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Accounting for Healthcare Capitalism

The OECD numbers and the development of Healthcare Capitalism (1972 - 2001)

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Abstract

This article examines the genesis and features of OECD health accounts to understand the development of Healthcare Capitalism. Created in the early 1970s, those accounts focused on the budgetary constraints of health systems, as opposed to their institutional characteristics, or their health outcomes as was developed at the World Health Organization since the 1950s. This focus led to an assessment of health systems strictly limited to their economic viability as measured by the ratio of public health expenditure on GDP – the “Poullier line”, as it is called from the name of Jean-Pierre Poullier, the creator of OECD health accounts. The article shows that the prominence of OECD health accounts stems not from their inherent accuracy but from the interplay of dynamics within the field of international health organizations and the political arenas of influential member states, including the United States. In 2000, the delegitimization of WHO leads major countries to redirect their funds to OECD, hence making the budgetary considerations on health systems dominant in international organizations. The alignment of the most specific international organization of the field on an economic assessment of health systems leaves no alternative voice and renders Healthcare Capitalism unavoidable.

Introduction: did numbers create (healthcare-)capitalism ?

As previously stated by scholars such as Max Weber (2013), Werner Sombart (1953, p. 38), and Joseph Schumpeter (2005, p. 123), accounting lies at the core of modern capitalism (Carruthers and Espeland 1991, pp. 32–33, Bryer 2000, Chiapello 2017). By making the world calculable, accounting allows for forecasting, projecting into the future, and comparing various units – all operations being at the core of capitalism (Braudel 2004). Ultimately, it extends beyond private businesses to also apply to states. Since the 1980s, literature on accounting and quantification has observed an “explosion” of indicators (Bezes *et al.* 2016), an art of “governing by numbers” (Rose 1991, Supiot 2015) that exerts seductive effects of accountability for governments (Merry 2016), while simultaneously taking a central place in neoliberal governmentality (Hibou 2012, Bruno and Didier 2015). Consequently, we now live in a “world of indicators” (Rottenburg and Merry 2015).

This article extends this line of reasoning to the realm of health, a domain wherein the value is notably challenging to quantify, and the free-market model hardly prevalent (Arrow 1963). It contends that the numerical translation of health has been pivotal in fostering a market paradigm within health-system reforms¹. This translation facilitated the assessment of health systems through economic metrics – principally the proportion of health expenditures to Gross National Product (GNP) – and contributed to the marginalization of distinct health system attributes, reducing them to mere indicators like life expectancy.

This hypothesis is tested using the case of the health-related work of the Organization for Economic Cooperation and Development (OECD), an intergovernmental organization often deemed influential in the making of global social policy (Deacon and Kaasch 2009), and frequently described as a “Club of the Rich”². In political science, its claims on international health numbers are supposed to derive from its pretension to “campaign on expertise” (Dostal 2004) and provide “better solutions for better lives” (its motto). “Playing the idea game” (Marcussen 2004), since it has no binding power over its member states (Hadjiisky 2023), the organization is also analyzed as instrumental in gathering epistemic communities (Haas 1992, see Demortain 2017 for a critique) composed of health systems experts sharing the same set of values and disseminating their viewpoints in various international organizations (Deacon 2007, Birn 2009). Furthermore, the Organization is at the genesis of nowadays dominant health accounts making it an under-studied but crucial case to study Healthcare Capitalism (Batifoulier and Diaz-Bone 2021).

Born in the early 1970s, the OECD health indicators take the form of health accounts inspired by national accounting, which have gained widespread adoption. They were endorsed in the 2000s by other international entities like the World Bank and the World Health Organization, as well as by nations that annually report health accounts³ (Rathe *et al.* 2018). Indeed, “OECD data is [today] almost the sole source of quantitative data for international comparisons, on the basis of which diagnoses supporting the liberal transformation of health protection systems are established” (Hassenteufel 2014, p. 40). Contrary to the irenic account of international health expertise endorsed by many IO scholars, I

¹Following Alain Desrosières, I will therefore use the notion of *quantification* – the process of introducing a convention and then to measure (Desrosières and Kott 2005) – as opposed to *measurement* – “inspired by the traditional epistemology of the natural sciences, [that] implies that something exists in a form already measurable according to a realistic metrology” –, in order to stress the importance of conventions to agree on what is to be measured (Desrosieres 2008, p. 11).

²For example in the article “What countries can learn from PISA tests?” published by *The Economist*, 10 December 2016 (cited in Leimgruber and Schmelzer 2017, p. 15).

³Even for countries not pertaining to the Organization, that gathers 38 members in 2018, all among the most developed countries of the planet.

aim at explaining this agreement on OECD health accounts as an example of the victory of economic thinking embodied by the Organization over the public health point of view that used to prevail in the field of health systems reform and that was represented by WHO. I contend that international organizations struggle for national and private fundings that have become increasingly prevalent in their regular functioning (Chorev *et al.* 2011). Though focused on OECD, the article also takes into account health accounting practices in the most medical international organization of the field: the World Health Organization (WHO). Following Weber, Sombart, and Schumpeter, I argue that OECD health accounts have been instrumental devices in the making of Healthcare Capitalism. I show that OECD health accounts are deeply rooted in budget constrain as opposed to WHO accounts that aimed at instrumenting a public health point of view on health systems reforms. This struggle over international health numbers is understood as offering a unique perspective to understand Healthcare Capitalism and its dissemination.

The concept of Healthcare Capitalism underlines that the intrusion of private actors, such as pharmaceutical industries, private insurance, or private hospitals, into the realm of health care provision was not only a by-product of contemporary renewals of capitalism but also a process of endogeneization of health by capitalism under the stewardship of the state (Batifoulier and Da Silva 2022, p. 2). It thus exceeds the focus on the clinician-patient relationship that forms the core of critical health economics (Davis and McMaster 2017, pp. 12–13). Following the economy of conventions and the sociology of quantification, I argue that numbers – in this case, health accounts – form the logical operator of this process of endogenization: just as the state historically needs statistics to govern its population (Foucault *et al.* 2004), private operators such as pharmaceutical industry, private insurance or private hospitals need numbers to assess the profitability of investments in the healthcare market. Furthermore, the OECD doesn't limit its task to numbers but also crafts recommendations that broadly follow the global health policy agenda, as highlighted by Batifoulier: “to find the right incentives to move closer to market functioning” (2021, p. 16). Therefore, numbers both reveal and hide aspects of what is broadly conceptualized as health systems Gorsky and Sirrs (2017), and delineate the limits of conceivable reforms.

