

## Evidence-Based Policy as “Soft Rationalization”

### The Institutionalization of Quality Indicators in the French Hospital Sector

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#### Introduction

During the last decades, the rise of evaluation and accountability has been a major social evolution. Worldwide and in a huge variety of social contexts, new evaluation practices have been deployed for the sake of transparency, performance and efficiency principles, by administrations or agencies, non-governmental organizations or private actors. This broad movement has been analyzed under different labels: explosion of the “audit society” (Power, 1997), rise of social processes of “commensuration” (Espeland & Stevens, 1998) relying on “trust in number” (Porter, 1996), development of quantification in public policies through the international diffusion of “New Public Management” (Hood, 1995). Despite the apparent diversity of concepts, these approaches share the common insight whereby this movement relies on the diffusion of managerial ideas, economic knowledge through complex technical devices, “tools of government” (Hood, 1986) or “policy instruments” (Lascoumes & Le Galès, 2004) able to produce public measures, like assessment devices or performance indicators (Bevan & Hood, 2006). Such devices have been increasingly created and implemented by “technical bureaucracies” (Benamouzig & Besancon, 2005). Their promoters often claim they are part of a shift towards “evidence-based policies” relying on robust quantitative data, on validated assessment methodologies, on scientific knowledge and global expertise.

The goal of this paper is to question the impact of this “evidence-based” shift in public policies. I proceed through the sociological analysis of one case: the institutional genesis of quality indicators (QIs) discreetly implemented in the French hospital sector since the beginning of the 2000s<sup>1</sup>. For decades, the French hospital sector has been affected by reforms claiming to optimize its regulation (Moisdon, 2000 ; Pierru, 2007). Alongside the highly

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<sup>1</sup> This paper presents a selection of results from a thesis which analyzes this public policy from its institutional genesis to its local implementation (Bertillot, 2014). The thesis describes the organized (Musselin, 2005), instrumental (Lascoumes & Le Galès, 2004) and cognitive (Benamouzig, 2005) dimensions of this public policy, through a qualitative methodology crossing interviews with institutional leaders, analysis of written sources and investigations in four hospitals. In this paper, I rely on an analysis of fifty interviews with social actors who participated in the construction of this public policy and on a corpus of 170 sources published between 1995 and 2011.

visible and quite conflictual deployment of payment instruments inspired by *New Public Management* ideas (Belorgey, 2010), tools assessing the quality of care have been more quietly generalized since the late 1990s (Castel & Robelet, 2009). Quality indicators are amongst the most recent of these devices. QIs assess how hospitals are organized to prevent nosocomial infections; they evaluate the traceability of medical and paramedical activities in patient records; they quantify compliance with professional guidelines and bureaucratic standards. QIs have been made to enhance patient information, to provide tools for quality improvement at the local level, and to rationalize the public regulation of hospitals. They are increasingly used to compare hospitals, to display quality scores and to equip regulatory contracts. According to their promoters, they have been built as *évidence-based quality indicators**ö* (Fache & al., 2014 ; Leleu & al., 2011). In this paper, I argue that the institutional trajectory of QIs reveals some mechanisms by which evidence based bureaucracies can secrete a *ósoft-rationalization**ö* policy. In other words, the institutionalization of QIs in the French hospital sector reveals a shift in policy-making towards a more discreet, diffuse and subtle way to govern professional bureaucracies (Mintzberg, 1982) and to strengthen the control of weak public regulators on autonomous health professionals (Hassenteufel, 1997). Throughout the process of their invention, conception and institutionalization, QIs have been built to be both *ómethodologically robust**ö* and *ósocially acceptable**ö*, while carrying a strong normalization of health organizations and professionals. The *ósoftness**ö* of this rationalization process relies on the search for compromise, the mitigating of conflicts and the dilution of tensions through instrumental and institutional ambiguities.

In order to understand how this happened, it has to be admitted that this process cannot be reduced to the genesis of an *óinstrumentation**ö* (Lascoumes & Le Galès [dir.], 2004) deployed in the 2000s. The policy through QIs is rather made of a set of social actors, measurement techniques and assessment knowledge, which have incrementally progressed towards what is mostly a reason to act *ó* the idea that hospitals should be *óaccountable**ö* (Power, 1997) about the quality of their care. The institutional trajectory of quality indicators can therefore be analyzed as that of a *cognitive reason*; that is, a composition of parts, integrating cognitive, social and material elements, whose more or less successful organization produces conviction effects (Benamouzig, 2005). Cognitive reasons are composite elements whose composition varies according to uses (Benamouzig, 2014). Subject to variations, cognitive reasons have nevertheless their *óown strength**ö* relying on their tangible form, their materiality and the knowledge they are made of. These characteristics confer them a relative autonomy in relation to different social uses. Tracing the genesis of this *ópolicy**ö* means following the successive compositions and re-compositions of the cognitive reason for accountability of French hospitals. To do so, I first trace how this cognitive reason emerged as a public problem in the second half of the 1990s (1). Then I describe how this cognitive reason has been *óembodied**ö* in tangible indicators through a prudent institutionalization process in the 2000s (2). Finally, I argue that cognitive and material characteristics of Qis allow to analyze them as a soft normative government technology (3).

## 1. The Emergence of a Public Problem in the 1990s

The beginnings of the public policy based on *ö evidence-basedö* QIs are dating back to the late 1990s. At this period, there was neither concrete *ö instrumentationö* nor clear *ö policyö*, but an uncertain and composite idea which was emerging as a new *public problem*<sup>1</sup>: hospitals should be accountable for the quality of their care and health regulators should ensure this accountability. At this seminal era, principles, objectives and measurement tools were gradually explored and invented by a small world of pioneers in quality measurement, who began to compose the cognitive reason of hospital accountability. This emergence was shaped partly by social mobilizations in the public arena and partly by expertise processes in more confined spheres under the aegis of the State.

### **Accountability Initiatives**

Two social mobilizations were converging in the late 1990s to promote the idea that hospitals should publicly account for their care quality. The first movement was embedded in the media sphere, through the rise of a new journalistic genre. Hospital rankings<sup>2</sup> emerged as a first form of *ö non-bureaucraticö* public measurement of quality. The magazine *ö 50 millions de consommateursö* published the first *ö ranking of emergency wardsö* in 1992. A few years later, in 1997, the magazine *Sciences et Avenir* published a *ö black list of hospitalsö* then, in 1998, a *ö ranking of hospitalsö*<sup>3</sup>. Three French journalists published these first rankings. Inspired by the US trend towards a huge variety of rankings, they gradually specialized in this new kind of press publication. These *ö pioneersö* have undertaken a shift from the approach of hospital news as *faits divers* towards a more global and analytic view of the healthcare system. They started to challenge what they characterized as medical corporatism and lack of hospital security. They began to blame the government and the health authorities for their weaknesses and their inability to reform the health system according to *ö general interestö* of patients and citizens.

*ö Every time, it was the story of a ö hunting accidentö. [...] The ö unfortunate deathö in hospital or ö death on prescriptionö... There was absolutely nothing on processes, efficiency, and no overview of health organizations or the system.ö (Interview with a journalist, Le Point, 2010)*

At the end of the 1990s, the journalists managed to access official medico-administrative databases produced by health institutions in order to equip their rankings with more systematic data than the survey they used to send to hospitals. After having repeatedly seized the Committee on access to administrative documents (CADA), they gained access to

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<sup>1</sup> Among a broad research field, I rely on scholars suggesting to disengage from sequential, linear, ballistic and public-centered views to study the more complex *ö social processes that help build or strengthen a definition [i ] of what appears to be a problem [i ], its solution and the process that will lead to deal with itö* (Gilbert and Henry [dir.], 2009, p. 21), with a particular attention to the cognitive dimension of such processes, which involve *ö framingö* activities (Goffman, 1974 ; Snow & al., 1986) as well as *ö symbolic construction and reconstruction operationsö* (Padioleau, 1982).

