The Battle for Health in France:
The Role of Ideas and Discourse in Constructing the Political Economy of Health Policy Reform (1990-2010)

by

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Martin Schain
DEDICATION

For Niccolo, whose unbounded joy and enthusiasm have given a renewed vigor and sense of wonder to life.
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ABSTRACT

This dissertation examines the role of ideas and discourse as forces of resistance and change in French health policy making. Drawing upon the leading medical press as well as the popular media, official documents and the contributions of social policy experts to public debates, this research focuses on four major reform episodes and other more gradual trends during the 1990s and 2000s, showing how broad paradigmatic notions such as solidarity, the liberal practice of medicine and the hospital as a public service, however well-anchored in the ideological and cultural repertoire, faced challenges from a new widely-held economic approach to health in the age of austerity. Unlike earlier welfare state scholarship that often presented France as immobile and unwilling to change, the case of health policy reform demonstrates how widely cherished deep core notions like solidarity have been stretched to adapt to a new policy environment. Crisis framing and the need to reform combined with a refashioned solidarity rhetoric served as malleable tools used to justify change and a redefinition of social and individual responsibility in the financing and provision of health care. Neoliberalism, market ideology and this economic view of health, dominant in the international policy community, were central in the diffusion of policy ideas and discourse, providing the arguments and justifications for a new policy mix. While there was often political and social resistance to what was viewed as a right-wing plan to dismantle the French social model, many in the French health economic and policy communities were receptive to the neoliberal critique and helped to translate policy ideas coming from managed care and managed competition into the French setting. Reform trends included greater state involvement over the financing and management of care, the extension of health coverage to the poorest, a new gatekeeper role for physicians, an increased role for the market in insurance and provision, a reduction in the share financed by public insurance and increased user charges for patients.
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CHAPTER 1 - The Ideational Turn in the Study of Welfare State Change: A Novel Approach to French Health Policy and Politics

1.1 Introduction

Restrictions on drug coverage, higher co-pays and deductibles for patients, widespread overbilling and violations of national fee schedules by doctors, refusal by specialists to treat the poorest of patients, a growing scarcity of rural practitioners, and finally, public hospitals in deficit under threat of closure or restructuring—this snapshot in 2010 belies the image of the French health system admired for its quality of care and broad coverage and given top ratings by the World Health Organization just eight years before. How did the French, known for their high degree of solidarity in social protection and excellence in health, find themselves facing the specter of a potentially significant transformation in the system that had served them so well?

A few years before, the popular documentary *Sicko* had glorified the French health system as an exemplar of universal rights placed in sharp contrast to that in the US where health care was merely considered a benefit. Yet, at the same moment when Michael Moore’s internationally acclaimed film lauded a simplified and hyperbolic view of French social protection, new French President Nicolas Sarkozy was proposing new health insurance deductibles requiring patients to participate in health costs as a way to make them more accountable for the country’s health expenditures. At the June 2006 *Convention Santé* of the *UMP*, the candidate Sarkozy rhetorically asked if there exists any insurance without deductibles—“*y a-t-il une seule assurance sans franchise*?” He argued that a deductible was the only way to make patients responsible (“*responsabiliser les patients*”). In his view,
deductibles would provide a better remedy for health financing shortfalls than would tax increases that, he affirmed, would only dampen competitiveness.¹

This neoliberal refrain reflects an ideological framing of the problem on two fronts—the general neoliberal belief in the burden of public social spending on economic competitiveness, and the notion that the principles of private insurance better regulate health spending by using out-of-pocket mechanisms to influence wasteful patient behavior. In an even broader sense, Sarkozy’s word choice implies a strategy to recast health care as a business like any other, in a deliberate attempt to place doubt in the minds of the French about the sustainability of their current system and to make the case for the need to reform. Had a neoliberal paradigm in health finally found a purposeful ally in President Sarkozy? Was this a sudden major policy shift or a simple continuation of a general trend in French health policy reform? Was this an indication that a new coherent paradigm would instruct all health policy choices? Was this part of an incremental erosion of health care as a right in the broadest and most egalitarian sense of the term? Most importantly, what role did the battle over ideas play in health policy reform? How did policy prescriptions (like the introduction of deductibles) and their justifications contribute to the political framing of problems and solutions in the health care debate?

From this example, it is evident that ideas about health policy solutions often reflect a certain way of thinking and a particular worldview. Political and policy rhetoric and debate draw on moral visions of what is right and desirable in society. These visions carry with them broad, often historically charged, cultural norms and beliefs that affect the policy process. Health and social policies not being conceived in a vacuum, larger social and economic paradigms exercise a cognitive and normative effect on ideas about whether and how to provide health care. Conversely, policy ideas are often a subtle and even surreptitious vehicle

used to introduce a new worldview. Clearly fraught with tensions, the debate over how health care should be paid for and provided often draws the opposition of collective versus individual responsibility, freedom of practice versus cost control, patient choice versus equality of access, all of these principles being elements of larger ideal-type paradigms. In any system, there is a continual arbitration between these perceived dichotomies and yet many systems are hybrid in nature and combine a mix of ideas from more than one ideal-type (such as economic liberalism or social democracy).

This study, which traces trends in both the financing and organization of the French health sector and the justification for these policies, examines the effect of old and new ideas on health policy, derived from both broader ideological and cultural models and narrower sector-based paradigms. Ideas about health policy and social protection and the discourse, arguments and justifications that accompany them constitute the explanatory variables. These can be conceived in general as ideational and discursive forces that can exert an impact on the construction of reform imperatives and the content of social legislation as well as on institutional resilience. Change or lack of change—the health policy mix—is the dependent variable. “Ideational forces can either favor significant policy change or reinforce existing institutional paths through the reproduction of a dominant paradigm and the production of frames justifying existing policy arrangements” (Béland 2005a, 13). In effect, this research seeks to shed light on how old and new ideas and discourse influenced the immobility or adaptation of the health care system in France. To this end, the aim is to distill what contributed to change and what was mobilized for resistance to change and how these ideational and discursive processes occur.

This chapter focuses on the study of change. First, it introduces the movement to bring ideas into the welfare state studies as an explanation of change in the era of austerity. Building upon the historical institutionalist literature, it shows how the notion of punctuated
evolution combined with the less functionalist concept of strategic learning can be useful in understanding incremental change. Second, it draws upon a growing literature pointing to France’s adaptive capacity in the context of liberalization and welfare state adjustment, showing why France cannot shake the reputation of immobilism. Third, it examines the processes involved in changes to social protection that have accompanied the shift to the market and the broader evolution in the thinking about the economy. The ways in which reforms have taken place—often through layering and stealth—reflect the existence of competing broad paradigms, an attachment to old ways, as well as new approaches to emerging problems. Finally, it explores how these new approaches to change relate to the existing literature on French health policy and politics.

1.2 Studying Change in the Era of Austerity: The Movement towards Ideas

In the post-Keynesian era of budget austerity, challenges faced by advanced welfare states necessitated policy innovation eventually leading to greater salience of ideas in welfare state studies (Taylor-Gooby 2005b). The post war expansionary period in social protection culminated in “crisis” at the end of the trente glorieuses initially giving rise to a flourishing welfare state crisis literature. Demands for retrenchment in the 1980s and 90s ushered in the era of permanent austerity and the dilemma of squaring the welfare circle (Pierson 2001; Taylor-Gooby 2005a, 9).

2 The results of the Welfare Reform and Management of Societal Change project led to two conclusions with regard to European social policy reforms: 1) it was widely agreed that state intervention had to be reduced, and the involvement of individuals and others enhanced, to meet welfare needs in the new post-Fordist, global environment and 2) governments had become keenly aware that social policy must be used to bolster national competitiveness (Taylor-Gooby 2005a, 9). While paradigm and discourse changes were observed, the editor, taking a more structuralist point of view, concluded that economic and political developments were the underlying driving forces of change.

