeological approach can also fruitfully be applied to the analysis of action research outputs in health policies and management. It requires that health systems and policies be explored in the light of their outputs and outcomes, and that the dialectic between economic and political actors’ roles, relationships and health decisions be explored in the light of their demonstrated weaknesses. The most important feature in these evaluations is the link between the problem study – the conditions structure (in HSR-E, an issue of health sciences, management and policy) and the study of the praxis (an issue of sociology, history and political sciences).

Merely decoding policy substance and structures does not permit analysis of the complex interactions between actors (e.g. between a regulation institution and health professionals). Far from phenomenological traditions, critical researchers should thus consider hypotheses generated by the ex-ante context knowledge and consistent with a critical epistemology of human sciences. If researchers aim at contributing to the debate on human rights and essential needs (access to care, teaching, food, water, air and justice), they should make explicit the possibility conditions of their studies – e.g. their own system of values, what is known of the prevailing ‘epistémé’, and their research conditions. The researcher’s commitment to introduce change in the social world and to learn from his/her strategies and conditions of successes and failures are essential to the praxeological approach to HSR. In public universities, research independence should be conceived as an academic goal and an evaluation standard.

⁷⁹ Examples of concepts belonging to the public health doxa are “governance”, “stewardship”, “regulated market”, “accountability”, “responsiveness”, “transparency”, “rule of law”, “allocative efficiency”, public private partnership, purchaser provider split, managed care, management property split, and DALYs.

Bibliography

Albert, X., Bayo, A., Alfonso, J.L., Cortina, P., & Corella, D. 1996. The effectiveness of health systems in influencing avoidable mortality: a study in Valencia, Spain, 1975-90. *Journal of Epidemiology and Community Health*, 50, (3) 320-325 available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1060290/>

Andoh-Adjei, F.-X. 2010. Assessing the performance of district mutual health insurance schemes in Ghana. *International course in health development (ICHHD) (46;2009/2010; Amsterdam) (Master in Public Health)*. Royal Tropical Institute, Amsterdam.

Arjona, R., Ladaique, M., & Pearson, M. 2001. Growth, Inequality and Social Protection. *OECD Labour Market and Social Policy Occasional Papers (51)* 1-80 available from: <http://www.oecd.org/dataoecd/58/44/34699478.pdf>

Balandier, G. 1967. *Anthropologie politique*, 1re ed. Evry, France, Presses Universitaires de France.

Baldwin, R. & Cave, M. 1999. *Understanding regulation: theory, strategy and practice*, 1st ed. Oxford, UK, Oxford University Press.

Banerji, D. 1986. *Social Science and Health Service Development in India. Sociology of Formation of Alternative Paradigm*, 1st ed. New Delhi, LokPaksh Publishers.

Barthes, R. 1957. *Mythologies*, 1st ed. Paris, Editions du Seuil.

Baudrillard, J. 1972. *Pour une critique de l'économie politique du signe*, Paris, Les Editions Gallilard.

Becker, H.S. 01-Mar-2011. Quand les chercheurs n'osent plus chercher. *Le Monde Diplomatique* available from: <http://www.monde-diplomatique.fr/2011/03/BECKER/20226>

Behague, D.P. & Storeng, K.T. 2008. Collapsing the vertical-horizontal divide: An ethnographic study of evidence-based policymaking in maternal health. *American Journal of Public Health*, 98, (4) 644-649 available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2376990/>

Bennett, S., Creese, A., & Monasch, R. 1998, Health insurance schemes for people outside formal sector employment, Division of Analysis, Research and Assessment, World Health Organization, Geneva, Switzerland, ARA Paper number 16, WHO/ARA/CC/98.1, available from: http://whqlibdoc.who.int/hq/1998/WHO_ARA_CC_98.1.pdf

Bennett, S., Dakpallah, G., Garner, P., Gilson, L., Nittayaram phong, S., Zurita, B., & Zwi, A. 1994. Carrot and stick: state mechanisms to influence private provider behavior. *Health Policy and Planning*, 9, (1) 1-13 available from: <http://www.ncbi.nlm.nih.gov/pubmed/10133096>

Bennett, S., Hanson, K., Kadama, P., & Montagu, D. 2005, Working with the Non-State Sector to achieve Public Health Goals, World Health Organization, Geneva, Switzerland, Making Health Systems Work: Working paper No. 2 (WHO/EIP/healthsystems/2005.2), available from: http://www.who.int/management/working_paper_2_en_opt.pdf

Bennett, S. & Ngalande-Banda, E. 1994, Public and private roles in health: a review and analysis of experience in Sub-Saharan Africa, World Health Organization - Division of Analysis, Research and Assessment, WHO/ARA/CC/97.6, available from: http://whqlibdoc.who.int/hq/1997/WHO_ARA_CC_97.6.pdf

Bourdieu, P. 2000. *Esquisse d'une théorie de la pratique (précédé de trios études d'ethnologie kabyle)*, Paris, Les Editions du Seuil.