<sup>2</sup> For a more detailed analysis of these rankings and their social construction, see Pierru (2004).

<sup>3</sup> Hospital rankings have been major commercial successes and have become commonplace in France. Since 1997, near 50 hospital rankings were produced in the regional or national press. Nowadays, various rankings are published in newspapers as *Le Point*, *L'Express*, *Le Nouvel Observateur*, or *Le Figaro Magazine*.

documents from the review boards of hospital budgets<sup>4</sup>, to annual statistics of hospitals<sup>5</sup> and to the main information system of hospitals (PMSI)<sup>6</sup>.

The ömisappropriationö of data from health regulatory institutions had an important framing effect on these press publications. It has led journalists to establish öperformanceö rankings with öwinnersö and ölosersö, mainly indexed on hospital activity levels, without clearly defining which dimension of hospital activity was then assessed: it was then difficult to understand if rankings were assessing economic performance, quality or security of care. But rankings have nevertheless been a first form of public measurement incorporating a number of tangible öindicatorsö. Activity levels in surgery wards were meant to assess the routine training of surgical teams. Mortality rates after certain surgical operations normally not leading to a fatal outcome were used to estimate the safety of care. Rates of caesarians in maternity hospitals were taken as indicators of bad organization. Straightaway, the journalists have framed the problem towards the ötransparencyö of information, and their initiative have been far from going unnoticed, as first rankings have aroused a lot of conflicts and denunciations. Healthcare professionals and managers have challenged chosen indicators. Activity or mortality criteria were strongly disputed<sup>7</sup>. In short, through these rankings, journalists have invented measure instruments which escaped from governmental and bureaucratic control. They have labeled the absence of such official measures as a highly visible problem. They have also designated someone to *blame* for this problem: healthcare professionals and regulators ó accused of collusion and conservatism.

The second movement promoting hospital accountability in the late 90s was structured around the mobilization of patients against nosocomial infections. In the French healthcare sector still bearing the marks of AIDS<sup>8</sup> and the contaminated blood affair, a new scandal broke on the media scene in September 1997, the *affaire de la Clinique du Sport*. Between 1988 and 1997, nearly 60 patients of this private hospital had been contaminated by a dangerous bacterium ó *xenopi* ó due to inadequate sterilization in surgery<sup>9</sup>. This affair emerged first as a personal struggle, when one of the infected patients and her husband, Beatrice and Alain Michel Ceretti, started to publicize the ordeal and the medical wandering following her contamination during a minor operation which led her to be gradually paralyzed. The Ceretti couple acted as a whistleblower. They relied on media to reframe nosocomial infections from confined medical expertise to public political sphere (Carricaburu, 2009). The couple repeatedly denounced the öcold cynicism of the hospital managers, the incompetence of the so-called medical öspecialistsö, the failure of the public

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<sup>4</sup> Produced by the *Commission d'évaluation des budgets hospitaliers* (CEBH) of the *Assurance Maladie*.

<sup>5</sup> The *Statistique Annuelle des Etablissements* (SAE) is collected annually by the Ministry of Health.

<sup>6</sup> The *Programme de médicalisation des systèmes d'information* (PMSI) automatically measures hospitals activity at the national level. It has been used in a pay-for-activity mechanism since the middle-2000s.

<sup>7</sup> For example, after the publication of its öblack-listö in 1992, the magazine *50 millions de consommateurs* faced 72 lawsuits and had to publish 50 pages of öanswer rightsö from emergency wards professionals and managers (Pierru, 2004).

<sup>8</sup> Since the 1980s, AIDS patients have been getting organized in associations and engaged in social movements claiming more recognition, power and equality in the French healthcare system and its regulation (Barbot, 2002).

<sup>9</sup> For more detailed analysis of this healthcare affair and its political consequences, see Carricaburu (2009).

authorities but also the blindness of those who failed to see her pain and did not believe in her sufferingö (Ceretti, 2004). This two-person struggle has progressively been growing into a larger social movement through the creation of an association built to represent nosocomial infections victims, called *Le Lien*<sup>10</sup>. The association began to publicize the moral dimension of the scandal and to claim a fair compensation for the victims of the affair<sup>11</sup>, before expanding its action to the representation of all nosocomial infection victims in France. In the late 1990s, *Le Lien* has strongly criticized the opacity of the official nosocomial surveillance system, and accused the national committee in charge of evaluating and managing nosocomial risks<sup>12</sup> to be made mainly of örisk producingö professionals. The association has adopted a öde-containment strategyö (Carricaburu, 2009) by publicizing definitions and issues of the öproblemö of nosocomial infections in various media.

From 1999, *Le lien* has begun to advocate for the creation of an official and transparent information system, controlled by the healthcare regulators, aiming at measuring rates of nosocomial infections in hospitals and at establishing public comparisons. Although health professionals in charge of the national surveillance system were initially reluctant to this initiative, policymakers have been more and more sensitive to it, especially as a charismatic personality like Alain Michel Ceretti was defending the cause of the association. Far from remaining in a pure opposition strategy, he has made contacts at the highest level of the administration and showed *Le Lien* was willing to cooperate with health ministers and health regulators if they undertook such an official initiative. The association has quickly made of such öofficial State rankingö about nosocomial infections an essential claim of its struggle. It has thus contributed to *specify* the public problem, by centering it on the measurement of nosocomial infections, in order to claim better information about quality and security of care.

### State Experts and the Premises of Official Measures

These movements claiming hospital auditability have met a third movement embedded in the more öconfinedö sphere of health public institutions and expertise, which has also participated actively in the construction of the öpublic problemö. On the one hand, health regulatory agencies have contributed to ölicitö the social mobilizations for auditability of the 1990s, by making hospital rankings both öthinkableö and öfeasibleö (Pierru, 2004). Journalists have been able to use medico-economic databases and to rely on the support of some key-experts acting from their position inside health agencies. Similarly, *Le Lien* has succeeded in moving policy makers only because its struggle disrupted an already existing national surveillance system<sup>13</sup>. On the other hand, this confined expertise world has been put under great pressure by the challenging convergence of press rankings and patient

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<sup>10</sup> In French, the acronym öLIENö means östruggle, information and studies about nosocomial infectionsö.

<sup>11</sup> The association took a successful legal action against medical practitioners. In March 2010, two of the three practitioners were found guilty of concealing the first infections to patients and then sentenced to prison terms.

<sup>12</sup> This committee is called the *Comité technique des infections nosocomiales* (CTIN).

<sup>13</sup> A surveillance and regulatory system emerged in the 1960s in order to deal with the first bacterial resistance. In the following decades, öhospital hygieneö became a recognized medical speciality. In the 1990s, a whole nosocomial infection surveillance policy developed (Carricaburu, 2009). It was coordinated by the *Institut national de veille sanitaire* (INVS). Its purpose was to establish a national information system in order to measure nosocomial infections and reduce their frequency.

mobilizations. Public policy actors òin the hot seatö had to respond and take action. They then began to look for what could be an òofficialö measurement of hospital quality.