3 For the classical reference on France, see Rosanvallon (1981).
During the 1990s, the retrenchment literature concentrated mostly on the resilience of institutions in this climate of “the new politics of the welfare state,” characterized by unremitting fiscal pressures considered to be at odds with the institutional resistance sustained by widespread popular support and large constituencies defending social entitlements (Pierson 1994, 2001). In this context, historical institutionalism achieved prominence owing to its aptitude to explain the role of policy feedback and legacies in path dependency and the weight of formal political institutions and veto points, enjoyed by vested interests, in the capacity of welfare states to withstand demands for retrenchment (Immergut 1992; Pierson 1994, 2001).

From his early studies of the politics of retrenchment in the UK and the US, Pierson imparted two major findings. First, while an ideological assault had been waged on the welfare state under Thatcher and Reagan, there was no evidence of its dismantling. Second, due to the deep popular support for the welfare state, the new politics of retrenchment were characterized by blame avoidance, decremental changes and cuts by stealth as opposed to the credit claiming of the politics of expansion (P. Pierson 1996; P. Pierson 2001; C. Pierson 2007). Subsequently, a debate ensued over the “dependent variable problem” and the ambiguity of the notion of retrenchment. Some argued for the conceptual distinction between retrenchment 1) as entitlement cutbacks and 2) as change in the institutional structure, questioning the usefulness of the term and making the case for moving entirely beyond retrenchment to focus, not on quantitative changes, but mainly on structural ones (Green-Pedersen 2004; Palier 2006). Finally, Pierson (2001) himself expounded a view of

4 Squaring the welfare circle refers to the dilemma of increased pressures on welfare state programs in a time of fiscal constraints.
5 For a review of the retrenchment literature, see Green-Pedersen and Haverland (2002).
6 The second finding is related to the first, because the ideological assault did pose a threat and caused resistance. However, these unexpected forms of change—decrementalism and stealth in a strategy of blame avoidance—hold the potential to lead to a sedimentation of alternative ideas.
welfare state reform as restructuring in three forms: re-commodification, cost containment and recalibration. There was thus a shift in welfare state studies from addressing whether retrenchment was taking place to what type of restructuring was underway.

Heavily influenced by the new institutionalism, much of this literature was mostly concerned, then, with either typologies of the welfare state\(^7\) or identifying and qualifying institutional change\(^8\). In both cases, questions revolved around what types of welfare regimes could be identified or what type of restructuring was happening in social policy reform? By focusing on the issues of retrenchment, path dependency, convergence and divergence, these pursuits did not address the questions of how and why changes were occurring? Finally, historical institutionalists recognized the limits of their theories to account for structural (post-formative) changes in welfare state institutions themselves (Hay 2006; Palier 2006; Streeck and Thelen 2005b). In order to understand what was engendering these adaptations, it became necessary to bring other explanatory factors into consideration. Once institutional or policy change had become the dependent variable, the focus turned to qualifying these changes as well as how and why they were occurring.\(^9\) Taking the institutional reforms as the dependent variable brought ideas squarely into the fore.

In the era of retrenchment, the mere notion itself that the existing welfare state arrangements were unsustainable had an impact on the way that reforms were approached. Furthermore, instead of thinking of retrenchment in terms of spending cutbacks, this new approach examines how qualitative change or the shifting of fundamental institutional principles is linked to the erosion or the fortification of rights. A reorientation towards ideas and the welfare state—linking how and why change occurs—helps to establish a direct and

\(^7\) On the debate surrounding Esping-Andersen’s classic text (1990) and the competing typologies, see Arts and Gelissen (2002).

\(^8\) For a typology of institutional change, see Streeck and Thelen (2005a).

\(^9\) On institutions becoming the dependent rather than the explanatory variable, see Palier (2006).
dynamic relationship between change and conceptions of social rights. Ideational processes can provide insight into how and why policies are changing. For example, shifting notions toward personal responsibility can have a profound effect on the logic of rights to health and can lead to re-commodification, shifting risk back to the individual and the erosion of social rights.

In an increasingly rich literature, ideational approaches had been gaining currency as part of a general challenge, mostly by institutionalists, to rational choice dominance in political science. In this movement, ideas were viewed predominantly as either a complement to historical institutionalism or a means to bridge the divide between sociological and historical institutionalism. Above all, ideas possess explanatory power with regard to change, an area where traditional institutional approaches were lacking. In welfare state studies, it became widely accepted that historical institutionalism had been most successful in its ability to account for variations in welfare state regimes and the path dependency and stickiness of their institutions, but ideas eventually emerged as mechanisms of change serving to complement these approaches.

As a starting point for many ideational studies, Peter Hall's seminal work (1993) on the paradigm approach laid bare the way policy ideas and their frameworks contain within them shared belief systems or worldviews. Hall defined a policy paradigm as an interpretive “framework of ideas and standards that specifies not only the goals of policy and the kinds of instruments that can be used to attain them, but also the very nature of the problem they are meant to be addressing” (279). From his observations on British macroeconomic policy

10 For an extensive treatment of the role of ideas in public policy making, see Braun and Busch (1999).
11 On ideas as a complement to historical institutionalism, see Béland (2005a, 2005b, 11-39). For recent contributions in historical institutional analysis of challenges to the welfare state including the complementarity of historical and sociological (cultural) approaches, see Rothstein and Steinmo (2002).
making in the 1970s and 80s, he constructed a model of policy framing consisting of three layers and their corresponding orders of change—instrument settings (1st order), basic techniques and instruments to reach policy goals (2nd order) and the overall goals of the policy paradigm (3rd order).

Although this analysis provided scholars with useful tools for classifying different types or levels of change, it relied heavily on the notion of policy legacies and social learning through policy failures and anomalies arising out of the existing paradigm. While Hall acknowledged the role of politics in the ultimate decision to opt for a particular paradigm, his original description of the impulse to change gives primary importance to structural policy failure as the trigger for reform and says little about the social and political act of framing policy failure or the need for reform (potentially a contrived need in the absence of objective/real policy failure). In effect, this traditional concept of social learning “does not capture the constant struggle between ideological models and policy understanding that make political actors draw different lessons from previously enacted models” (Béland 2005a, 5). Consequently, this concept of social learning, purported to underscore the importance of ideas, implies an automatic or mechanistic learning process.

Colin Hay introduced an alternative concept, strategic learning, which better captures both the agency and structure involved in institutional change. Actors’ make calculations

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12 Hall’s policy paradigm was intended to be both technical and ideological and to improve upon the notion of social learning, yet it did little to show how ideology shapes and influences social learning.

13 According to Hall, “the movement from one paradigm to another that characterizes third order change is likely to involve the accumulation of anomalies, experimentation with new forms of policy, and policy failures that precipitate a shift of the locus of authority over policy and initiate a wider contest between competing paradigms” (1993, 280). Some have criticized Hall’s depiction of a dominant paradigm enjoying hegemony across an entire policy community. It is more likely that competing paradigms or different versions of the same paradigm coexist and overlap within a policy area (Taylor-Gooby 2005a, 5). Whereas the paradigm approach tends to overemphasize the coherence and adhesion to one narrative and one dominant paradigm, it is preferable to explore competing paradigms and to put the accent on the dynamic battle over ideas in a given policy area.
based on their assessment of the range of strategic options they believe to be feasible, possible and desirable—these being shaped by the dominant policy paradigm. In an attempt to develop a more dynamic and evolutionary conception of policy change, Hay showed how one can combine incrementalism, strategic learning and crisis into a more complex and complete model, of punctuated evolution, in which incremental adaptation is punctuated by major paradigm shifts during moments of perceived crisis (2001, 200). In the words of Hay, …exercises in strategic learning conducted within the context defined by a pervasive policy paradigm will tend to associate policy failure, where they (are perceived to) occur, with relatively parochial factors such as inappropriate choices or settings of policy instruments, rather than with the obsolescence of the very policy paradigm itself. Consequently, paradigm shifts tend not to occur as a result of social or strategic learning on the part of experts, policymakers, bureaucrats, or civil servants. Instead, they are generally associated (at least within advanced liberal capitalist democracies) with highly politicized and public debates about the desirability and feasibility of contending political goals. Such open political contestation, I suggest, tends in turn to be associated with moments of widely perceived institutional and state crisis….The conception of policy change and institutional transformation that thus emerges is one not of ‘punctuated equilibrium,’ but of ‘punctuated evolution’—of policy evolving through the iterative unfolding and adaptation of a paradigm to changing circumstances, punctuated periodically by crisis and paradigm shift…. (ibid.)