Focusing on the making of OECD health accounts from the early 1970s and their success in 2000 offers a unique contribution to the history of health economics, and to a central question in political science and the sociology of quantification: the role of numbers in policy-making. In the realm of political science and political economy, the assertion that ideas, or numbers, influence policy has gained considerable traction. Scholars like Peter Hall (Hall 1993), Mark Blyth (2013), and Martin Marcussen (2004) underscore the crucial role of economic ideas and economists in shaping policy and political outcomes (see Hirschman and Berman 2014 for a review). In the sociology of quantification, Alain Desrosières has outlined that the social legitimacy of statisticians comes less from the quality of the numbers they produce than from their ability to insert themselves into broader socio-political projects by establishing themselves as essential points of passage (Desrosières 2010). Following these two strands of literature, I contend that ideas, numbers, and experts may influence the policy process when they align with the interests of dominant actors in the field.

In this article, I show that OECD health accounts were not, at least initially, especially accurate, and that their dissemination owes much to their alignment with political agendas in dominant OECD countries. Furthermore, I argue that the aspects of health revealed in these accounts have been limited to two numbers: health expectancy and the rate of public health expenditures in GDP (Gross National Product). The statistical relationship

between these two numbers, which form most of today's national health policy worldwide, is even referred to as the "Poullier line," named after Jean-Pierre Poullier, the creator of OECD health accounts in the early 1970s (Durand 2004, p. 88). By examining Healthcare Capitalism – a limit case since health is so hard to quantify – I follow the theoretical pathway charted by Weber, Sombart, and Schumpeter to interrogate: firstly, how did health, as a social concern, transition into a subject of economic interest taken care of in an economic international organization such as OECD? Secondly, what impact has health accounting exerted on the economization of healthcare?

This investigation is grounded in comprehensive research undertaken during a PhD from 2014 to 2019. I searched OECD, World Health Organization (WHO), and French Planning archives, and conducted interviews with national and international civil servants to understand the way health accounts have been created, and negotiated between IOs and countries. These qualitative insights are further enriched by participation in all OECD meetings on health that took place in 2018 and 2019, as well as by statistical materials not presented here but taken into account for interpretation, including analysis of the professional profiles of OECD health experts, lexicometric analysis of OECD reports on health, and a network analysis of the citations of OECD reports to assert the progressive diffusion of health accounts worldwide.

The article follows a chronological presentation, linking individuals, organizations and the types of numbers they produce. The first part focuses on the creation of OECD health accounts under the supervision of Jean-Pierre Poullier. It shows that OECD health-related work was funded on the condition that OECD numbers focus on public health expenditures, contrary to the work done at the WHO at the same time. In the second part, the article shifts from the analysis of OECD health numbers to the recommendations the Organization produces in a new series of reports beginning in 1992. I show that far from the initial expectations of their creator, OECD health numbers get enrolled in a larger critique of public expenditure. In the third part, the article shows that OECD numbers gain legitimacy as they are used outside the OECD, especially when WHO numbers are delegitimized in 2000, leading to an OECD-WHO-Eurostat framework of health accounts very much inspired by initial OECD health accounts. Finally, the article concludes on the link between health accounts and Healthcare Capitalism: by focusing on the economic dimensions of health systems, health accounts obscure the link between healthcare spending and health outcomes; it also hides the unequal participation and gains of the various social classes to health expenditures. Since the only variables taken into account become public health expenditures and GDP, recommendations vary around the amount of expenditures that should be socialized, and the ways to limit them instead of asserting social inequalities in access to healthcare.

1. “At OECD (...) I could only make programs if I asked the question: ‘how much do we spend on health?’”: the disembedding of health and social issues (1972-1992)

The health-related work of the OECD initially stems from the unique work of Jean-Pierre Poullier, a Belgian economist trained in Switzerland and in the United States and hired in 1972, at the age of 40 to work on social indicators. The program on social indicators is rapidly abandoned, and Poullier focuses on health, but with a specific point of view inspired by his training in the US with Robert Denison, a pioneer in national accounting. Jean-Pierre Poullier's unique position at the crossroads of cultures and disciplines profoundly

influenced the trajectory of OECD health accounts. Educated in political sciences in Geneva, and further in economics at Yale, Poullier's international background equipped him with fluency in both English and French and a career that spans several continents, currently residing in Florida.

Poullier's methodology diverged from the WHO's prevalent practice at the time, which typically involved comparisons based on the system's mode of insurance (Gorsky and Sirrs 2017). Far from being interested in the institutional differences between health systems, Poullier focuses on the economic dimensions of health systems. His initiative to embark on a "functional study" aims at evaluating – in a fashion inspired by national accounting – the major aggregates determining health expenditures:

"I was pursuing a goal, which I still have, I wanted to show that health policies are human resources policies and are absolutely essential for good growth policies. They are essential for good income distribution policies. (...) I will never hide that if someone asked me if there was a philosophical substrate, or a preconceived idea, yes, it was not to impose that but to show that it was important. (...) People from the Ministry of Finance are ready to spend if they see that there is a result! (...) that's why as early as 1976, I told them that we are going to put it to all of them that they do not know what they are spending their health expenditures on! That way, the finance ministries will all say: 'listen, we're going to cut your budgets because you can't tell us what it's for.' And I succeeded... there have been innovations that were even created in the United States because I had foisted, on the people who make social programs, I had put in their way, I had foisted finance ministry people on them."