A small number of epidemiologists, health economists, public health specialists and management scientists had been actively participating in the development of medico-economic databases under the aegis of the health administration in the 1980s<sup>14</sup>. In the second half of the 1990s, these persons were considered as the main data experts in France. They were familiar with issues related to the measurement of hospital activities and the possible uses of such data. Some of them had studied foreign information systems and were embedded to international expertise networks on these issues. Some of these experts answered to the publication of rankings in shaping a methodological controversy loaded with political issues. In 1999, the journal *La Recherche* offered them a platform through a *dossier* entitled òShould We Rank Hospitals?ö (Naiditch & al., 1999). In three articles presented as an òevidence-basedö and òconstructiveö critique of press rankings, the experts argued that òpublishing very questionable performance indicators is not the best way to support the healthcare system transformation<sup>15</sup>ö. They questioned the òscientismö of press rankings, while sustaining the need to better share information with the public and to claim the need for establishing trust with the health professionals being evaluated rather than brutally assess their activities through rankings.

Some of these experts have perceived the debates generated by accountability initiatives as revealing the emergence of new expectations in terms of òevidence-basedö public measures of healthcare quality. They have gained the support of a few health agencies leaders convinced that would be the òsense of Historyö and began to work on the premises of public measures that could be both òevidence-basedö and òacceptableö by healthcare professionals. Two different frames of such measures began to be processed in the early 2000s. A working group on òhealthcare performanceö was made under the aegis of the Direction of research, evaluation, studies and statistics (DREES) of the Ministry of Health, chaired by a Professor in public health (Lombrail & al., 2001). Its approach was presented as open, multi-dimensional and sensitive to professional uses of performance assessment. This work group has òimportedö a theoretical framework on healthcare performance developed in Quebec. Experts have examined several existing indicators, but they have not produced any concrete òofficial indicatorö. At the same time, a research project has been designed under the aegis of the private hospital union (UHP), before getting the support of the national agency for accreditation of health organizations (ANAES<sup>16</sup>). The project was under the direction of a researcher in management science named Etienne Minvielle. Resolutely pragmatic, the research team has sought to establish a tangible *Guide Rouge*<sup>17</sup> of robust indicators able to

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<sup>14</sup> These experts were part of a research group attached to the French national school of public health (ENSP). It was named òIMAGEö, which means òmedical information to help in the management of health organizationsö. They produced theoretical knowledge and practices analyses about hospital information systems, specifically the various components and various uses of the PMSI (Benamouzig, 2005, p. 308).

<sup>15</sup> This is the title of the introduction of the *dossier*.

<sup>16</sup> This federation of private hospitals then sought to highlight the quality of care in its health organizations. When the president of the UHP became director of the agency in 2002, he took the research project with him.

<sup>17</sup> In reference to the famous Michelin's òGuide Rougeö devoted to hotels and restaurants.

measure quality, which could be used to improve quality processes in hospitals. Their approach has been mainly management-sciences driven. These two research projects have come together to highlight methodological difficulties in using existing databases to produce unquestionable QIs and hospital rankings that could be recognized as *öevidence-basedö*.

For their part, political and health regulatory institutions leaders have first developed a strategy of *öblame avoidanceö* (Weaver, 1986) which also consisted in *öreportingö* the blame on the only professional actors. For example, at an OECD conference in 2002, Bernard Kouchner *ó* then Minister of Health under the Jospin Government*ó* regretted that the French evaluation system was limited by an *öopaque medical power and a lack of medical competitionö*. He also highlighted his willingness to *ömake performance indicators the more visible and the more transparent possible"* and emphasized that *öwhat is encouraging [...] is that journalistic performance rankings are based on data provided by the Health administrationö* (Pierru, 2004, p. 268-269). However, this *öreporting the blameö* strategy has been less and less tenable as the imperative of a performance measurement was increasingly supported by international organizations<sup>18</sup>. In addition, the French experts had begun to elaborate a *ösofterö* comparative public measurement system. Because an *öofficial measurement systemö* would have allowed health regulators to take control on hospital accountability and answer the insistent claims of *Le Lien*, the idea had been gaining ground in the ministerial cabinets since the early 2000s. In this context, the *ömeasureö* was officially set on the political and institutional agenda on March 21, 2003, when the Minister Jean-Francois Mattei formally seized the *Institut National de Veille Sanitaire* (INVS), demanding the regulators to design a national dashboard of nosocomial infections<sup>19</sup>.

The case of French QIs shows that evidence-based policies should not be regarded as self-evident, rational or linear responses to obvious issues. At first, the genesis of this policy has rather taken the shape of a *problem* that appealed exploratory and uncertain answers from a variety of social actors. It has emerged in a collective process, under the action of a small world of measure entrepreneurs embedded in different social worlds, but who have all contributed to compose the premises of an instrumentation that would allow hospitals to be accountable for their quality of care. In 2003, at the end of this seminal period, evidence-based hospital accountability was a real objective for public policy. Still unclear, this *öcognitive reasonö* (Benamouzig, 2005) already had content. It carried the principle of a State control of hospital quality, inseparable from the idea that such control must be instrumented by legitimate and acceptable techniques. But this patchwork of ideas, principles and measuring tools still had to become tangible and generalized *öquality indicatorsö*.

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<sup>18</sup> In a broader context of economic concerns about raising health costs, International organizations like OECD and WHO have also been promoting performance and quality measurement for several years.

<sup>19</sup> This inscription on the political agenda took place in a turbulent political context. Following the government change in 2002, the new ministerial team around J. - F. Mattei decided to nationally generalize a payment-for-activity system for all French hospitals *ó tarification à l'activité* (T2A). After the *öheat waveö* scandal in the summer 2003, the Minister also sought to demonstrate he was regaining control over the safety of care.

## 2. The Prudent Institutionalization of QIs in the 2000s

The effective deployment of öquality indicatorsö in the French healthcare sector has been taking place since the beginning of the 2000s. The process that has taken shape in this period can be characterized as a *prudent institutionalization* of these policy instruments. Health regulators have then been constructing ötechnically robustö and öpolitically acceptableö quality indicators over an incremental process (Lindblom, 1959), marked by tensions that have been overcome by cognitive activities and institutional compromises. This process has produced QIs that could be claimed as part of an öevidence-based policyö.

### **A Discreet Bureaucratic Engagement**

The order of the Minister has first embarrassed health regulatory institutions. Investing in such an öofficial rankingö then appeared risky and uncertain, at a time when measurement techniques were far from stabilized. For these reasons, the Ministry of Health's engagement has initially been ambivalent. The Ministry's Direction in charge of hospital regulation (DHOS) directly collaborated with the *Institut national de veille sanitaire* (INVS) to meet the Health minister demands, while the Ministry's Direction in charge of research, evaluation, studies and statistics (DREES) stayed in the background and sought mainly to establish knowledge on indicators and their uses rather than to "produce" QIs in a pragmatic sense. On the side of the agency in charge of regulating quality, ANAES teams were incorporated in 2004 in a new *Haute Autorité de santé* (HAS) whose broader perimeter retained quality improvement and accreditation as core missions<sup>20</sup>. The agency was then transformed into a scientific authority formally independent from the Ministry of Health, typical of an öevidence based bureaucracyö. The new instance has first been hesitant about the place to give to quality measurement. At this time, experts in charge of the assessment and improvement of medical practices were very attached to the öevidence-basedö character of assessment tools, which was a *prerequisite* for its legitimacy among health professionals. Among them, the example of hospital rankings aroused great suspicion about the possibility of designing sufficiently robust QIs. In addition, experts in charge of hospital certifications were much attached to a öpeer-ledö approach of assessment, based on local qualitative analysis in a öcontinuous improvement of qualityö sense, which was quite different from national, quantitative and comparative measurement logics.