The notion of social learning, adopted by itself as an explanation of change, omits these power and ideological elements in the policy process, whereas Hay’s strategic learning is more evocative of the political calculations and struggles that characterize policy action. Social learning posits a functionality of ideas that assumes their inherent capacity to explain and persuade actors of their appropriateness. In social learning, ideas are not viewed as tools or resources deployed by actors but are considered to be functionally suited to respond well to the problems at hand. Thus, social learning conceived as a response to policy failures
diminishes the independent power of ideas as beliefs (put forth by powerful agents) by assuming their persuasiveness is due to this functional quality. In light of these criticisms, a less mechanistic and more political view of policy change would accord a larger importance to the ideological struggles and political conflicts that are glossed over in much of the institutionalist literature.

However, although Hay’s contribution accounts for both incremental adjustments and major punctuations, it may overstate the clear temporal distinction between gradual change and the moment of contestation and crisis, as well as the need for public awareness and open debate for paradigmatic change to become possible. In a separate effort to “move beyond the punctuated equilibrium model,” incrementalism as gradual transformation has been associated with the different ways in which institutions have changed incrementally and cumulatively through processes of economic liberalization in advanced political economies (Streeck and Thelen 2005a). In this new view of institutional dynamics, gradual changes can be significant without a major moment of crisis and upheaval. Incremental technical changes can often be so imperceptible that the public does not interpret them as an outright challenge to the existing thinking, let alone as a coherent paradigm shift. Yet these marginal adjustments, combined with a more subtle broader ideological discourse (often redeploying the old ideological repertoire to new ends), hold the potential to alter perceptions and set in motion major societal change. Changes accumulating over time can lead to a creeping paradigm shift, which does not need to be overt.

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15 Either social learning should be reconceptualized to recognize the contingent and constructed elements of perceived failures and crisis, or a more apt term such as strategic adaptation might be adopted in order to account for agency while also avoiding the structuralist/functionalist ring of the term, learning.
16 The five broad modes of gradual change have been called displacement, layering, drift, conversion and exhaustion.
Hence, significant transformative change or a major departure from the dominant worldview can occur in different ways: 1) an incremental, steady process that eventually alters the underpinning logic and changes ways of thinking or 2) an outright successful framing and debate of the need to reform, by recasting institutional goals and earning political and public legitimacy or 3) some combination of the two. In the first instance, incremental change involves the (*a priori* or *a posteriori*) evolution of deeper notions;\(^{17}\) while in the second case, the deep structure is openly debated and modified. In both cases, changes in the deep structure frames—the ideas underlying policy—lead potentially to paradigm shifting. Contrary to popular notions, the French economy has undergone transformative changes carrying implications for the welfare state and placing pressures on its underlying societal and policy paradigms.

1.3 France’s Adaptive Capacity: Liberalization and Welfare State Adjustment

In social and economic matters, France has often been taxed with being one extreme and then its opposite. Initially considered the welfare laggard, France eventually became one of the biggest social spenders (Levy, Miura, and Park 2006, 95). Likewise, France was held up as an exemplar of rapid modernization in the post-war period and then later considered to be among the most immobile (Vail 2004, 152). Indeed, the French, along with other Bismarckian or Continental, welfare regimes were long judged to be among the most resistant to change and characterized by a “frozen” welfare landscape (Esping-Andersen 1996). Bismarckian institutions, believed to exhibit structural impediments to change, were thought to be virtually incapable of adapting to new global economic conditions in the age of austerity. However, a burgeoning literature demonstrated that the conventional wisdom, portraying French welfare

\(^{17}\) The process of evolving deeper notions can both precede and succeed incremental change.

Both of these ostensible contradictions can be explained by the socially constructed mythology about France’s immobilism contrasted sharply with the reality of its adaptive capacity. In other words, perceptions have tended to be stickier than institutions.\(^{18}\) Three reasons explain the persistence of the frozen welfare myth. First, the welfare state literature and social scientists themselves fueled the myth by their methodological bias. In part, the myth of the frozen welfare state derived from the approach used in the field, drawing most conclusions from comparisons of aggregate social spending figures. This narrow focus on social spending in many studies (following the works of Esping-Andersen on de-commodification and Paul Pierson on retrenchment) created a bias toward the stasis narrative with regard to both France and Germany (Vail 2004).\(^{19}\) Aggregate spending data reveals little about the content of spending and does not detect such phenomena as cost shuffling—when new programs are funded by rechanneling existing resources (Levy 2001a). When new objectives are pursued by shifting funds to new programs, change can remain undetected. In the case of French health spending, a focus on the level of public spending as relatively stable as a portion of total health expenditures conceals the fact that public coverage for certain care has diminished as public spending becomes concentrated more heavily on long-term and serious illnesses and hospital care (see chapter 5). Furthermore, by using social spending figures as evidence of stasis, social scientists have participated in the social construction of myths, by taking for granted, and thereby, reproducing the assumptions of policy makers as well as claims made in the prevailing political

\(^{18}\) While perceptions may be sticky (even in times of incremental change and stealth), institutions and ideas (on some level) can, nevertheless, undergo an imperceptible evolution.

\(^{19}\) The focus on social spending also neglects the “hidden” or “shadow” welfare state to be found, for example, in fiscal incentives or the regulation of private social benefits (Hacker 2006b). This is why some formal institutions may remain stable as the ends they serve mutate.
discourse. The neoliberal diagnosis often sets the terms of the debate by posing questions in terms solely of the size of the welfare state (or of health spending) as a percentage of GNP. An increase in total net spending does not necessarily constitute an expansion of the welfare state in terms of objectives, results or outcomes or in terms of the generosity of its benefits or protection against risk. Often, a rise in spending as a percentage of GNP is erroneously conflated with increased social protection. Similarly, an increase in health spending should not be assumed to constitute an expansion of health provision. Such crude quantitative analyses make unfounded assumptions about the content and outcome of spending—the social consequences of welfare arrangements. With spending held constant or increasing even, change (by stealth or otherwise) in the structural foundations of social protection can nonetheless occur, leading to major transformations and ultimately risk-shifting as well (Hacker 2004, 2006a).

A second reason for misperceptions about France is that the politics of stealth contributed to a lack of clarity about what had actually occurred in both the economic and social policy areas. Many reforms were not broadcast openly. Contrary to popular representations, liberalization wrought deep transformation and disruption in the broader economy, making France among the most productive in the world (Gordon and Meunier 2001). This process of profound macroeconomic change produced a widespread national malaise due to the gap between rhetoric and reality—between what was said and what was

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20 In many ways, the stasis narrative is an outgrowth of the neoliberal narrative, because the neoliberal expectation would be a wholesale repudiation of the public sector. If the public sector fails to shrink, the neoliberal analysis assumes stasis or uses the appearance of stasis as a justification for further calls for retrenchment.
21 Some economists have demonstrated the sexist character of the notion of GNP which does not account for productive activities (such as domestic services) provided predominantly by women. See Gadrey (2009).
22 A specialist of US social policy, Hacker (2004) militates for the conceptualization of the welfare state as a broader public-private economy of welfare whose purpose is protection against risk (and not other objectives such as redistribution of income or poverty alleviation).
done—in the social, economic and political spheres (Culpepper, Hall, and Palier 2008). A politics of stealth allowed for the transformation of both the market and the state, albeit ultimately creating suspicion and mistrust of the political elite.