Published in 1977, his first attempt splits health expenditures in four aggregates: hospitals, medical services, medical goods and other expenditures (OCDE 1977, p. 15); and health financing in three: central and local administrations, employer contributions and employee contributions. Compared to the work done at WHO at the same time, the 1977 OECD report appears much more grounded in economic thinking.

Since the 1920s the health service of the League of Nations, and then the WHO have published reports focusing on health systems organization: the number of doctors and health workers, hospitals and hospital bed, as well as vaccination rates were compared to various outputs such as mortality or morbidity rates in a public health fashion (Gorsky and Sirrs 2017, p. 368). In the 1950s and 1960s, major health economists such as Brian Abel-Smith add institutional considerations in these reports, comparing the effects of healthcare financing organization on health outputs (Abel-Smith 1963).

In those reports, economic efficiency remains subordinate to public health criteria: vaccination, periodic examinations of children within the school framework, transportation costs of a person in an ambulance, care provided for eyes, ears, and teeth "not only through specialized treatments but also by the provision of prostheses and aids" as well as "all services that clearly fall within the scope of health" (Abel-Smith 1963, p. 25). Testifying to the nascent state of the space of equivalence (Desrosières 2001) he seeks to construct, Abel-Smith highlights that countries "will likely not be unanimous in defining a hospital or the specialists who work there." The data used are also limited: number of doctors, pharmacists, number of beds, dentists, and midwives per 10,000 inhabitants. Produced within a medical organization (all WHO Director-Generals, for example, were doctors before 1998) (Chorev 2012), the health accounts proposed by Abel-Smith support public health policies and are in no way intended to limit health expenditures.

The work of WHO is rooted in public health, while OECD health-related work remains rooted in a questioning about public expenditure. Named *Public Health Expenditure*, the 1977 OECD report is part of a series called *Public Expenditures* launched by the OECD Committee of Economic Policy. Its introduction states that “the working group is currently striving to draw general conclusions regarding overall public expenditures, by examining the choices that may need to be confronted and the financial problems that may need to be addressed” (OCDE 1977, p. 6).

On the contrary, Jean-Pierre Poullier’s groundbreaking approach to health economics is distinguished by its strategic orientation towards the concerns of finance ministry budgeters, focusing on the sector’s public expenditures – an aggregate he aimed to incorporate into national accounts from a Keynesian viewpoint. This approach facilitated extensive collaborations with health economics scholars, including Simone Sandier in France, and with national bureaucracies.

Comparative Timeline of OECD and WHO Investments in Health Issues

Year	OECD Events and Metrics	WHO Events and Metrics
1960s	Inclusion of basic health expenditure data in broader OECD statistics.	WHO collects global health data focusing on infectious diseases and mortality rates.
1980s	Development of OECD health accounts by Jean-Pierre Poullier, aligning data with member states’ economic policies. Metrics include health expenditure and economic indicators.	Continued focus on infectious diseases, introduction of expanded metrics for immunization coverage and disease prevalence.
1992-3	Increased OECD focus on health data and recommendations into a new “Health Policy Studies”.	Crisis at WHO and competition with the World Bank.
1998	First edition of “Health at a Glance,” comparing health indicators among member countries. Metrics include life expectancy, health expenditure, and healthcare resources.	Continued publication of World Health Statistics, focusing on mortality, morbidity, and access to healthcare.
2000	Formalization of health as a priority with structured working groups. Metrics expanded to healthcare quality and efficiency.	Release of the World Health Report leading to criticisms and funding shifts from WHO to OECD by some countries.
2001	Common framework of Health Accounts between OECD, WHO, and Eurostat, inspired by OECD’s Poullier’s work.	Expansion of metrics to include broader health system performance and financing indicators.
2004	Health becomes a “central priority” for the OECD; formal working groups and regular publications on health systems performance.	WHO expands its Global Health Observatory, focusing on comprehensive health metrics including non-communicable diseases, health systems, and global health expenditure.

In 1976, Poullier offered an initial assessment of health expenditures, intending to “show that health systems were advancing in all countries without a dashboard, without

a real objective”⁴. This effort particularly resonated with the United States, the OECD’s principal contributor and the nation with the highest health spending, leading to an invitation for Poullier to share his methodology with American health administration experts in Baltimore. The seminar confirmed the U.S. interest, securing funding for the health expenditure program and attracting George Schieber, a senior official from the Health Care Financing Administration, to the OECD in 1984. Schieber’s involvement ensured a temporary financial foundation for the health expenditure assessment program through a five-year American grant. This support granted Poullier a degree of independence from DELSA, the Department for Employment, Labour and Social Affairs⁵, which traditionally prioritized labor issues over health in the context of general questioning over the Welfare state. Subsequent reports not only concentrated on the accounting dimensions of expenditures but also adopted a “policy-oriented” stance as a prerequisite for American backing. The initiative extended beyond merely creating a database and presenting statistics; it aimed to propose actionable reforms.

Subsequent reports expanded on the financial aggregates presented in earlier documents like *Health in Numbers: 1960-1983* (1985), by incorporating more detailed financial analyses of specific sectors, such as hospitals or the medical profession. However, these analyses consistently focused on the expenses these sectors generate rather than the health outcomes they achieve. This shift marked a significant departure from WHO health system evaluations, emphasizing financial sustainability and efficiency over direct health impacts, thereby reflecting a broader trend towards the economization of health policy within the OECD framework. Poullier’s approach to making health a viable program within the OECD hinged on framing it in terms of expenditure:

“At the OECD, politically I could only make programs in health if I asked the question: ‘how much do we spend on health?’ (...) why has so little been done by the WHO and others? Because everyone was attacking health! [They were saying] we have a Bismarckian system or we have a state expenditure system, or we have a household expenditure system, or a business expenditure system, which is the American system...but when we’ve said that, we’ve said nothing, because the French Bismarckian system has nothing to do with the German Bismarckian system!”⁶

In this excerpt of interview, Poullier clearly demarks the OECD health-related work to the one performed at the WHO that focused on systems’ institutional characteristics. This focus on the financial dimensions of health systems stems both from his training as

⁴Interview with Jean-Pierre Poullier, may 2018.