In this context, the engagement of regulatory institutions between 2003 and 2006 has been both discreet and prudent. Their ölow-noiseö investment have mainly taken the shape of a research project, named COMPAQH<sup>21</sup>, which inherited from the flow of ideas, principles and indicators previously designed by the *öGuide Rougeö* project born under the aegis of the private hospital union. COMPAQH has been designed as a hybrid project, at the interface of the world of regulatory institutions, the world of academic research and, to some extent, the world local hospital sphere. It has been an öapplied research projectö funded by the Direction

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<sup>20</sup> The *Haute Autorité de Santé* has been created in the aim to promote quality, security and democracy in the French health care system. It is in charge of the evaluation of drugs, medical devices and practices.

<sup>21</sup> *Coordination pour la mesure de la performance et l'amélioration de la qualité hospitalière*. For an overall presentation of the COMPAQH project in English language, see Corriol & al. (2008).



of Hospitals (DHOS) of the Ministry of Health and the HAS. It has been led by a researcher in management science, Etienne Minvielle, attached to the *Centre de recherche en économie et gestion appliquées à la Santé* (CREGAS), under the supervision of INSERM and CNRS. The local hospital world has also been well represented in the project, through the voluntary participation of thirty private and public hospitals and the official support of the main hospital federations. The different interests of these three worlds were converging in a pragmatic quest for official indicators that would be more consensual, more robust and less questionable by health professionals than hospital rankings. The managers of voluntary hospitals wanted to position themselves as *õpioneersö* of quality measurement and improvement. Researchers viewed such indicators as a scientific innovation, at a time when quality measurement was still an emerging theme in management sciences. For their part, leaders of regulatory institutions were looking for a way to engage with little exposure in this risky policy that could become a source of conflict.

*õThere was an interest in it for everyone. [...] For the health regulatory agencies, such a project is interesting in that it allows to move forward, to let a research team explore the subject... And if it is getting messy or rubbish, then õit's Researchö. As researchers, we were happy because we had good working conditions, we had institutional supportí ö (Interview with a COMPAQH researcher, 2011)*

From the beginning, the project has been framing the instrumentation being constructed so that it would *õalignö* (Snow & al., 1986) the meaning of QIs with the different expectations and objectives of the actors involved. These structural framings have been critical to reduce tensions and increase supports. The project has first defined a set of key objectives corresponding to the priorities of regulatory institutions and researchers. The control of nosocomial infections ó a crucial priority for the Ministry of Health ó has been the first COMPAQH's framework. Under the influence of the HAS, the assessment of professional compliance with clinical standards has been set as another key priority of the project. COMPAQH has then selected a small number of quality indicators<sup>1</sup> to be experimented in the the panel of hospitals. This selection has been made through a consensual method that allowed the researcher to select the QIs considered both robust and acceptable according to the ANAES criteria<sup>2</sup>. In April 2006, the steering committee selected the indicators that could be generalized: five indicators to control nosocomial infections, six indicators to assess the quality of care from the patient record and one patient satisfaction indicator. Presented as *õtechnicalö*, these framings settled on political choices as well. Some potential QIs like mortality rates have been tested and then excluded because of metrological issues that weakened their robustness and their acceptability<sup>3</sup>. This process has been producing primarily *processes* QIs rather than *results* QIs that would have been a source of conflict; QIs

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<sup>1</sup> In 2003, COMPAQH shortlisted 43 of the 280 indicators listed in the *õGuide Rougeö* research project. It finally tested 37 indicators between 2004 and 2006.

<sup>2</sup> In a methodological guideline published in 2002 and entitled *õConstruction and use of indicators in the health field. General principlesö*, the French national agency for accreditation of hospitals (ANAES) listed criteria to define what a *õgoodö* indicator is: simplicity, acceptability, validation, relevance, reliability, accuracy, reproducibility, sensitivity, specificity, ability to be communicated.

<sup>3</sup> For example, the QI *õMortality rates in low mortality risks diagnosis-related groupsö* is excluded in 2004, mainly because of *õadjustmentö* issues, i.e. problems to adjust the raw mortality rates according to specific mortality or morbidity risks for some patients according to their state of health.

assessing the *traceability* of care practices rather than assessing directly the quality of these practices; QIs to design *public inter-hospital comparisons* rather than individual practice QIs ó more usable in peer-comparison professional approaches.

From this period, the COMPAQH project has been quietly instilling the principle of public comparative measurement, while avoiding political and professional conflicts. But before 2005, the project did not really explicit any in-depth analysis of the concrete uses of these comparative QIs, which remained very vague and implicit. In practice, the issues of quality uses have been superseded by the need for a pragmatic construction of instruments. Anyway, the first stage of this institutionalization has resulted in the embodiment of what was a vague cognitive reason in the first tangible "official State indicators". Going through an external scientific expertise ó backed by regulatory institution ó has been a way to discreetly advance a measurement of quality for the purpose of inter-hospital public comparison. If it has somewhat taken the policy away from the "official ranking" required by the minister, it has also created a set of QIs labelled as "validated" and "generalizable".

### **QIs between Institutional Competition and Compromise**

Between 2006 and 2012, State-QIs have been stimulating new interests within a pluralistic public regulation made up of competing bureaucracies. Willing to seize hospital auditability, the different regulatory organizations have been trying to stand out from each other in accordance with their own issues. More and more bureaucratic actors have been appropriating the State indicators around a variety of objectives invented over time, fueling a true "race towards indicators". In this period, public regulators have looked for a compromise concerning the various possible uses of quality measurement.

The Ministry of Health has been the first institution to seize these QIs. It has used them as a "public diffusion" instrument, to publicly spread information about the quality of care in hospitals. The participation of all French hospitals to the "national dashboard of nosocomial infections" has been made mandatory since 2005. In the years following the first ministerial publication, this use of indicators has been institutionalized through an online "information platform on healthcare organizations" ([platines.gouv.fr](http://platines.gouv.fr)<sup>1</sup>) updated annually, which has been displaying a lot of information on hospital activities and quality. The positioning of the DREES changed for this occasion in 2006, as the "scientific" Direction of the Ministry of Health did not want to be marginalized in the policy-making of quality measurement. Under the influence of one of its expert, the DRESS increasingly engaged in the development of the Ministry's website, began to take part in the steering committee of the COMPAQH project and initiated a framework on patient satisfaction indicators, while continuing to support alternative research projects promoting of a more "peer-comparison" use of quality assessment.