Third, protests against change were misinterpreted as the inability to change when, in fact, they spoke volumes about the magnitude and depth of the transformations already having taken place. The ensuing malaise attested to an acute sense of the social disruptions that would follow, despite public and institutional opposition, stoking fears about their potential consequences. “It is precisely because France changed so dramatically that we would expect its citizens to undergo the current ‘malaise’ that seems to permeate French society. Maybe malaise is proportional to the disruptions experienced in the national model” (Meunier 2006, 4). What appeared to be institutional inertia, social and cultural conservatism and a stubborn unwillingness to adapt was in many ways a reaction to the deep-felt tumult and nostalgia for a social order that was keenly perceived to be slipping away. Therefore, the impression of stasis and the mythology about France’s inability to change were compounded by the visibility of a vociferous opposition that perceived a very real threat to the existing system of social protection. In short, the reaction to change has been interpreted as the inability to change.

To avoid the pitfalls of these analyses tending to underestimate change, Vail (2004) affirms that the welfare state should be viewed as an integral feature of a particular form of welfare capitalism, making up a larger politico-economic order. “We must be attentive to changes in particular areas of social policy that may not be reflected in spending figures, as well as how these developments shape, and are shaped by, broader developments in national political economies” (ibid., 153). Social policy is intricately linked to developments in the

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23 As Levy (2001a) suggests, it is precisely because dirigisme receded that social policy became an electorally salient theme and that social issues became politically potent incorporating campaign themes revolving around “social cohesion,” “social exclusion,” and “healing the social fracture” (260). In a way, the social was severed from the economic in the post-Keynesian order making it a political sphere unto itself.
broader political economy, the two interacting to shape welfare state adjustment. In that same vein, health policy should be understood as part of a system of social protection linked to other areas—such as labor-market policy—within the wider national political economy. As an example, social contribution exemptions granted to employers (*les exonérations de charges*) constitute *de facto* subsidies for low-wage job creation efforts in the context of high unemployment. From the 1990s, the conventional wisdom about high non-wage labor costs and the need to shift towards employment friendly policies guided labor market policies of both the Left and the Right. In this context, the *trou de la sécu* (the social protection regime’s deficit)—brandished as a justification for health cost controls—resulted partially from labor market policies having exacerbated the deficit. In such instances, ideational and institutional choices made in one sector can be exploited to also delegitimate other indirectly related policies.

In order to dispel the frozen welfare myth and the stasis narrative, analyses need to expose the link between ideas and developments in the broader political economy and their relationship to welfare state policy as well. The question then becomes how have changes in the broader political economy affected social and health policy? The macro-economic policy paradigm bears implications for other policy sectors as well. Absent a wholesale adoption of neoliberalism in health policy, changes in the thinking about the larger economy nevertheless have had repercussions for welfare adjustment and the health sector, too.

Most significantly, the great U-turn (Schmidt 2002b, 79, 187) engaged France in a chain of successive, related transformations. Opting for monetary stability and continued membership in the European monetary system, President François Mitterrand’s 1983 decision to eschew Keynesian-style spending and currency depreciation marked a watershed moment
and the end of the *dirigiste* era. The dismantling of *dirigisme* in France entailed the tightening of monetary policy, the privatization of national companies, the abandonment of state-led industrial policy, and the weakening of labor in industrial relations (Levy 2005a, 172-174; Levy, Miura, and Park 2006, 111). As part of a neoliberal economic modernization strategy working in concert by the 1990s (Hall 2001, 176-179), *dirigisme* was abandoned in favor of European integration, a strong currency, private enterprise, a more flexible labor market and more active state spending.

Grappling with the twin problems of slow growth and high unemployment (brought on in part by the *franc fort* policy), social policy shifted from Keynesian demand-side supports to employment-friendly labor policy, targeting and growing social assistance programs. Under *dirigisme*, workers were protected by trade barriers and recourse to depreciation in monetary policy. Without these macroeconomic tools to provide protections, the French state sought other means. In effect, this French form of neoliberalism meant the state’s retreat from allocation of resources in the pretax economy where the market’s role was clearly expanded.

However, contrary to presuppositions about neoliberalism, the market did not replace or eclipse the state. The state simply moved into new territory, namely providing social protection and incentivizing the labor market. While the market’s role expanded, the state did not retreat. To the contrary, it took on new tasks and new missions, in the case of France, essential to market-making. France’s state-centric tradition proved to be more compatible with redeployment of the state than with retrenchment (understood as rolling back the state) (Levy 2001a). New state activities were vital to achieving economic liberalization. In this view,

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24 What is often depicted as a functional imperative in hindsight was, in fact, a political choice between old *dirigiste* policy and the commitment to a united Europe.
26 Jonah Levy eschews the term “neoliberalism” and speaks mainly of the age of liberalization. Levy, Miura and Park (2006) critique Hall and Soskice’s *Varieties of Capitalism* approach that, by according a central role for firms and employers, tends to prematurely anticipate the withering of the state.
both de-dirigisation and sustaining the newly liberalized economy necessitated intervention by the state, with a view to making labor markets and social protection more employment friendly and, among other things, to actively promoting market competition. “In France, de-dirigisation was purchased at the expense of expanded state activity in the social arena. Getting the state out of industrial policy required getting the state into social and labor market policy” (Levy, Miura, and Park 2006, 95). New state activities were not merely responses to liberalization but prerequisites to making it possible. In effect, new social measures and liberalization were two sides of the same coin.

As a corollary to neoliberal macroeconomic policy, therefore, the French state redirected its efforts and grew spending in the welfare state. Through redeployment of the state into market-conforming, rather than market-directing activities, a “social anesthesia” strategy was adopted with the goal of mobilizing public resources to pacify, divide and demobilize potential opponents of market-led adjustment (Levy 2005b). According to Levy, side payments to those with the most to lose from liberalization spread the cost of economic adjustment to the collectivity, instead of letting it fall solely on the victims. By adopting the social (rather than the economic) treatment of unemployment, the French state opted to facilitate and cushion major economic change, demonstrating a capacity, once again, to adapt, rather than a predisposition towards inertia and immobility.

In the context of a commitment to the European project and the need to meet the fiscal and monetary criteria set out at Maastricht, “neoliberal” reforms transferred activities of the

27 “Early retirement programs, labor market training, subsidies for low-wage hires, and a guaranteed minimum income were part of a panoply of measures designed to ease the social dislocation prompted by the move to the market—policies that took French state spending to unprecedented heights” (Levy, Miura, and Park 2006, 109).

28 This terminology is used widely in public debate to characterize a situation in France seen as a trade-off between strong social protections and high unemployment whereby the working population benefits from high protection levels and the unemployed are compensated through social benefits.
state to more market-supporting and regulatory roles. Meanwhile, modernization projects were heavily influenced by notions from the manuals of the *new public management*. Pursued by Prime Ministers from both Left and Right—from Michel Rocard to Edouard Balladur, from Alain Juppé to Lionel Jospin, *efficiency and economy* in both state and public institutions became the watchwords of this new policy direction (Machin 2001, 151-155). Albeit pursued by all, retrenchment, liberalization and privatization occurred in different forms depending on who governed. Levy (2001a) contends that the main difference between Left and Right policies was to be found in who was made to pay for adjustment. By making the Right’s constituents bear the costs of adjustment, the Left under PM Jospin put its own spin on neoliberal ideas, as opposed to the Right under PMs Balladur and Juppé who spread the burden of adjustment to a wider swathe of the population (including their own constituents).29

However reluctant the political class and the French public, some neoliberal principles had become commonplace, such as the use of market mechanisms and a greater reliance on the private sector. The scholarly literature recognized that there had been a turn to the market, notwithstanding the continuing debate over the degree of neoliberalism that French society would tolerate. Without doubt, France had become more market-oriented, whatever the appellation. In the age of liberalization and budget austerity, social protection and health did not go unaltered.