⁵The OECD consists of three main bodies ; the Council, representing member countries; the approximately 250 committees where members of the Secretariat and representatives of the member countries meet, most often twice a year, to work on specific themes; and the Secretariat, based in Paris, which includes some 2000 international civil servants of the OECD unevenly distributed across the twelve departments (for example, the Economic Policy Department (ECO), or DELSA, the Departement for Employment, Labour and Social Affairs) of the Organization. ECO also prepares the country reviews – the most visible product of the Organization – and its director is also the Organization’s Chief Economist. Beyond material domination, it thus also enjoys symbolic domination over the other OECD departments.

Similar to WHO budget, OECD funds are divided into two parts: part one, contributed annually by member countries based on GDP (making the United States the top contributor, with a share capped at 25% of the budget); part two, granted on a voluntary basis by member countries for work on specific topics. Up until 2000, the funding for the health unit predominantly came from the second part, initially through a US grant obtained in 1985, and then through more targeted voluntary contributions from other member countries. From 2000 onwards, these were supplemented by contributions from the European Commission.

⁶Interview with Jean-Pierre Poullier, may 2018.

an economist rooted in Keynesian accounting, and from the pressures of OECD principal funding source: the United States.

The efficacy and impact of the OECD health accounts are not rooted in their absolute accuracy or inherent truthfulness but more, as undelined by Desrosières, from their ability to insert themselves into broader socio-political projects by establishing themselves as essential points of passage (Desrosières 2010). Insights from interviews with George Schieber, the American official who joined the OECD on secondment in the autumn of 1984, shed light on the somewhat improvisational nature of the database's construction. Schieber's recounting of conversations with Jean-Pierre Poullier reveals a process marked by educated estimations and assumptions rather than strictly empirical data gathering:

“I remember asking [Poullier], how do you make your numbers? I really wanted to understand, you see...he never showed it until they made him... after I left. (...) But I remember, I asked him, and he says, ‘Oh, I just found them by relying on national accounts, and making assumptions about public and private health expenditures, and public and private investments in health, and I found the numbers’! and he says, ‘Oh, I just found them by relying on national accounts, and making assumptions about public and private health expenditures, and public and private investments in health, and I found the numbers’! (...) we would just sit in my office or his office, and we would look at, for example, Sweden, you know, just the public health consumption and the level of taxes in Sweden, then we looked at the investments – I think we managed to find that –, and then we looked at the private part, and it wasn't there! And I was saying, ‘but where did you get this number from?’ and he would say, ‘Oh, I know where to find them’ (laughs) (...) He had all the numbers in his head.”

Jean-Pierre Poullier's statistical innovation lay in integrating these health-related numbers into the political agendas of predominant OECD countries, such as the US and the UK, amidst a perceived “crisis” of public spending. Contrary to the neutrality claimed by its creators, the OECD health accounts reflect predominantly economic concerns, in sync with the political goals of Reagan-era United States.

The organization of healthcare systems, including aspects such as the mode of physician compensation, the mandatory or voluntary nature of insurance, or the methods for financing social security, is largely neglected. The reports are characterized primarily by tables that compare the health expenditures of member states based on selected criteria: public vs. private spending; hospital, medical, or pharmaceutical expenses; and price indices. Moreover, the public health indicators, which would allow understanding what the health expenditures are dedicated to and whether they produce effects on the population, are quite poor: besides life expectancy and infant mortality, these are indicators that are difficult to link to the achievements of the healthcare system; for example, the number of people injured in road accidents, consumption of alcohol, tobacco, and butter, the number of victims of domestic accidents, etc. (OECD *et al.* 1985).

While expenditure indicators are developed with a level of sophistication from the outset, the outcome indicators remain rudimentary, supporting an expenditure control approach that is predominantly focused on accounting. This orientation underscores a broader trend within the OECD health accounts, where economic considerations overshadow comprehensive evaluations of health system performance. The emphasis on financial metrics at the expense of detailed health outcomes reflects the economic priorities of the period, sidelining a holistic understanding of health system efficacy. Thus, the OECD health accounts not only reveal the economic preoccupations of

the dominant countries of the Organization but also contribute to a discourse that prioritizes fiscal management over the complexities of healthcare provision and public health.

Fundings for the health-related work of the OECD are indeed very constrained. Archives display many letters from Poullier lamenting the lack of resource for the health working group of the OECD that mainly consists of Poullier, and one, sometimes two assistants until Schieber comes to second him. Resources for the OECD health working group indeed come almost uniquely from newly elected Ronald Reagan's government. Primarily interested in limiting public expenditure, US fundings come at the expense of the evaluation of the redistributive dimensions of health expenditures that were initially important for Poullier. Poullier's efforts underscored a critical juncture where health, traditionally sidelined, became embedded within the broader discourse on economic efficiency and fiscal restraint. Indeed, as health became an important part of OECD work, the Organization departed from the mere presentation of numbers to develop policy recommendations.

2. From numbers to policy recommendations (1992 - 1999)

During the 1990s, the OECD health accounts became a central reference for comparing health expenditures, used by numerous researchers and administrative officials. Facilitating the rise of questions about the economic viability of health systems (with, for example, the emergence of the "Social Security deficit" theme in France (Duval 2007)), I show that these accounts were consistent with the new managerial framework of health systems advocated by various governments in dominant countries of the OECD: indicators of expenditures multiply and are more and more refined while health indicators remain limited to life expectancy, which is never splitted by social category, nor region of origin. Poullier thus lamented in a 1990 report that "despite some progress, OECD countries do not measure the outcomes of their health system well because appropriate indicators are scarce. International organizations have limited their data collection to a small set of 'standardized' indicators" (OCDE 1990, p. 140).