But the HAS was not willing to leave the monopoly of quality indicators to the Ministry of health. From the mid-2000, it has deployed a much clearer policy towards inter-hospital public comparison. The evidence-based institution has endorsed the national

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<sup>1</sup> The website has now changed its name to [www.scopesante.fr](http://www.scopesante.fr).

publication of inter-hospital measurement while emphasizing the quality improvement objective of such public comparison. It has also found a clearer place for the quality indicators in its internal activities. This both *cultural* and *practical* shift has not happened without tensions, since the engagement of the HAS in public comparison measures had been raising debates for years. Some experts and leaders had been closer to a *peer-regulation* approach. They had feared this shift would bring the agency closer to an external control that would go over its mission and endanger its legitimacy towards health professionals. Discussion was also focused on the *operational capacity* for the new instance to develop indicators. This broad reluctance has been overcome *from within* by two health economists hired by the director of the HAS. All three were committed to using quality measurement. In 2005 and 2006, they framed this policy as inexorable through the production of briefing notes and literature reviews. They convinced their colleagues that the strategic interest of the agency relied on participating in the development of these QIs. In 2006, the strategic Board of the HAS ó the *Collège* ó decided to create a specialized internal team on quality indicators and to integrate QIs in the agency's national certification process<sup>1</sup>. This use of QIs has been difficult to implement. But after a few years, it took a concrete shape in 2009 through the agency's third certification standard which included for certain criteria the *scoring* corresponding to the QIs results. This convergence between QIs and certification has firmly anchored the measurement within the main institution in charge of regulating hospital quality.

These increasingly visible initiatives of the Ministry and the HAS quickly aroused other public actors' interest in the late 2000s. Politicians rediscovered that these indicators were usable to claim a voluntarist action on hospital quality and transparency towards both patients and tax-payers. A good example of the use of QIs in terms of *political communication* is offered by President N. Sarkozy when he called to *publicize, for each hospital, a few simple indicators such as mortality of infection rates*<sup>2</sup>. Another example is offered by Minister of Health R. Bachelot, who willingly presented herself as *the Minister of quality of care*. Her Cabinet team negotiated an agreement with the French newspaper *L'Express* so that it published its hospital rankings ó including the official State QIs ó the same day as the annual press conference on the national dashboard of nosocomial infections in the Ministry of Health. Quality measurement has also been invested by other institutional actors who have begun to formalize new *economic regulation* uses for QIs, although this kind of uses had been so far little emphasized by public regulators. The public Health Insurance ó la *Caisse nationale d'assurance maladie* (CNAM) ó had been funding hospitals for decades. However, in the early 2000s, it had been evicted from their evaluation in the favor of the Ministry of Health. The institution was nonetheless invited to follow the COMPAQH project in 2007. To stand out from State regulators, the CNAM was the first to implement in 2009 a *pay for performance* through a contract for GPs practices

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<sup>1</sup> The French *certification* is a national audit process, under the supervision of the *Haute Autorité de Santé*. Hospital professional evaluators (mostly managers, doctors, nurses) visit and control each hospital's organization and medical practices. Results are made public for every hospital, through a *certification report*. In most countries, such processes are named *accreditation*.

<sup>2</sup> This is a quote from the speech of Nicolas Sarkozy at Bletterans (September 18, 2008).

improvement called *contrat d'amélioration des pratiques individuelles* (CAPI<sup>1</sup>). By doing so in the community sector, the CNAM has contributed to give strength to the idea that quality measures in hospitals could be used in a payment perspective. This potential ðnewö use of QIs has been reinforced by the parallel engagement of the national Agency promoting performance in healthcare ó *Agence nationale d'appui à la performance des établissements* (ANAP<sup>2</sup>) which began in 2009 to incorporate QIs in a regulatory tool developed to rationalize negotiations between supervisory authorities and hospitals. This diagnosis tool, named ðHospi Diagö, has been intended to be the ðcommon foundationö for the regulatory contracts between hospital management and regional health agencies ó *Agences régionales de santé* (ARS). This tool has been bringing closer the ðfinancesö and ðqualityö components of hospital regulation since 2010.

Thus, each institution has appropriated QIs while promoting its own objectives. This institutional competition towards quality measurement has been growing without major conflict since the second half of the 2000s. The tensions between these different perspectives have been largely ðbufferedö within the COMPAQH project, where an institutional compromise have been forged through the intellectual work of researchers, through negotiations within COMPAQH's steering committee and through many negotiations carried out by the thematic working groups. Throughout the ðtechnicalö construction of QIs, COMPAQH shaped their various uses while taking care not to exclude any of these uses.

*ðOf course there was tensioní The challenge is to have a minimum of indicators that can meet our different objectives. Even if ðtheö universal indicator... I do not really believe in it! But that's what we want.ö (Interview with an expert of the Ministry of Health, 2010)*

The institutional compromise has been reached at the cost of an ðambiguous agreementö (Palier, 2005). If the various policy makers have agreed on the need to use a set of official QIs to build an auditability policy, they have not necessarily agreed on tangible uses. There has never been a clear choice about the main goal of such policy. However, the institutional path of the COMPAQH project is far from having been neutral. In the late 2000s, the project has been brought considerably closer to public institutions. If the local uses of QIs ó both for professionals and managers ó have been regularly reaffirmed in the project's reports, COMPAQH has mainly made progress in external regulatory uses such as public comparison, regional regulation and economic incentives for quality improvement.

The institutionalization of QIs was well visible in the French hospital law of 2009<sup>3</sup>, which made it mandatory for hospitals to publicize their ðquality resultsö. The law has been providing that the directors of regional regulatory agencies (ARS) have the right to give financial penalties to hospitals reluctant to do so, up to a maximum of 0.1% of their financial allocation. This mechanism has not been intended to directly ðrewardö good results or

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<sup>1</sup> The CAPI is a contract for voluntary GPs who engage to improve certain practices regarding medico-economic issues, such as the prevention of chronic diseases or the optimization of prescriptions. Both progress made and level reached are valued through a financial incentive (up to 10% of additional income).

<sup>2</sup> The ANAP was created to control healthcare spending. The agency designs and spreads management tools, organizes the coaching of hospital managers by consulting firms, supports the health administration and the regional health agencies).

<sup>3</sup> *Loi portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires* (HPST).

öpunish" bad results, but to make hospitals öplay the gameö of transparency. Although parliamentary debates in 2009 were particularly stormy about other aspects of this law, QIs were mobilized by both majority and opposition parliamentarians as a pragmatic öevidence-basedö policy instrumentation without any own political meaning. This inscription of QIs in the French law revealed the success of the construction of QIs sufficiently consensual to allow public regulators as a whole to regain control of hospital auditability. It also locked the institutional commitment to the cognitive reason of auditability.

Although their construction had first aroused considerable reluctance, in fifteen years, these quality indicators have become unavoidable and constraining. This paradoxical institutionalization has been made possible by the great prudence with which their promoters advanced the policy they embodied. Step by step, hospital auditability has taken shape in tangible instruments which quietly gained influence over hospital policy. However, despite the prudence which marked the process of their construction, QIs are not öhalf measuresö.

### 3. Governing through Indicators

Quality indicators are composed of formal theories and doctrines which are embodied in technical forms. They are made of calculation processes, evaluation standards and quantitative results. QIs can therefore be considered as a ömachineö that can be deconstructed analytically in the perspective from the sociology of technics<sup>1</sup>. Without proposing here a tedious description of each QI<sup>2</sup>, it is useful to analyze their most prominent generic characteristics in order to make sense of the policy they embody. It therefore appears that these instruments are built to *softly normalize* hospital quality.