29 The argument made is that increases in the CSG enacted by the tandem of Prime Minister Lionel Jospin and Finance and Economy Minister Dominique Strauss-Kahn (which affects all earning and not only wages) effectively decreased the burden on workers in health care financing. In theory, this type of incremental tinkering provides a way of making the better-off pay for the less well-off, as well as for assistance based programs like the CMU.
1.4 Structural Change in French Social Protection: Layering, Dualization and Stealth

Structural reforms in French social protection have been associated with processes of layering, dualization and change by stealth. Early historical institutionalist scholarship, addressing qualitative and structural questions and the content of social legislation, pointed to the adaptive capacity of the French welfare state. In the area of social protection, France seemed to have changed more than had been publicly acknowledged and without an explicit reframing of the paradigm.\(^{30}\) As early as the late 1990s, the institutional robustness of welfare states and the applicability of path dependency theory under shifting conditions were placed in doubt (Bonoli and Palier 1998; Palier and Bonoli 1999). Bonoli and Palier observed that French health, as well as unemployment and retirement, reforms in the early 90s had been mostly incremental and path-dependent, but that, on occasion, other reforms amounted to innovative, structural changes modifying the logic of the system as well as the associated politics and power relationships.

This historical institutionalist brand of analysis was very effective in qualifying institutional changes and identifying their effects on distributional and power arrangements. It also showed how changes in institutional features produced repercussions for actors and constituencies and potentially more wide-reaching consequences for the welfare state. Indeed, an innovative reform can constitute the first step to a shift in the institutional path. Moreover, innovative reforms that effect structural change tend to open up new windows of opportunity for subsequent and even deeper change, often through spillover.\(^{31}\)

Following Halls’ three orders of change, Palier (2002a, 2002b) has described how French governments engaged in three kinds of policies to address the “welfare state crisis.” In

\(^{30}\) For some time, this change by stealth went largely under the broad public radar or was not widely understood as opening the way for paradigmatic change.

\(^{31}\) While spillover seems to imply functionalism, agency is still required for actors to seize upon a moment of opportunity to promote the initial as well as the subsequent change.
the 1970-80s, they increased the level of existing instruments by increasing contributions in the form of payroll taxes (first order change). In the early 1990s, they pursued “limited retrenchment” by enacting sector-based reforms such as new unemployment benefits and new methods for calculating pensions (second order change). This type of change utilized new instruments while keeping the previous institutional logic, thereby avoiding a direct and open attack on the paradigm itself and what were construed in the conventional wisdom as institutional impediments to reform.\(^{32}\) Finally, throughout the 1990s, full-fledged structural reforms (third order changes) began to test the primacy of the social insurance logic of the French welfare state.

Clearly deviating from the Bismarckian social insurance paradigm, third order reforms added a new layer to the old by turning to means-testing (new forms of access to benefits), broad-based taxation (new financing mechanisms) and increased state, as well as private sector, involvement to the detriment of the social partners (new management arrangements). In effect, these structural changes altered the goals and logic of the French welfare state that had been earlier predicated on a bread-winner model of horizontal professional solidarity and income maintenance.\(^{33}\) Flying in the face of both the stasis narrative and the frozen welfare myth, the institutions of social protection in France underwent significant evolution.

Many of these changes are “at the same time incremental and transformative” (Streeck and Thelen 2005b, 2) thereby defying expectations derived from the sharp distinction between evolutionary and revolutionary change. In the case of France, institutional change has been described as both the conversion of state activities from industrial to social policy (Levy 2005b), as well as a process of layering in the field of social protection (Palier 2005). As discussed above, in conversion, “institutions are not so much amended or allowed to decay as

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\(^{32}\) If ideational factors precede the institutional, then the impediments are ideational at the base.

\(^{33}\) Palier (2008) calls this evolution “the long goodbye to Bismarck.”

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they are redirected to new goals, functions, or purposes” (Streeck and Thelen 2005b, 26).  

Hacker (2005) proclaims the need to examine outcomes and the “actual consequences” of institutional behavior (as opposed to simply the formal institutions themselves). Only then is it possible to ascertain fundamental change as actors switch from one logic of action to another, even when the institution purportedly shows few outward, formal signs of change. By taking a deeper look at state functions and objectives, Levy (2005b) was able to show that the large French state apparatus (assumed to be static by the crude measure of its size of the GDP) shifted its attention and resources to new objectives.

At the same time, another process was occurring around the edges of the existing system. In layering, “reformers learn to work around those elements of an institution that have become unchangeable” (Streeck and Thelen 2005b, 23).  

Historical institutionalists (Palier and Bonoli 1999; Palier 2002a, 2002b) have long emphasized how the configuration of the Bismarckian institutions of social protection in France constrained the possibilities for adaptation, which would offer a potential explanation for why layering was privileged as a way of addressing new problems and new risks. In a highly contributive system—when the payer and the beneficiary are one and the same, social protection and (in-group) solidarity enjoy a high degree of legitimacy. Those already inside the system prefer to maintain it as it is, even at the expense of higher contribution levels, as long as benefit guidelines are tightened at the same time. Hence, the social partners (both employers’ and employees’ unions) stood to gain

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34 Conversion is defined as “redeployment of old institutions to new purposes” and “new purposes attached to old structures” (Streeck and Thelen 2005b, 31).
35 Layering is defined as a process whereby “new elements attached to existing institutions gradually change their status and structure.” It is characterized by “faster growth of new institutions created on the edges of old ones,” “a new fringe [eating] into the old core,” the “new institutional layer [siphoning] off support for the old layer,” the “presumed ‘fix’ destabilizing existing institutions” and a “compromise between the old and the new slowly turning into defeat of the old” (ibid).
36 In social insurance, benefits are conceived as a form of deferred salary and therefore an individually earned benefit, (not a social transfer).
by closing out others while consolidating their place in the system. Under such conditions, layering of new protections and benefits for those excluded from the existing arrangements provided a politically ambiguous, but acceptable, route to change.\(^{37}\)

In the early reforms, social anesthesia was achieved simply by raising contributions in order to help the victims of the "crisis." Later, the context of high unemployment, the criteria for European monetary integration and new social risks generated new compromises. First, reinforcement of the existing system was accomplished by strengthening the contributivity (the need to pay in to qualify for benefits) of social insurance for the employed population as a form of professional solidarity, on the one hand, and by separating out tax-financing of non-contributory benefits, on the other hand, for those covered by what is referred to as national solidarity (a form of public assistance). Social insurance was reinforced for the employed and insured (a path dependent phenomenon), while a more residual minimal social safety net was developed for the uninsured (a path departure). The resulting dualization\(^{38}\) (through layering) of financing and benefits, combined with new types of individual insurance, eroded old forms of solidarity and began to shift some risk back to the individual.\(^{39}\)

\(^{37}\) Arguably, in this type of layering, there is both a path dependent and an adaptive element. The existing administrative structures were resistant, yet policy entrepreneurs were able to invent adaptive strategies.

\(^{38}\) For a detailed presentation of the dualization process, see (Palier 2002a, 264, 2002b 271-273). Begun in the late 80s and early 90s, the dualization is two-fold. First, the population becomes divided between those covered by social insurance (professional solidarity) and those covered by social assistance (national solidarity). Second, risks (or different sectors in social protection) are divided into two categories: those that fall under the purview of contributive social insurance and those that are covered by national solidarity with more means-tested flat-rate benefits. Thus, unemployment and retirement remain in the domain of the social partners in a Bismarckian arrangement, while health, family and poverty-alleviation and new means-tested benefits are transformed into a Beveridgean scheme financed by taxation increasingly administered by the state.