The creation in 1992 of a new series of reports, "Health Policy Studies," signals the OECD's ongoing work on this theme. Aimed at "efficiency", these reports are in fact mainly guided by cost control, as is clearly stated in the series' first report' forewords :

"According to the analysis, all member countries face roughly the same issues in managing their healthcare systems – which was to be expected. But what is more surprising is the convergence of the pursued objectives, the similarity of the solutions adopted to achieve them, despite the diversity of cultures and the particular nature of national institutions. It should be emphasized that this convergence occurred without prior consultation. The countries studied here have all resorted to experiences focused on common themes and have been constrained by budgetary austerity." (OCDE 1992, p. 3)

However, while health status indicators remain limited, expenditure indicators are expanded. While the initial OECD health reports were limited, from a Keynesian perspective confident in the multiplier effect of these public expenditures, to the objectification of expenditures, the "Health Policy Studies" series innovated by offering comparisons of public health policies, invariably justified by the limited nature of available public resources and evaluated by the level of public expenditure.

This marked a paradigm shift in economic thinking. The OECD, according to a rhetoric that is now half descriptive, half prescriptive and present in the foreword of each report, consistently emphasizes the "convergence" of its member states, both in terms of problems

and solutions. But the ‘policy-oriented’ ambition of these reports introduces a novelty: whereas the initial OECD health reports concentrated on analyzing expenditure levels, the “Health Policy Studies” series leverages the system of health accounts to offer recommendations.

Until the end of the 1990s, the OECD’s expertise in health was predominantly recognized for its comparative analysis of countries’ health expenditures. It was a minor aspect of the organization’s activities representing a budget of less than eight million francs in 1999, which is less than 0.5% of the OECD’s total resources, in a context marked by budgetary constraints.

The rationalization of health expenditure proposed by Poullier with health accounts therefore appears as both a rhetorical tool to legitimizing an organization (Meyer and Rowan 1977) and as a an “interpretive framing (...) [that] has a rhetorical purpose” (Carruthers and Espeland 1991, p. 35): it is possible to limit public expenditure thanks to health expenditure rationalization. The success of this promise for the Organization and member states rests on its compatibility with existing dominant political agendas as observed with the case of Reagan fundings in the 1980s and the assistanship of Schieber.

Influence of donor countries on IOs numbers appears when comparing OECD and WHO numbers.

Within the context of medical organizations operating on the principle of “one country = one vote,” such as the WHO, the primary objective of rationalizing health expenditure is to evaluate the impact of significant public health initiatives, like vaccination campaigns in low-income countries, in a logic quite close to development. In contrast, the OECD health accounts make health systems of different countries comparable in terms of their expenditures, while their institutional specificities (modes of healthcare reimbursement, physician remuneration, hospital location and management, etc.) are downplayed.

The first approach, particularly championed by the WHO, adopted a marginalist perspective, assessing the cost of a public health intervention against the resultant increase in life expectancy (factoring in quality of life for more comprehensive evaluations) to rank different medical interventions along an efficiency scale. This methodology is inherently outcome-focused, scrutinizing the diverse impacts attributable to public health programs. In juxtaposition, the methodology advocated by the OECD strives for alignment with national accounts, further disaggregating them into finer categories. Nonetheless, it notably diverges by manifesting minimal interest in health outcomes, such as quality-adjusted life years (Murray *et al.* 1994). The OECD’s approach, underpinned by a macro-economic rationale inspired by national accounting practices championed by Poullier, stands in contrast to the WHO’s approach, which is deeply rooted in a medical paradigm with micro-economic underpinnings. The WHO’s methodology is dedicated to comparing public health initiatives that have been central to its operations up until the mid-1990s (Chorev 2012).

Thus, two forms of legitimacy are in competition: for the OECD, the legitimacy of its endeavors in health is derived from the acknowledged excellence of its statistical endeavors in other fields. On the other hand, the WHO anchors its legitimacy in the uniqueness of health as a global public good. The universal provision of health is considered a moral imperative, with the enhancement of health seen as universally beneficial. This perspective underpinned the establishment of the WHO as a specialized agency of the United Nations, which was further emphasized during the Alma-Ata conference in 1978, where health was defined as “a state of complete physical and mental well-being.”

Those two paradigms of international health numbers face a general limitation of country fundings for IOs, leading to a struggle for international fundings and a paradigm shift within the WHO towards a broader, albeit cautious, perspective on social protection that

illustrates an alignment with global financial strategies aimed at optimizing health outcomes within the constraints of available resources (Chorev 2013). By the 1990s, the WHO's transition towards a more generalized – and tempered – stance on equality in social protection resonated closely with the approach propounded by the World Bank, particularly since the publication of the *Investing in Health* report in 1993 (Deacon *et al.* 1997). This approach posits that the indigent should be granted access to a basic “health-care net” that would facilitate their participation in market production. Furthermore, in an era characterized by constrained resources, it is suggested that nations under coverage must depend on international aid to augment the funds dedicated to healthcare. More generally, the focus shifts from health as a holistic measure of development stated at the Alma-Ata conference to health as a vehicle for productivity, economic growth, and human capital (Noy 2021).

During the 1990s, the WHO faced a severe leadership crisis. The election of Dr. Nakajima in 1988, followed by his re-election in 1993 despite lacking support from the United States, sparked allegations of vote-buying. Although Dr. Nakajima initiated measures against tobacco and alcohol consumption and advocated for an increase in public-private partnerships, these actions did not prevent a growing international skepticism towards the WHO. This mistrust led several states to retract their funding precisely when such exceptional funds were becoming more crucial in the budgets of international organizations (Chorev *et al.* 2011). By 1998, the WHO found itself unable to offer alternative health programs compared to those of other international organizations, which, despite ostensibly pursuing similar goals, introduced methods alien to the WHO's medical ethos. As Anne-Emmanuelle Birn notes, “the new financial actors in international health advocated for ‘efficient’ reforms: reducing governmental health expenditures (including in other social sectors), decentralization, privatization, market-based competition, and the provision of basic packages of technical interventions” (2009, p. 60).

Facing this “multifaceted crisis,” the WHO had to adapt to survive. The change in leadership with the replacement of Nakajima by the first non-physician director, Gro Harlem Brundtland, in 1998, and the publication of the *World Health Report* in 2000, reflect two forms of isomorphism identified by Paul DiMaggio and Walter Powell, which concern the replication of organizational solutions implemented in other similar organizations (mimetic isomorphism) and the homogenization of professional profiles within these organizations (normative isomorphism) (1983).