#### **öConsensualismö and Plasticity: Constitutive Softness of QIs**

Throughout the social process of their construction, the official QIs have taken the shape of a ösoft technologyö which reveals itself through two generic characteristics. First, QIs embody a non-confrontational approach of quality assessment. This appears clearly in the analysis of the main characteristics of four typical QIs (see Figure 1 below). The attention to prevent conflicts with health professionals is visible in the chosen dimensions of quality that are measured. Most of the national QIs are öprocessö indicators. They do not aim at measuring results of care, but rather at evaluating the organization, procedure or traceability of care on the patient record. Some of them are öresourcesö indicators, measuring inputs or means used to guarantee safety and security of care. Few of them are closer to öresultsö indicators, in the sense that they measure the traceability of recommended practices in the care of specific disease (such as stroke in its acute phase). But none is built to assess the results of care through mortality rates, for example. The attention to prevent conflict is also

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<sup>1</sup> This perspective helps to understand how techniques incorporate and öhardenö ideas, work, relationships, how technical devices öcrystallize human actionö (Simondon, 1989). It allows to take these devices and their öown lifeö seriously, as they are characterized by *öa number of features [which are] more or less independent from original willsö* (Moison & al., 1997, p. 92). It also helps to understand how this policy instrumentation öreveals a (fairly explicit) theorization of the relationship between the governing and the governedö because *öevery instrument constitutes a condensed form of knowledge about social control and ways of exercising itö* (Lascoumes & Le Galès, 2007, p. 3).

<sup>2</sup> The national official indicators are listed in a table in appendix.

visible in the chosen scale of evaluation. These QIs measure quality at the level of hospitals rather than at the level of wards, consultant teams or practitioners. They do not directly öblameö individuals or teams like did the öblack-listsö of hospitals in the 1990s.

**Figure 1. Characteristics of four typical QIs**

Indicator name	Quality dimension	Type of indicator	Meaning and mode of calculation	Target in 2012
<b>ICSHA</b> (Hand-rub consumption as an indicator)	Hygiene and prevention of nosocomial infections	Resources	How many litters of hydro-alcoholic solutions (disinfectant) have been bought in the hospital compared to the target (score/100)	100% = 20 litters for each 1000 days of hospitalization
<b>SURVISO</b> (Surveillance of infections in surgery)	Prevention of surgical site infections	Process	Is there any epidemiological monitoring of patients after surgery in the different services, compared to the target?  (score/100)	100% = surveillance in each surgery service
<b>IPAQSS DAN</b> (Quality of anesthesia medical records)	Quality of care for anesthesia	Process	Quality of care during anesthesia. Can we found traceability of recommended practices on 13 criteria in the patient record?  (conformity score/100)	90% conformity
<b>IPAQSS IDM</b> (Quality of Stroke medical records)	Quality of care for stroke patients	Process/ results	Quality of care after the acute phase of stroke. Can we found traceability of recommended practices on 6 criteria in the patient record?  (conformity score/100)	90% conformity

This consensual perspective also appears in the data collection processes needed for the calculation. Health professionals have an important role since most indicators are not automatically calculated from databases. They require a specific data collection and criteria checks from random samples of patient records. Some of them also require collection of administrative evidence attesting the existence of organizational processes or specific committee meetings. In other words, professionals have the opportunity to control and to understand what is going on with these indicators.

Second characteristic: the softness of QIs has also something to do with their plasticity, that is to say their openness and flexibility towards a plurality of social actors, types of knowledge and pragmatic uses. The indicators were built to equip three modes of uses, allowing them to serve the goals of different actors. First, QIs are first presented as a device of öpublic diffusionö in line with the main objective of transparency towards patients and taxpayers. They are then presented as a public regulation instrument for the hospital sector, through the HASö certification process, the contractual regulation at the regional level and the emerging financial incentives for quality improvement. Finally, they are presented as an öinternal leverö for assessing and improving quality at the local level. According to their advocates, QIs should be used by hospital managers, by quality managers, by medical practitioners and, more generally, by the different professionals involved in quality related

committees. These QIs are also notable for their cognitive plasticity, that is to say their ability to hybridize various types of reasoning relying on several types of knowledge, techniques and beliefs. These indicators have a true cognitive density. Their professional legitimacy relies on guidelines for clinical practice published by medical learned societies and grounded on *evidence-based* publications. Their *validity* relies also on statistical reasoning and epidemiological techniques grounded in the field of *metrology* or *science of measurement*. Their institutional goals rely on management sciences or economic theories. As measuring devices aiming at opening the *black box* of health hospital *production*, QIs are informed by the agency theory framework<sup>1</sup>. These various modes of reasoning coexist within these composite devices. Their plasticity allows them to anchor in a plurality of cognitive arguments and social practices.

### **Public Display and Comparison: Discreet Normativity of QIs**

Indicators are primarily a quantification tool. Each QI aims at measuring a dimension of hospital quality, according to a formalized process. It *materializes* social rules and technical operations in the form of a tangible object and it allows the calculation of a numerical measure. But this quantification is especially intended to *evaluate* this dimension of hospital quality. As Bevan and Hood (2006) have argued, indicators are built on assumptions which represent synecdoche (taking a part to stand for a whole). QIs evaluate an immeasurable empirical reality *ó hospital quality* *ó* by breaking it down into a set of measurable aspects, each of these aspects being measured according to relevant criteria. Because of this unavoidable simplification of reality, quantification tools are characterized by a certain *lexical poverty* in comparison to the *abundant richness* of the empirical world (Moison [dir.], 1997). The indicator builds a *reflection* or *artifact* of hospital quality that has the advantage of being simple, quantified and unequivocal. Thus, these QIs are anything but neutral. They aim at *evaluating* a certain form of hospital quality, but above all they aim at *improving* it<sup>2</sup>. That is why QIs implicitly or explicitly work in relation to norms, standards, or targets. In other words, they constitute a normative technology. Their strength goes far beyond the search for consensus that led to their construction. The normativity they carry relies on two critical aspects of the way they operate.

First characteristic: this technology is characterized by its orientation towards a large scale public display of information. Quality measurements produced by the quantification apparatus are communication tools that can be formatted in tangible supports of information like reports, press kits or governmental websites. These supports are broadly diffused towards both regulatory institutions and general public. QIs are meant to be publicly displayed in the

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<sup>1</sup> Theorized by Jensen & Meckling (Jensen & Meckling, 1976). In a context of pressure on resources, QIs are meant to *equip* some *principal* (the public regulator controlling the investment of collective resources in the healthcare system) with information about its *agents* (health professionals and health organizations). The reformers assume these agents are benefiting from favorable information asymmetries and the *principal* needs information about their activities in order to make sure agents are acting accordingly with the principal's interests (an efficient and qualitative production of healthcare). QIs are meant to be used in a contractual frame, in relation with incentives and sanctions, in order to make agents do what *principals* want.

<sup>2</sup> This tension has already been highlighted regarding management tools (Moison [dir.], 1997), statistics (Desrosières, 1993) or ranking devices (Espeland & Sauder, 2007). This is an absolutely core feature of QIs.

metrical form of scores, numbers, classes or ranks. They can also take the shape of visual diagrams or tricolor signals. Figure 2 shows an example of such a public display of QIs.

Figure 2: Public Display of QIs (source: institutional website, 2010)

**Qualité de la prise en charge (MCO) - Année 2010**

★ ★ ★  
Classe A  
Des Meilleurs...
★ ★ ☆  
Classe B  
...aux...
★ ☆ ☆  
Classe C  
...Moins bons
☆ ☆ ☆  
Classe D  
Les non répondants

Intitulé	Résultat de l'établissement (valeur + fouchette)	Évolution par rapport à l'année précédente	Positionnement par rapport à la moyenne nationale
Tenue du dossier patient	76 ± 4 ★ ★ ☆	Non Concerné	
Délai d'envoi du courrier de fin d'hospitalisation	64 ± 11 ★ ☆ ☆	→	
Evaluation de la douleur	48 ± 11 ★ ☆ ☆	→	
Dépistage des troubles nutritionnels	64 ± 11 ★ ☆ ☆	↗	
Tenue du dossier anesthésique	95 ± 2 ★ ★ ★	→	
Prescription médicamenteuse dans l'infarctus du myocarde (BASI) Afficher le détail des indicateurs composant le score BASI	Non concerné		

This table comes from the Ministry of Health website [platines.gouv.fr](http://platines.gouv.fr). It presents the results of a small hospital for the indicators that have been generalized by the HAS. Information about quality is both displayed in a numerical form and synthesized in colored charts.