\(^{39}\) Although to a much lesser extent, this risk-shifting phenomenon resembles in some ways what Jacob Hacker (2006a) calls the “great risk shift” in the United States, which, in the name of personal responsibility, involves “a massive transfer of economic risk from broad structures of insurance, including those sponsored by the corporate sector as well as by government,
As Hacker (2004) admonished, risk can be privatized (as he observed in the case of the US) without privatization of the welfare state but through strategies of stealth, obstruction and indirection. In France, increasing contributivity inevitably reduces the amount guaranteed by social insurance. Shrinking social insurance leads to more private coverage. Even those covered by the base regime have seen their social contributions increased while those of employers have been reduced. Both benefits and access have been restricted. Both the number of people and the benefit level under social insurance programs was diminished in the name of saving the social insurance system (Palier 2002a, 260). Then, new benefits had to be developed to cover those excluded from the old system. Partly a cause and a reflection of this dualization of social protection, the notion that the system itself was guilty of generating social exclusion and the existence of an “insider/outsider” problem had already gained currency.  

In the latter phase of reform, the corporatist social model and the social anesthesia strategy were openly credited with creating the insider/outsider problem.

Undoubtedly, innovative changes can set institutions down a new incremental path, but this still begs the question of what prompts innovation and what is underlying change? An historical institutionalist account almost implies that institutional changes emerge spontaneously or out of structural necessity thus altering the goals and logic. Instead, it is crucial to consider the way ideas and discourse have influenced changes in social protection. While typologies of change provide analytical frameworks for what has changed and by what processes, they should be enhanced to shed light on why change occurs. While being able to classify types of institutional change is important, this approach does little to explain what factors nurtured the opportunities for change and why particular choices were made.

onto the fragile balance sheets of American families” (6). This growing economic insecurity in the United States parallels the rise of précarité in France.

Dualization becomes a self-reinforcing vicious cycle. Exclusion leads to dualization; dualization of social protection, in turn, adds to exclusion. The dualization of social protection and exclusion from the productive economy are thus mutually reinforcing.
Palier (2005) has asserted that institutional impediments had to be removed in order for the system to become more inclined to change.\textsuperscript{41} Because much change occurred by stealth or was couched in old rhetoric, it appears that the institutional changes caused the change in logic. Yet it is the furtive nature of reforms that makes it difficult to identify objectives and motivations. However, a social constructivism suggests that, at a bare minimum, ideas and institutions are mutually constituted (Smith 2006).\textsuperscript{42} Despite the underground or technocratic nature of these institutional changes, either ideas both precede and produce institutions or the two are mutually and simultaneously constituted. At the very least, the idea of the need for change, delegitimization, (or something new in the form of layering) must precede any effort to enact change (Blyth 2002). When delegitimation is not possible and open contestation does not occur, layering may appear as the most desirable and viable strategy.

While the main objective may not have been to entirely change the logic of the system, the ideas and/or discourse which brought about change preceded institutional reforms. The logic was changed as the new institutions were conceived not as an \textit{a posteriori} consequence of them. Institutions cannot change without the prior or, at minimum, the simultaneous evolution of the ideas underlying them. “Structural changes in social policy are achieved through ambiguous measures rather than via a clear ideological reorientation” (Palier 2005, 138). Still, while it was not a coherent set of ideas or an outright, blatant political project to make the French system of social protection more residual or more state-controlled,

\textsuperscript{41} There is an inherent redundancy and contradiction in saying, in essence, that the system must change to become more apt to change...in order to allow for change. Perhaps in this instance, France was simply more apt to change in an evolutionary, incremental fashion, and claims of immobilism were likely based on expectations of openly revolutionary, radical change.

\textsuperscript{42} Grappling with the question, “\textit{Which Comes First, the Ideas or the Institutions?},” Smith explores how legal and political institutions have contributed to the reification and construction of racial identities in the United States, concluding that “ideas can produce political change only when particular, identifiable political institutions, groups and actors advance them” (2006, 109).
ideas are at the root of these evolutions, whether originating at the deep core, the policy paradigm or the policy level (see chapter 2).

Indeed, whether conducted by stealth or presented as the only way to salvage the existing system, these structural reforms rendered France’s social protection more malleable and further prone to change. Yet, many of these structural reforms in the social protection regime display the ambiguous elements in change. Paradoxically, social benefits seem to be eroding for the greater salvation of the system. As Hacker (2004) asserted, when institutions are legitimate and popular and change is politically difficult, reformers sometimes turn to conversion or erosion of old policies. The erosion of benefits can serve as a political strategy to reduce support for the welfare state without launching a direct, explicit attack on it. Once the modes of solidarity altered—shifting to targeted programs and a more vertical distribution, the system risks losing legitimacy with the more well-off, namely the middle and upper classes who become potentially more susceptible to a new political and social discourse. Hence, there is a kind of feedback loop between ideas, interests and institutions.

1.5 Institutions and Interests (and Ideas) in French Health Policy and Politics

Rooted in the historical institutionalist tradition (Immergut 1992; Wilsford 1991) and/or political sociology (Wilsford 1991; Hassenteufel 1997), studies of French health politics have concentrated primarily on health care institutions and interests. Inclined to stress asymmetrical power relations between historically important actors, they have mostly been limited to some form of political sociology with a narrow focus on relations between doctors and the state (Godt 1989b; Hassenteufel 1997; Wilsford 1991). Steeped in state-centric institutionalism, they often focus on the question of the state’s autonomy and its capacities within a given set of institutions vis-à-vis doctors’ political organizations.
From her comparative study of Switzerland, France, and Sweden, Immergut (1992) submitted that the institutional design of decision-making was determinant in the different health policy paths taken by these three countries. In other words, the organizational configurations of the broad political system in which decisions are made “produce different logics of interest group power” (ibid., 25). The formal political institutions either constrain or empower different interests, determine the veto points available to them and affect their strategic behavior. In France, Immergut found, the strong executive under the institutions of the Fifth Republic diminished the number of veto points that could be used by the medical profession, allowing for more decisive state intervention in health politics. By contrast, weak coalition governments provided powerful interest groups numerous veto points in the parliamentary system of the Third and Fourth Republics.

In a similar study seeking to understand why the French medical profession’s political power declined while US doctors maintained power, Wilsford (1991) explained this disparity by the existence of a strong, autonomous state alongside divided and fragmented physicians (organizational particularism) in France and a weak (stateless) state and relatively united physicians in the United States. He tested how the policy making process (the institutional state structures) and organizational cohesiveness (of doctors) in each country affected organized medicine’s ability to assert its interests and influence outcomes, on the hypothesis that both state strength and professional organizational strength and cohesiveness matter. In Wilsford’s account, the strong (unitary) state operated with relative autonomy, playing on doctors’ divisions and fragmentation rendering them unable to resist restrictions on their power (measured by the state’s success in dampening doctors’ incomes). While all mature

43 All three countries considered the same range of plans at the outset including national health insurance, a national health system and the subsidization of health insurance. In the end, according to Immergut (1992) (who assumed doctors’ interest to be the same in all three countries), it is the particular legislative process of each country with its institutional and procedural rules that gave voice to some interests over others.
health systems faced the fiscal imperative placing doctors and their incomes under pressure, political institutions combined with doctors’ organizational strength and cohesiveness ultimately determined how much the state might tame doctors’ power. At variance with Wilsford, Immergut asserted that “interest-group power—and specifically medical dominance—thus depends on the veto points within political systems and not on the properties or organization of particular groups” (1992, 32). In short, for both, institutional structures alone mattered most. While Immergut privileged political institutions, Wilsford considered the organization of interests to be equally relevant to explain health policy outcomes.