Bunker, J.P. 2001. The role of medical care in contributing to health improvements within societies. *International Journal of Epidemiology*, 30, (6) 1260-1263 available from: <http://ije.oxfordjournals.org/content/30/6/1260.full>

Bunker, J.P., Frazier, H.S., & Mosteller, F. 1994. Improving Health: Measuring Effects of Medical Care. *Milbank Quarterly*, 72, (2) 225-258 available from: <http://www.milbank.org/720203.html>

Chomsky, N. 2003. *Understanding Power: the indispensable Noam Chomsky*, 1st ed. New York, Random House, Inc.

Clastres, P. 1974. *La société contre l'État*, Paris, Les éditions de minuit.

Consortio de Investigación Económica y Social. 2011. *Investigaciones sobre salud*. available from: <http://www.cies.org.pe/investigaciones/salud>

deSardan, J.-P.O. 2010. *Anthropologie médicale et socio-anthropologie des actions publiques. Dispositifs de recherche, commanditaires, réformes...* *Anthropologie & Santé*, 1, available from: <http://anthropologiesante.revues.org/86>

Deleuze, G. & Guattari, F. 1980. *Mille plateaux*, Paris, Editions de Minuit.

Foucault, M. 2004. *Philosophie :anthologie*, Collection Folio essais (No 443) ed. Les éditions Gallimard.

Grindle, M.S. 2011. Good Enough Governance Revisited. *Development Policy Review*, 29, s199-s221 available from: <http://dx.doi.org/10.1111/j.1467-7679.2011.00526.x>

Guarnizo-Herreño, C.C. & Agudelo, C. 2008. Equidad de Género en el Acceso a los Servicios de Salud en Colombia. *Revista de Salud Pública Colombia*, 10, (Sup (1)) 44-57 available from: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0124-00642008000600005

Halimi, S. 2011. Ne rougissez pas de vouloir la lune. *Le Monde Diplomatique* available from: <http://www.monde-diplomatique.fr/2011/07/HALIMI/20760>

Illich, I. 1981. *Némésis médicale. L'expropriation de la santé*, Paris, Editions du Seuil.

Jaulin, R. 1970. *La Paix blanche - Introduction à l'ethnocide*, Paris, Éditions du Seuil (Combats).

Lagomarsino, G., Nachuk, S., and Singh Kundra, S. 07-Nov-2009. Public stewardship of mixed health systems. Synthesis report from the Rockefeller Foundation - Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries. Results for Development Institute (in collaboration with The Rockefeller Foundation)

Locke, J. 1999. *An Essay Concerning Human Understanding* (First Published 1690). The Pennsylvania State University available from: <http://experiment.iitalia.com/librarysplit2/John%20Locke%20-%20An%20Essay%20Concerning%20Human%20Understanding.pdf>

London School of Hygiene & Tropical Medicine. 2011. Financial Statements for the year ended on 31 July 2009. available from: http://www.lshtm.ac.uk/aboutus/annualreport/financial_statements_2008_09.pdf

Mann, J. 1998. Public health: ethics and human rights. *Sante Publique*, 10, (3) 239-250 available from: PM:9881024

Marx, K. & Engels, F. 1972. *L'idéologie allemande*, Paris, Editions Sociales.

Morin, E. 1979. *Le paradigme perdu: la nature humaine*, Paris, France, Editions du Seuil.

Moscovici, S. 2003. *Psychologie Sociale*, 1st ed. Paris, Presses Universitaires de France.

N'Diaye, P. 2006, "Chapitre 10 : Le développement des mutuelles de santé en Afrique," In *L'assurance maladie en Afrique francophone – Améliorer l'accès aux soins et lutter contre la pauvreté*, G. Dussault, P. Fournier, & A. Letourmy, eds., Washington, DC: La Banque Internationale pour la Reconstruction et le Développement/La Banque mondiale, pp. 311-330.

Nolte, E., Scholz, R., Shkolnikov, V., & McKee, M. 2002. The contribution of medical care to changing life expectancy in Germany and Poland. *Social Science and Medicine*, 55, (11) 1905-1921 available from: http://www.demogr.mpg.de/publications/files/1257_1042711497_1_Avoid-Germ-Poland.pdf

Pan American Health Organization 1965, Health planning: Problems of concept and method, Pan American Health Organization, Washington, DC, Scientific Publication 111.

Polack, J.-C. 1971. *La médecine du capital*, Paris, Editions François Maspero.

Schutz, A. 1972. *Collected Papers I. The Problem of Social Reality (Phaenomenologica)*, 1st ed. Springer Publishers.

Segall, M.M. 2003. District health systems in a neoliberal world: a review of five key policy areas. *International Journal of Health Planning and Management*, 18, (Suppl 1) S5-S26 available from: <http://www.ncbi.nlm.nih.gov/pubmed/14661938>

Séry, J.-P. & Letourmy, A. 2006, "Chapitre 6 : Couverture du risque maladie en Afrique francophone : état des lieux, défis et perspectives," In *L'assurance maladie en Afrique francophone – Améliorer l'accès aux soins et lutter contre la pauvreté*, G. Dussault, P. Fournier, & A. Letourmy, eds., Washington, DC: La Banque Internationale pour la Reconstruction et le Développement/La Banque mondiale, pp. 197-225.