Through these public display devices, indicators are explicitly designed to change behavior and hospital actors, leading to forms of reactivity<sup>3</sup>. Because of their relatively simple, unambiguous and comprehensible form, such numerical results can easily circulate, especially since the complexities of their definitions and modes of calculations often tend to vanish in this broad circulation (Porter, 1996). Numbers are likely to be seized and reinforced by a large range of social actors: not only second generation press rankings ó which include these official QIs ó but also patients, hospital managers and professionals. Even when there is no evidence that this circulation is effective, the social actors' expectations about the ability of these scores to circulate constitute a powerful factor for the ability of these devices to penetrate organizations and change behavior (Espeland & Sauder, 2007). Public measurement values certain elements officially identified as worthy of attention (Power, 1997). Public measures are likely to be accepted for their results by those who are well ranked, while suspicions of bad faith weigh on those who criticize the methodology leading to a poor evaluation. And even when the methodology is strongly called into question by social actors,

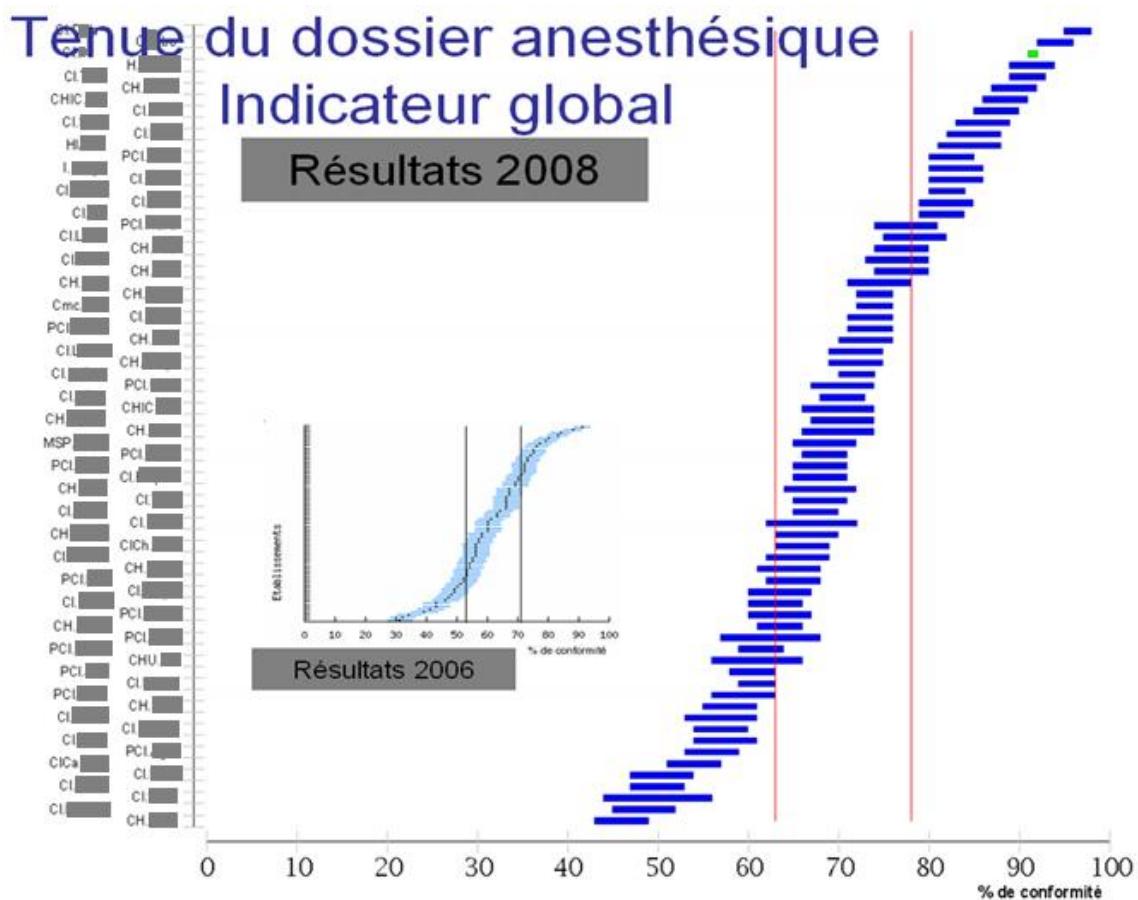
<sup>3</sup> I refer here to the reactivity analyzed by sociologists who studied the rankings in the USA: because people are reflexive beings who continually monitor and interpret the world and adjust their actions accordingly, measures are reactive. [ ] Individuals alter their behavior in reaction to being evaluated, observed, or measured. (Espeland & Sauder, 2007, p. 2-6).



the social power of such public measures is still strong (Sauder & Espeland, 2009). Technical and cognitive operations related to the indicators are likely to arouse practical *“learning”* at the local level. Stunned by a bad score, a hospital manager could reinforce locally the nosocomial infections surveillance team. Surprised by a mediocre score on the criterion of traceability of medical prescriptions, a doctor could change his way to fill in the records.

Second feature: this technology is characterized by the massive use of comparison. QIs participate in a *“commensuration”* process (Espeland & Stevens, 1998) creating equivalences between several dimensions of quality of care, and between different kind of hospitals. It leads to measure in the same *“metric”* system a plurality of elements that could not be have been *“equivalent”* without such a measurement process (Desrosières, 1993). Numerical measurements of QIs can be aggregated to generate statistical distribution and to build rankings. Through simple formalization materialized in tables, charts, lists or maps, each hospital can be positioned relatively to others or compared to targets. Hospitals can be compared with each other across a geographical territory. Comparison of the results can take time into account, so as to quantify progress. It is also possible to compare each hospital’s result to a *“standard”*. This standard can be relative (comparison with the average of institutions of the same status and the same size) or absolute (comparison with a performance *“minimal threshold”* or *“target to be achieved”* by all hospitals). Figure 3 shows an example of these comparison devices.