The 2000 *World Health Report* marked a normalization in the discourse of the WHO aligning its methodologies, presentation, authorship, and messaging closely with those characteristic of reports by the World Bank or the OECD. Jean-Pierre Poullier's move to the WHO in 1998 to assist in the creation of this report under Chris Murray's direction, with a team predominantly composed of World Bank economists, underscores this shift. Whereas the WHO's “Health for All” strategy of the 1970s focused more on specific diseases than on health systems at large, the pivotal “year 2000 moment” denotes the WHO's shift towards a more targeted healthcare approach, acknowledging the limitations of resources available and echoing a sentiment prevalent among other international organizations in the health sector.

3. The “year 2000 moment” : conflict between intergovernmental organizations and alignment on OECD numbers

The success of OECD numbers must be understood in a relational way: the success of 2000, when the OECD framework of health accounts is adopted by other IOs of the field

(Eurostat and WHO, and then the World Bank later in the 2000s (Rathe *et al.* 2018)) is linked to the relative demonetization of WHO in the international field of health systems reform, that itself stems from the disappointment of many developed countries in face of its 2000 *World Health Report*.

The WHO 2000 *World Health Report* was met with considerable controversy, particularly for its inclusion of a ranking of different national health systems, which attracted widespread criticism. This report, coordinated by Chris Murray, a health economist from the World Bank, epitomized the “cultural revolution” underway at the WHO. It was grounded in economic principles similar to those used by the OECD, such as an interest in quasi-market mechanisms, the adoption of international comparison schemes initiated by the OECD in the late 1970s, and the utilization of numerical indicators for performance measurement. As analyzed by Frédéric Pierru (2003), the backlash against the report was severe: its goals, methodologies, and dissemination faced scrutiny in both national and international forums. A primary issue with the report was its ranking of health-care systems globally, placing the United States 37th, between Costa Rica and Slovenia, with Australia at 32nd, and Japan at 10th. The report’s criticisms were notably acute, emanating from both the health economics community and governmental entities, particularly regarding the late notification of countries about their rankings. Another significant critique was the reliance on estimates rather than actual data, owing to the absence of comprehensive statistical data from some countries. In the academic sphere, distinguished health economists, especially from the United States like Alan Williams, expressed their disapproval through critical pieces in leading journals such as *Health Economics* (2001). According to the contemporary analyses of health economists and historians examining the WHO, the organization achieved its goal: to demonstrate, following the missteps of the “Nakajima era,” a pivot towards “evidence-based” public policies (Lee 2009). In this context, “evidence-based” referred to the reliance on numerical evidence, simplifying diverse national health systems into a singular figure or score to create a synthetic ranking.

The controversy caused by the report led to the departure of its coordinator from the WHO. Its publication also coincided with the redirection of American, Australian, and Japanese funds (three poorly ranked countries, given their health spending) from the WHO to the OECD. However, this came with the express condition that the new health division of the Organization should not produce any rankings in its subsequent endeavors. During the discussion of this division’s prerogatives, the Japanese delegate:

“Warned against analyses that included explicit rankings. Mr. Hurst [a member of DEELSA] explained that there was no significant difference between the OECD and the WHO in terms of definitions and conceptualization of performance. However, the OECD would focus on understanding the causes and variation of performance and avoid any ranking of countries”⁷.

Frédéric Pierru’s interview with Jean-François Girard, the French delegate at the Ottawa conference, sheds light on the strategic positioning that underscored the OECD’s enhanced focus on quantifying health systems. Jean-François Girard outlined the initiative as a collaborative effort between the OECD and the Canadian federal government. He interpreted the conference as a reaction by OECD-contributing, northern countries against what he described as the WHO’s ‘southern’ approach, particularly in relation to the contentious issues of ranking and performance evaluation :

“it was an operation set up between the OECD, which is why the OECD played a significant role, and the federal government of Canada. In clear terms, this

⁷SG/ADHOC/HEA/M(2001)1 : 4.

conference appeared as a counteraction [contrefeu] by the countries that contribute to the OECD, the wealthy countries of the North, against a somewhat ‘southern’ approach of the WHO, and against these problems of ranking and performance evaluation. Well, the northern countries got scared because, indeed, with the WHO report, the South took the lead and claimed it, Brazil, etc. Behind this are significant stakes and struggles, and the methodology in particular was fiercely debated at this Ottawa conference” (cit. in Pierru 2003, p. 278).

The OECD’s health project was formally inaugurated at this Ottawa conference, held on November 5 and 7, 2001, under the banner “Measuring Up – Improving Health System Performance in OECD Countries.” The event drew more than 400 attendees and concluded with a publication that candidly mirrored the domination of the OECD over WHO concerning the evaluation of health system performance. The discussions at the conference revolved around identifying best practices for accurately gauging health system performance indicators and devising optimal strategies for employing these measures to enhance health system efficacy.

The same year, the OECD released its inaugural System of Health Accounts, which employed a classification system rooted in national accounts – categorized by industry and function – reflecting the vision of Jean-Pierre Poullier. While the health accounts manual suggested additional data on trade and the breakdown of expenditures by age, sex, and disease, these elements were not incorporated into the classification structure. The primary objective of this system was to enhance international comparability. Both Eurostat and the WHO adopted the OECD-initiated classification, with the OECD maintaining the role of secretariat for the International Health Accounts Team, responsible for the manual’s updates (Rathe *et al.* 2018, p. 4).

By 2004, health was elevated to a “central priority” within the OECD. The funding primarily originated from WHO report’s poorly ranked countries (notably Japan, the United States, and Australia) urging the OECD to dedicate a division with expanded resources to health issues. By 2000, the OECD health division had successfully established its dominance in the production of health accounts. The classification system, initially almost solely advocated by Poullier, had achieved widespread acceptance across all major international health organizations. Such is the system’s influence that countries are required to present their health accounts in the OECD’s format to qualify for certain loans (Rathe *et al.* 2018, p. 3).