In the past, the state demonstrated its capacity to achieve its goals linked with the governance of hospitals and social insurance funds and the expansion of coverage, while medical unions squabbled amongst themselves. Immergut (ibid.) suggested that major policy changes occurred only when the executive took bold action at a moment of political and institutional crisis. She demonstrated that in the Third and Fourth Republics, while lacking professional and organizational cohesion, French doctors (especially the urban, liberal elite concentrated in the major cities of Paris, Lyons and Marseilles) enjoyed disproportionate privileged access and influence in parliament and were thus able to gain concessions or obstruct reform at every turn.

With the advent of the Fifth Republic, the executive virtually eliminated parliamentary veto points by enacting major reforms by executive decree and ordinances, rather than

\[44\] Immergut focused on the effects of constitutional rules on the entire health policy making process. She specified that “although policy making is sometimes considered as separate from electoral and legislative politics, the French case has shown that institutions affect the legislation that sets specific policies in motion and the interest-group bargaining that surrounds the legislative process. The institutions did not determine the range of policies considered or the interests of specific groups – that is, institutional constraints did not screen out particular ideas or interests. Rather, the institutions affected both the ability of executive governments to introduce new policies and the incentives to politicians in parliament to depart from the executive program” (1992, 126).
parliamentary law, most notably hospital modernization in 1958, the establishment of departmental fee controls in 1960 and reforms of the administration of social insurance funds in 1967. By 1971, conventions between doctors and the health insurance funds applied to all and doctors were finally integrated into a system of fee-setting negotiated at the national level. In 1984, hospitals shifted to global budgeting to control runaway hospital costs and remove incentives built into a respective payment system based on daily bed occupation rates. The state, hence, made considerable moves to gain some control over the financing of both ambulatory and stationary care.

However, both Wilsford’s and Immergut’s analyses were based on the period of welfare state expansion. It has been posited that retrenchment politics differ from those of expansion. Rejecting the notion of state strength, Vail (1999) points out that, in “retrenchment” politics, state autonomy bears particular liabilities. In essence, the state must shoulder the majority of the blame due to its autonomy. In France, power is concentrated and the state’s elite responsible for reforms. Thus, state autonomy “often impedes rather than facilitates retrenchment by creating adversaries out of necessary allies and rendering elusive the avoidance or diffusion of blame (ibid., 313). Consequently, state capacity tends to become diminished, because state autonomy turns institutional strength into a political liability or weakness. As a result, many earlier assumptions about the strength (or capacity) of the autonomous French state do not hold up in the era of austerity and fiscal restraint. “State autonomy thus may not yield, and indeed may be antithetical to, a capacious state in the context of welfare retrenchment” (ibid., 311). In the earlier literature, state capacities were substantial due to either the lack of veto points (Immergut 1992) and/or the fragmentation of

45 State capacity is defined as the elite’s ability to implement policy (Vail 1999).
46 Wilsford (1991) acknowledged that, in the French state’s strength, also lies its weakness. The French state is vulnerable to demonstrations, boycotts, strikes and it cannot easily share blame.
the medical corps (Wilsford 1991).\textsuperscript{47} In Vail’s view, conversely, state capacities are diminished, because autonomy becomes a liability when the state confronts vested interests over benefit cutbacks. For this reason, welfare reforms in the 1990s only succeeded when they appeared to be consultative (and not heavy-handed) and when elites were able to exploit divisions among opponents rather than trying to overwhelm them.

While doctors including those in France may have experienced a relative loss of control in European and other health systems (Hassenteufel 1997),\textsuperscript{48} perhaps health politics should not be viewed as a zero-sum game between the state and doctors (or the medical lobby). In systems, where doctors have been more involved in their administration such as the United Kingdom or Germany, doctors tend to retain greater autonomy and power (Hassenteufel 1998). French health politics seem to be characterized principally by the state versus doctors dichotomy and the political dynamics involving these two major actors. The zero-sum frame harks back to the early history of French medical unions created originally to defend the economic interests of its members. Historically, the identity and principles of the private-practicing physician (\textit{la médecine libérale}) were fashioned in political opposition to mandatory social insurance (Hassenteufel 1997; Immergut 1992). The literature underscores how the medical lobby developed and evolved in relation to the state. As Hassenteufel affirms, “the medical profession is permanently confronting the state even in its demands for greater autonomy” (1997, 11). Hence, doctors’ identities and interests are forged in their interaction with the state. Since the liberal professions thrive only because of the state’s guarantee of their monopoly power, doctors’ economic, social and political power depends on the state.

\textsuperscript{47} Wilsford argued that “the French state is abetted in its use of tactical advantages by both ideological and nonideological fragmentation of most interest sectors, including the medical profession (1991, 38).

\textsuperscript{48} Hassenteufel (1997, 18) evoked a crisis of representation of the medical profession due to divisions between generalists and specialists, contestation over dominant identities and internal and leadership problems. He attributed the passage with ease of certain reforms affecting medical practice to these problems.
However, this state versus doctor focus is insufficient to capture the full dynamics of health politics. One particular limitation with viewing doctors mainly in opposition to the state is that this ignores the power held by certain categories of doctors relative to each other. There is often an implicit assumption that doctors’ interests are uniform and derive purely from their material position vis-à-vis any other actor who might try to influence their ability to command high incomes. Wilsford’s conclusion about organizational particularism implies that fragmentation translates into weakness. Writing in the 1990s, Hassenteufel cited the establishment of RMOs (medical guidelines), the 1993 convention and the plan Juppé as part of a wider trend of the erosion of doctors’ power, yet later questions persisted about the effectiveness of these reforms in influencing physician behavior. Like Wilsford, Hassenteufel asserted that doctors’ divisions and a disconnect between union leadership and their members often contributes to the inability of doctors’ to resist this erosion. However, he also demonstrates how these divisions are due in part to challenges to the dominant identity of the medical profession. Disputes between doctors’ unions stem from differences amongst doctors themselves over fundamental notions concerning the practice of medicine ranging from the rejection of profit to the embrace of total liberalization of the health care system.

Contrary to the conventional wisdom, doctors’ political fragmentation can be turned into an advantage for some doctors over others. Just as the state can exploit divisions, unions can utilize their relationship to the state at the expense of other unions, whether working with the government or exploiting opposition to the government. While in France the fragmentation among doctors’ unions has most often been over issues of payment and financing, the fault lines between unions cannot be assumed to derive from pure material interest; they also reflect ideas about material interests, professional practice and how people define themselves and view their role in society. The French medical corps is not only divided by discipline, but
also by ideology. Over the years, a changing constellation of unions has emerged expressing new concerns and demands on behalf of a changing and diverse medical corps.

This zero-sum state vs. doctor opposition often frames the public debate, but it is not fully reflective of the complex reality of both organizationally fragmented, yet socially and politically powerful, doctors and an autonomous, yet liable, sometimes impotent and decreasingly unitary, state. Two alternative perspectives (Dutton 2007; Peneff 2005) further challenge the zero-sum opposition, presenting doctors as eminently powerful despite their political fragmentation. Dutton explored in detail how French physicians traded freedom of fee-setting for a guarantee of complete clinical autonomy as they were fully integrated into the system of national social insurance in the 1960s and 1970s. On the other hand, a politically united American Medical Association in the United States was unable to protect billing freedoms for Medicare patients in the 1980s. “The statutory protections enjoyed by French physicians repeatedly protected their diagnostic and therapeutic freedoms, while U.S. doctors, for all their political might, lost much of their sovereignty over medical decision making, even as their patients were confined to provider networks” (2007, 220). Paradoxically, in France, collective financing with state oversight has allowed liberal medicine to thrive, because French doctors effectively exchanged some financial freedoms for therapeutic freedom. Whether united or fragmented, both US and French doctors were unsuccessful in blocking government initiatives to control medical costs. In the French case, however, statutory protections remain in place and have become a point of strength for doctors contributing to a resurgent ultraliberal professional identity. Since the creation of a separate sector in 1980 in which doctors can set fees freely, certain doctors have used divisions to their advantage and the issue of fee-setting has become a salient political issue once again.