Figure 3. Chart from a Regional *“Benchmarking”* in Aquitaine (2009)



*This chart was constructed by the regional regulatory agency (ARS) in Aquitaine. It displays the score concerning conformity of hospitals regarding the traceability requirements for the anesthetic patient record. On the original chart, each horizontal blue bar represents the score of a named hospital<sup>4</sup>. The display takes into account a statistical confidence interval in order to avoid any contestation. The interval between the two vertical red lines represents the space regrouping the 50 % hospitals around the statistical average, also showing both the 25% above and below.*

The comparison is a powerful disciplinary normalization device (Foucault, 1975 ; Sauder & Espeland, 2009). The national targets are official norms. "Statistical norm" also has the power to assign hierarchical statutes, designating members of the best class and those of the worse class. Although the ranking system on the Ministry website does not adopt the logic of "individual charts", the ranking is clearly built to label and blame the "deviant" hospitals obtaining poor results or, even worse, those refusing to "play the game" of measurement, grouped in the class of non-responders. The inter-hospital comparison is built to claim there is variability in practices. It is made to arouse some reflexivity from hospital actors who try to understand the causes of their performance and some reactions to improve practices. This comparative approach relies on the assumption that social actors, faced with differences in scores, may fear the effects of a low ranking on their reputation. Through this internalization of disciplines, the evaluation criteria themselves are also given a normative status. Traceability of a number of professional practices and, more indirectly, practices themselves are emerging as a constraining rule. In addition, comparison builds the equivalence between scattered dimensions of quality. It concretely brings together in graphs or tables very different criteria based on both medical practice and organizational processes. All French hospitals, yet very diverse in terms of status and missions, are assessed using the same methods and the same set of indicators. In the same way as for statistics, the equivalence building process contributes to strengthen the integration of a public space (Desrosières, 1993) through common principles and shared words about hospital quality. Finally, the construction of this comparison might be the first step of an increased competition between hospitals regarding the quality of their care.

In short, QIs are a measurement technology aiming at transforming hospitals. Their legitimacy results from a mix of trust in numbers (Porter, 1996), through their mathematical capacity to objectively and simply describe a reality, and of faith in the rationality of action they will allow people to make. There is within and around QIs an integrated set of ideas and logics, a cognitive pattern which is intrinsically normative in the sense it aims at changing the state of a social system by having effects on people's minds and behaviors. Pragmatic and open to various social uses, QIs indicate to health social actors a number of institutional rules and expectations, enforced by a public displayed comparative system. QIs have a rigid normative core surrounded by more flexible and open characteristics. QIs embody a policy softly reinforcing the control of traditionally weak public regulators on health organizations and professionals.

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<sup>4</sup> In this example, I erased the designation of hospitals in order to preserve their anonymity.

## Conclusion: Understanding *Evidence Based Policies* through the Case of QIs

*This is not the *Big-bang*! This is a *small-steps* approach [...] By dint of saying indicators are available to improve quality, for reportingí Nobody can struggle against it. A few years ago, people were saying that quality was immeasurable! Today nobody can hold this position anymore!ö (Interview with a manager of the *indicators* service, HAS, 2012)*

The case of QIs shows how evidence-based policies can be a way to softly reinforce the control of traditionally weak public regulators on professional bureaucracies and autonomous professionals. This policy clearly carries a *rationalization* process. Far from being hollow and empty shells, QIs have a metrological robustness. Far from being neutral tools, they are open towards a plurality of normative and regulatory uses. In fifteen years, hospital quality has become *commensurate* through constraining and taken for granted *State indicators*. However, the way of proceeding of this public policy is original in that it is prudent, diffuse, embodied in *discreet instruments* (Bezes, 2004) carrying what I have analyzed as a *soft-rationalization* process. QIs have emerged step after step, avoiding arousing conflicts with hospital professionals. Through quality assessment, public regulators led the institutional transformation of the hospital sector almost *on the sly*<sup>5</sup>. The ambitions of QIs were forged and negotiated during this incremental process. The cognitive reason gained its *relative autonomy* (Benamouzig, 2005) while its uses strengthened and became more diverse. This *soft rationalization* relies on two transversal characteristics of this *evidence based policy*.

First, the softness of this policy relies on the small social world that has been carrying the indicators since the late 1990s. Policy instruments are often analyzed as a way for crafty regulators to achieve their unawed goals, because the increasing technicality of debates may allow them to de-politicize policy-making or to obscure the ideological load of policy programs<sup>6</sup>. The study of the social genesis of QIs rather brings me to highlight the incremental and collective nature of the process. This soft rationalization policy is not a *trick* from a few political leaders or policy-makers that would have been capable of imposing their will at a large scale. It results from the aggregation of a constellation of ideas and actions within a plural and fragmented institutional system, which has been competing about new and plurivocal uses of quality assessment all along the policy-making process. In other words, this evidence-based policy is not *governed* by some political elite according to some partisan agenda. Its normative charge has rather been *secreted* *in action* by the bureaucratic system, through the collective and interactive work of a small network of reformers, none of which being the only *inventor* of this collective evidence based policy.

Second, the softness of this policy relies largely on its cognitive dimension. Evidence-based policy holds largely through ideas. Promoters of the French QIs share a common base of knowledge and beliefs which converge in a particular *philosophy* of institutional regulation. They believe in the inevitability of an increased control of hospital activities; but

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<sup>5</sup> The contrast is striking compared to other hospital reforms such as the deployment of activity related payment instruments, which aroused many controversies and strong conflicts with health professionals.

<sup>6</sup> *For government élites, the debate on instruments may be a useful smokescreen to hide less respectable objectives, to depoliticize fundamentally political issues, to create a minimum consensus on reform by relying on the apparent neutrality of instruments presented as modern, whose actual effects are felt permanentlyö (Lascoumes & Le Galès, 2007, p. 17).*

they also consider that this development cannot be done without the participation and support of professional actors. This regulatory *öworldviewö* acquires a certain social ground through the institutionalization of quality indicators. Through their social and cognitive activities, promoters of QIs have been irrigating regulatory agencies with a flow of ideas, information and reasoning that have been critical to overcome institutional reluctance, to prevent conflicts, and to shape agreements. They have institutionalized these QIs by building their robustness, their legitimacy and their softness. In addition, this policy has been largely shaped by the hybrid and composite character of instruments. Quality of care is a polysemous notion. In their technicality, quality indicators arrange the principles of both *öEvidence Based Medicineö* and *öNew Public Managementö*. They articulate a rigid *öcoreö* of quantification and normalization with some plasticity relating to thematic evaluation, knowledge and uses.

This soft, discreet and diffuse way of proceeding is fairly typical of the policy-making of *öevidence based bureaucraciesö* like the HAS in France. The polysemous theme of *öquality of careö* offers a favorable context to this soft rationalization through evidence-based instruments. Similar processes may spread in other policy sectors, through assessment tools deployed in the name of *öeconomic efficiencyö*, *öquality of servicesö* or *öscientific excellenceö*. The case of QIs I presented in this paper may provide a point of comparison to scholars aiming at understanding the complex mechanisms through which assessment devices are able to exert a growing influence in yet reluctant social worlds in which they arouse hopes and engagementsí but also anxiety, discipline, pressure and disenchantment.

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## Appendix

List of the Official Quality Indicators Used in the French Hospital Sector (in 2010) :

### **- Indicators of the dashboard of nosocomial infections (Ministry of Health)**

Five indicators assess the organization of hospitals according to surveillance and prevention of nosocomial infections.

**ICALIN:** Composite Index activity against nosocomial infections (health policy)

**ICSHA:** Indicator of alcohol-based hand-rub consumption (hand hygiene)

**SURVISO:** Operating site infection surveillance indicator (surveillance of infections in surgery)

**ICATB Score:** Antibiotic consumption indicator (composite index of appropriate antibiotic use)

**Aggregate Score:** aggregate indicator (calculated from the previous four QIs)

### **- Traceability and continuity of care indicators (HAS)**

Five indicators assess traceability of information in patient records.

**TDP:** quality of medical record keeping

**DEC:** delay in sending information to general practitioners about patient's exit from hospital

**TRD:** traceability of pain evaluation in medical records

**DTN:** traceability of nutritional disorders evaluation in medical records

**DAN:** quality of anesthetic record keeping