Conclusion: the effects of health accounting on health policy

The hegemony of the *System of Health Accounts* ultimately makes it a valuable lens for understanding the contemporary characteristics of global health capitalism.

This article demonstrates that the prominence of OECD health accounts is not derived from their inherent accuracy but rather from the interplay of dynamics within specialized international health organizations and the political arenas of influential member states, including the United States. The OECD health accounts were initially developed by Jean-Pierre Poullier, an economist influenced by national planning and somewhat isolated at the OECD. He secured funding for this activity by aligning the collected data with the economic policy goals of member states, including the United States under Ronald Reagan in the 1980s. This influence led to an expansion of economic data used to describe health systems, while simultaneously narrowing health data primarily to metrics like life expectancy. From the outset, OECD health data were limited to health expenditure at the

expense of public health data, which were mainly collected by the WHO. Nevertheless, data collection in the 1990s led to policy recommendations that tended to favor competition in healthcare markets and contributed to health capitalism.

With the World Bank entering the field of global health in 1993 and internal scandals becoming public in member states, the WHO—still the international organization closest to public health issues—changed its initial paradigm to assess “health systems performance” in the late 1990s. However, the symbol of this paradigmatic change in the most medically-oriented international organization—the 2000 World Health Report—did not secure renewed commitment from member states to fund WHO activities. Instead, it generated a series of criticisms from industrialized but poorly ranked countries such as the United States, Japan, and Australia. These three countries redirected their funding from the WHO to OECD health-related activities on the condition that there would be no rankings. The “ad hoc group” on health at the OECD became a regular working group with annual funding from the organization, and health became a “central priority” of the OECD in 2004. Simultaneously, the health accounts initially developed by Poullier at the OECD formed the common framework for the OECD, Eurostat, and the WHO to compare countries’ health systems.

By instrumenting budgetary constraints instead of public health policies, OECD health numbers have enhanced Healthcare Capitalism. Furthermore, the delegitimization of the most medical IO of the field – WHO – has paved the way for reforms sharing the same set of values: healthcare resources are limited, hence reforms are necessary to preserve the system, money should “follow the patient”, and a certain amount of market principles in the healthcare system is necessary to make it more responsive. Repeated from the World Bank to the OECD, those advices are blind to public health concerns such as medical deserts, or social health inequalities.

Their effects on national health policy take various forms, but the investigation presented in this article sheds light on the academic commonplace of health systems convergence, by tracing its historical roots.

- Abel-Smith, B. 1963. *Coût et financement des services médico-sanitaires: La situation dans six pays*. Genève, Suisse: Organisation Mondiale de la Santé.
- Arrow, K. 1963. "Uncertainty and the Welfare economics of medical care." *American Economic Review* 53 (5): 941–973.
- Batifoulier, P. and Da Silva, N. 2022. "L'Etat et la santé. Une économie politique du capitalisme sanitaire." *Économie et institutions* (30-31, 30-31).
- Batifoulier, P. and Diaz-Bone, R. 2021. "Perspectives on the Economics and Sociology of Health. Contributions from the Institutional Approach of Economics of Convention – An Introduction." *Historical Social Research* 46: 734.
- Bezes, P., Chiapello, È., and Desmarez, P. 2016. "Introduction : la tension savoirs-pouvoirs à l'épreuve du gouvernement par les indicateurs de performance." *Sociologie du travail* 58 (4, 4): 347–369.
- Birn, A.-E. 2009. "The stages of international (global) health: Histories of success or successes of history?" *Global Public Health* 4 (1): 50–68.
- Blyth, M. 2013. "Paradigms and Paradox: The Politics of Economic Ideas in Two Moments of Crisis: Policy Paradigms in Two Moments of Crisis." *Governance* 26 (2): 197–215.
- Braudel, F. 2004. *Civilization and capitalism: 15th-18th century. Vol. 1: The structures of everyday life: The limits of the possible*. Berkeley: Univ. of California Press.
- Bruno, I. and Didier, E. 2015. *Benchmarking: L'État sous pression statistique*. Paris: Zones.
- Bryer, R. A. 2000. "The history of accounting and the transition to capitalism in England. Part one: theory." *Accounting, Organizations and Society* 25 (2): 131–162.
- Carruthers, B. G. and Espeland, W. N. 1991. "Accounting for Rationality: Double-Entry Bookkeeping and the Rhetoric of Economic Rationality." *American Journal of Sociology* 97 (1): 31–69.
- Chiapello, E. 2017. "Critical accounting research and neoliberalism." *Critical Perspectives on Accounting* 43: 47–64.
- Chorev, N. 2012. *The World Health Organization between North and South*. Ithaca, NY: Cornell University Press.
- Chorev, N. 2013. "Restructuring neoliberalism at the World Health Organization." *Review of International Political Economy* 20 (4): 627–666.
- Chorev, N., Rey, T. A., and Ciplet, D. 2011. "The State of States in International Organizations: From the WHO to the Global Fund." *Review (Fernand Braudel Center)* 34 (3): 285–310.
- Davis, J. B. and McMaster, R. 2017. *Health Care Economics*. 1st ed. Milton Park, Abingdon, Oxon; New York, NY: Routledge, 2017.: Routledge.
- Deacon, B. 2007. *Global social policy & governance*. Los Angeles (Calif.): Sage publ.
- Deacon, B., Hulse, M., and Stubbs, P. 1997. *Global social policy: International organizations and the future of welfare*. London ; Thousand Oaks, Calif: SAGE.
- Deacon, B. and Kaasch, A. 2009. "The OECD's Social and Health Policy." In *The OECD and Transnational Governance*, edited by R. Mahon, and S. McBride. UBC Press.
- Demortain, D. 2017. "Experts and the production of international policy knowledge: Do epistemic communities do the job?" In *The politics of expertise in international organizations: How international bureaucracies produce and mobilize knowledge*, edited by A. Littoz-Monnet. Abingdon, Oxon ; New York, NY: Routledge.
- Desrosières, A. 2008. "Historiciser l'action publique. L'État, le marché et les statistiques." In *L'argument statistique 1. Pour une sociologie historique de la quantification*, 39–56. Paris.
- Desrosières, A. 2001. "Entre réalisme métrologique et conventions d'équivalence : les ambiguïtés de la sociologie quantitative." *Genèses* 43 (2): 112–127.