Shapiro, J.M. 01-Jan-2007. Jack Shapiro: Stunning Update -- U.S. Life Expectancy Gains Continuing to Erode. available from: <http://www.clickpress.com/releases/Detailed/1413005cp.shtml>

Snow, J. 1936, "On the Mode of Communication of Cholera," In *Snow on Cholera: being a reprint of two papers by John*

Snow, M.D., New York: The Commonwealth Fund; London: H. Milford, Oxford University Press, pp. 57-203.

Stuckler, D., Basu, S., & McKee, M. 2011. Global Health Philanthropy and Institutional Relationships: How Should Conflicts of Interest Be Addressed? *PLoS Medicine*, 8, (4) e1001020 available from:

<http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1001020>

The World Bank. 1997. Health, Nutrition, & Population Sector Strategy. The World Bank Group available from:

<http://go.worldbank.org/1BO4F9LL30>

Unger, J.-P. & Criel, B. 1995. Principles of health infrastructure planning in less developed countries. *International Journal of Health Planning and Management*, 10, (2) 113-128 available from:

<http://www.ncbi.nlm.nih.gov/pubmed/10144230?dopt=Citation>

Unger, J.-P., Criel, B., & Mercenier, P. 1998, "L'approche verticale: une méthodologie d'identification des priorités stratégiques du contrôle des maladies tropicales," In *Intégration et recherche*, W. Van Lerberghe & X. de Béthune, eds., Antwerpen: ITG Press, pp. 17-43.

Unger, J.-P., De Paepe, P., Buitron, R., & Soors, W. 2008. Costa Rica: Achievements of a Heterodox Health Policy. *American Journal of Public Health*, 98, (4) 636-643 available from:

<http://ajph.aphapublications.org/cgi/reprint/AJPH.2006.099598v1>

Unger, J.-P., De Paepe, P., Ghilbert, P., & De Groote, T. 2004. Public health implications of world trade negotiations [Letter]. *Lancet*, 363, (9402) 83 available from:

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(03\)15191-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)15191-4/fulltext)

Unger, J.-P., De Paepe, P., Ghilbert, P., Soors, W., & Green, A.T. 2006. Integrated care: a fresh perspective for international health policies in low and middle-income countries. *International Journal of Integrated Care*, 6, (15) 1-10 available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1570879/>

Unger, J.-P., De Paepe, P., & Green, A.T. 2003a. A code of best practice for disease control programmes to avoid damaging health care services in developing countries. *International Journal of Health Planning and Management*, 18, S27-S39 available from: <http://onlinelibrary.wiley.com/doi/10.1002/hpm.723/pdf>

Unger, J.-P., De Paepe, P., Sen, K., & Soors, W. 2010. *International Health and Aid Policies. The Need for Alternatives*, Cambridge University Press Medicine ed. Cambridge, Cambridge University Press.

Unger, J.-P. & Killingsworth, J.R. 1986. Selective primary health care: a critical review of methods and results. *Social Science & Medicine*, 22, (10) 1001-1013 available from: <http://www.ncbi.nlm.nih.gov/pubmed/3526564>

Unger, J.-P., Marchal, B., & Green, A.T. 2003b. Quality standards for health care delivery and management in publicly oriented health services. *International Journal of Health Planning and Management*, 18, (Suppl. 1) S79-S88 available from: <http://onlinelibrary.wiley.com/doi/10.1002/hpm.722/pdf>

Widdus, R. & White, K. 2004. *Combating Diseases Associated with Poverty: Financing product development and the potential role of public-private partnerships*, 1st ed. Geneva, Switzerland, The Initiative on Public-Private Partnerships for Health, Global Forum for Health Research.

Wilson, A., Robertson, J., McElduff, P., Jones, A., & Henry, D. 2010. Does It Matter Who Writes Medical News Stories? *PLoS Medicine*, 7, (9) e1000323 available from: <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000323>

World Bank. 1993. *The World Development Report 1993: Investing in health*. Oxford University Press, Inc.

World Health Organization. 2010a. *The World Health Report 2010: health systems financing: the path to universal coverage*. World Health Organization available from: http://whqlibdoc.who.int/whr/2010/9789241564021_eng.pdf

World Health Organization 2010b, *World Health Statistics 2010*, WHO Press, World Health Organization, Geneva, Switzerland, available from: http://www.who.int/whosis/whostat/EN_WHS10_Full.pdf

Xu, K., Evans, D.B., Carrin, G., Aguilar-Rivera, A.M., Musgrove, P., & Evans, T. 2007. Protecting Households From Catastrophic Health Spending. *Health Affairs*, 26, (4) 972-983 available from:

<http://content.healthaffairs.org/content/26/4/972.full>

Zambrano, A., Ramírez, M., Yepes, F.J., Guerra, J.A., & Rivera, D. 2007. ¿Qué muestran las Encuestas de Calidad de Vida sobre el sistema de salud en Colombia? [In English: What do living standard surveys show about the health system in Colombia?]. *Cadernos de Saúde Pública*, 24, (1) 122-130 available from:

http://www.scielo.br/scielo.php?pid=S0102-311X2008000100012&script=sci_arttext