- Desrosières, A. 2010. "Words and Numbers: For a Sociology of the Statistical Argument." In *The Mutual Construction of Statistics and Society*, 41–63. Routledge.
- Desrosières, A. and Kott, S. 2005. "Quantifier." *Geneses* no 58 (1): 2–3.
- DiMaggio, P. J. and Powell, W. W. 1983. "The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields." *American Sociological Review* 48 (2): 147–160.
- Dostal, J. M. 2004. "Campaigning on expertise: How the OECD framed EU welfare and labour market policies – and why success could trigger failure." *Journal of European Public Policy* 11 (3): 440–460.
- Durand, J.-P. 2004. "Ces dix nouveaux pays qui interpellent les vieux systèmes de santé." *Les Tribunes de la santé* no 3 (2): 87–98.
- Duval, J. 2007. *Le mythe du "trou de la Sécu"*. Paris, France: Raisons d'agir.
- Foucault, M., Senellart, M., Ewald, F., and Fontana, A. 2004. *Sécurité, territoire, population: Cours au Collège de France, 1977-1978*. Paris: Seuil : Gallimard.
- Gebreiter, F. and Ferry, L. 2016. "Accounting and the 'Insoluble' Problem of Health-Care Costs." *European Accounting Review* 25 (4): 719–733.
- Gorsky, M. and Sirrs, C. 2017. "World health by place: The politics of international health system metrics, 1924–c. 2010." *Journal of Global History* 12 (03): 361–385.
- Haas, P. M. 1992. "Introduction: Epistemic Communities and International Policy Coordination." *International Organization* 46 (1): 1–35.
- Hadjiisky, M. 2023. "The politics of the OECD." In *The Elgar Companion to the OECD*, 50–66. Edward Elgar Publishing.
- Hall, P. A. 1993. "Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain." *Comparative Politics* 25 (3): 275.
- Hassenteufel, P. 2014. "Convergence." In *Dictionnaire des politiques publiques*, 180–188. Presses de Sciences Po (P.F.N.S.P.).
- Hibou, B. 2012. *La bureaucratisation du monde à l'ère néolibérale*. Paris: La Découverte.
- Hirschman, D. and Berman, E. P. 2014. "Do economists make policies? On the political effects of economics." *Socio-Economic Review* 12 (4): 779–811.
- Lee, K. 2009. *The World Health Organization (WHO)*. London ; New York: Routledge.
- Leimgruber, M. and Schmelzer, M. 2017. *The OECD and the International Political Economy Since 1948*. Suisse: Springer.
- Marcussen, M. 2004. "Multilateral surveillance and the OECD: Playing the idea game." In *The OECD and European Welfare States*, edited by K. Armingeon, and M. Beyeler, 13–31. Cheltenham, UK; Northampton, MA: Edward Elgar Pub.
- Merry, S. E. 2016. *The seductions of quantification: Measuring human rights, gender violence, and sex trafficking*. Chicago: The University of Chicago Press.
- Meyer, J. W. and Rowan, B. 1977. "Institutionalized Organizations: Formal Structure as Myth and Ceremony." *American Journal of Sociology* 83 (2): 340–363.
- Murray, C. J., Lopez, A. D., and Jamison, D. T. 1994. "The global burden of disease in 1990: Summary results, sensitivity analysis and future directions." *Bulletin of the World Health Organization* 72 (3): 495–509.
- Noy, S. 2021. "For the children? A mixed methods analysis of World Bank structural adjustment loans, health projects, and infant mortality in Latin America." *Globalization and Health* 17 (1): 6.
- OCDE. 1977. *Dépenses publiques de santé*. Paris: OCDE.
- OCDE. 1990. *Les systèmes de santé: à la recherche d'efficacité*. Paris, France: OCDE.
- OCDE. 1992. *La réforme des systèmes de santé: analyse comparée de sept pays de l'OCDE*. Paris, France: OCDE.
- OECD, Schieber, G., and Poullier, J.-P. 1985. *Measuring health care, 1960-1983: Expen-*

- diture, costs, and performance*. Paris: Organisation for Economic Co-operation and Development.
- Pierru, F. 2003. "14. Un classement révélateur. Les voies de l'économicisation de la doctrine de l'Organisation mondiale de la santé." In *Concurrence et protection sociale en Europe*, 265–290. Rennes: Presses universitaires de Rennes.
- Rathe, M., Hernández, P., Van Mosseveld, C., Pescetto, C., and Van de Maele, N. 2018. "Health accounts from past to present for a political arithmetic." *Revista Panamericana de Salud Pública* 42.
- Rose, N. 1991. "Governing by numbers: Figuring out democracy." *Accounting, Organizations and Society* 16 (7): 673–692.
- Rottenburg, R. and Merry, S. E. 2015. "A world of indicators: The making of governmental knowledge through quantification." In *The World of Indicators: The Making of Governmental Knowledge through Quantification*, edited by J. Mugler, R. Rottenburg, S. E. Merry, and S.-J. Park, 1–33. Cambridge: Cambridge University Press.
- Schumpeter, J. A. and Swedberg, R. 2005. *Capitalism, socialism and democracy*. Transferred to digital print. London: Routledge.
- Sombart, W. 1953. "Medieval and modern commercial enterprise." *Enterprise and secular change : readings in economic history*.
- Supiot, A. 2015. *La gouvernance par les nombres: cours au Collège de France, 2012-2014*. Nantes] [Paris: Institut d'études avancées de Nantes Fayard.
- Weber, M. 2013. *Economy and Society*.
- Williams, A. 2001. "Science or marketing at WHO? A commentary on World Health 2000." *Health Economics* 10 (2): 93–100.