49 See Dutton (2007) for a history of how French doctors succeeded in having the principles of la médecine libérale incorporated into the law through statutory protections. The Medical Charter enshrined the principles of liberal medicine into the 1930 law on social insurance.
From an even broader perspective, the sociologist, Jean Peneff (2005) examined the medical profession vis-à-vis the entire society. He asserted that, even though the profession seems to have suffered setbacks in its corporatist autonomy, it has gained tremendous importance in the public sphere (32). “Even though the medical corps has lost certain positions, it has compensated by conquering the favor of the social and political worlds for what constitutes a new market: the idea of ‘health’ will heretofore supplant that of ‘illness.’ Medicine has become a social problem and most likely the great social question of the century” (ibid., 15-16). Precisely because of the socialization of financing and the increased involvement of the state, the medical profession needs to engage politically, to garner public support and to exert pressure on the state.

In theory, the fiscal imperative experienced in many countries works against the influence of organized medicine. Based on earlier analyses predicting continued decline in doctors' power, it would have been difficult to imagine their rising incomes and increasing ability to defy fee-setting restrictions (see chapter 6). Some may have overestimated how much doctors could be contained by government regulation. “The intervention of doctors in the social arena represents a dreaded threat for politicians” (ibid., 199). Since doctors don’t have the same influence in parliament as they enjoyed in the past, they must use other means such as protest, boycotts, and demonstrations. More importantly, they must further rely on electoral politics, the media, discourse and public opinion.

Despite the earlier state's achievements and the relative loss of doctors' financial autonomy, the French medical profession continues to retain the ability to influence the public debate, the legislative process and public opinion. In France, the strong Rousseauian notion of the general interest still competes with particularist notions like la médecine libérale. Yet, at times doctors' unions present private-practice medicine as, not only compatible with, but the main line of defense in preserving solidarity and the general interest in the French health
system. Also, the doctor/patient relationship at the foundation of *la médecine libérale* has been sacrosanct and is continually advanced to thwart change and to assert doctors’ prerogatives.

In the past, major change happened when the strong executive took action in the face of divided doctors to strengthen and expand health for the general population. Whenever reforms have been seen to be a form of retrenchment, doctors often represent themselves as defenders of the system. The public also sees them as their primary line of defense for and within the system. Moreover, while there is increased intervention of the state in health politics, doctors have been able to inflict political damage at the polls. Through electoral punishment after the plan Juppé, doctors exercised a political veto point. Although not through traditional parliamentary channels, doctors still have more means of political influence than Immergut may have expected in the Fifth Republic. After doctors’ electoral desertion of the RPR following the Juppé plan, governments have been cautious about attempting reforms in the health sector. Doctors still have the ability to exercise a political veto or an electoral defeat. Doctors’ interests prevail over concern for the general interest at times. At the very least, they are able to prevent the most ambitious changes that fail to appear on the agenda for fear of political retribution.  

Immergut’s thesis cannot explain the difficulty the French state faces in enacting comprehensive health care reform long discussed by elites in the civil service.

What accounts for the power of doctors to resist at times and for government or the state to intervene successfully? Given the stability of Fifth Republic institutions, what explains the inability to pursue ambitious comprehensive reforms? Was it simply the opportunity provided by a crisis moment that allowed President Charles DeGaulle and Prime Minister Michel Debré to take bold action at the birth of the Fifth Republic? Was there something exceptional about the early Fifth Republic or about the politics of expansion? Has state (and

Even when doctors are able to veto a new reform, this is not simply a story of institutional structures. The ideas embodied in the existing institutions prevail. This is an example of when it is important to study what *did not* happen, not only what *did* happen in policy reforms.
executive) autonomy become a liability rendering similar actions improbable under the same institutional design? Does the state’s political liability account for its difficulty to contain the impulse of doctors toward expanded billing freedoms? Fifth Republic’s institutions are likely less unitary and in the era of austerity. It is not a question of whether the state is weak or strong; although the state enjoys certain capacities, it also bears liabilities. While conducive to state redeployment, French institutions may not be apt to produce bold executive action in health politics.

While the dynamics between doctors and the state are central to health politics, this is only part of the story. It is of utmost important to understand the ideas that animate state structures and doctor’s organizations as well as others such as the social partners, mutualists, private for-profit insurers, patients’ organizations, health care experts and the general public. The rise of neoliberal ideas would seem to mark a shift in tactical advantages towards employers and the private sector, while weakening the state, unions and the left. Yet the state has been able to enact some reforms mostly through incrementalism, while others have been stalled or left unimplemented. What then has been the role of paradigmatic and policy ideas and expert and public discourse? How well actors do in making their case or in shifting blame—the politics of argumentation and persuasion, in sum, still matter.

1.6 Conclusion

Although many popular and scholarly representations of France tend to paint a picture of sclerosis, French economic and social policies have undergone significant changes in recent decades. Many of the misperceptions about France’s adaptive capacity reflect recurrent themes about France’s inherent, historic immobilism perpetuated by academic and

51 During the 2005 social unrest in the French suburbs, many commentators asserted that the French state no longer existed.
lay observers, policy-makers and political actors alike. Nonetheless, France has adopted a strategy of liberalization and welfare adjustment that produced change in social protection. Much of this change has occurred through incremental, layering processes (sometimes by stealth) and the splintering of the system.

Despite the mythology surrounding the French welfare state, the French economy and social policy have evolved in ways that have implications for health policy and politics as well. Health and social policy must be examined in the context of broader questions of political economy. In the wake of the crises of the 1970s, French governments put an end to dirigisme, pursued liberalization and market reforms. The new moderate neoliberal macroeconomic policy paradigm posed challenges to the existing systems of social and health protection and provision. Defying neoliberal orthodoxy, however, the state did not shrink. Instead, it expanded its role both in social provision and in market-promoting activities.

Finally, however, acknowledgement of the practice of change by stealth need not obscure the role of ideas and discourse. When specific ideas are not proclaimed publicly and the rhetoric does not match the reality, cognitive frames and discourse still play a significant part nonetheless in reform politics. “Tracking the changes in ideas will show the paradigmatic shift in social policy that is underway in France, even though institutional stickiness and political protest against big changes would appear to counter the claim that the French welfare state has been radically changed” (Palier 2008, 107). Incremental change often appears functional and non-ideological. However, the ideological changes at the broader level of political economy—the ideological shift to monetarism—underscored deficits as a big problem in the economy; many other policies flowed from that basic tenet, the adaptation of social policy included.

By tracing the role of ideas and discourse, one can reconstruct the processes at work in the interaction between participants in the political process and the culture and institutions
within which they operate. Also, in this type of analysis, institutions can be viewed as either facilitators or impediments for those striving to advance a particular agenda. Furthermore, an analysis that is centered both on actors and their ideas can focus on both the organizational and ideological means of advancing policy alternatives, because it is concerned with how actors define their objectives and how they put forward their proposals. Essentially, this focus on ideas requires scrutiny of the content of policy measures and the arguments and justifications for them. It should give due attention to the policy communities and public discussions and the process whereby ideas give rise to reform initiatives and struggles. It should engage in discourse analysis of expert and policy papers, government documents and reports, lobbying activities, press reports and public opinion, examining the competing notions put forth in expert and public debates and seeking to understand why reforms might be considered legitimate. Above all, it should endeavor to establish the relationship between actors, the exchange of ideas and adopted policies.

In the case of health politics in France, a shift in thinking and practice during the 1990s and 2000s can be linked to the discussion of the crisis of the welfare state identified in the 1980s. Following the economic shocks of the 1970s, the turn from Keynesian to monetarism and the adoption of budget austerity to achieve monetary union, the health care system suffered financial strains much like the rest of the system of social protection in France. After the postwar era of continued expansion and extension of health care protection, the 1980s began a period of tightening and cost controls. While the initial response to financial demands and the need to meet EMU criteria was to increase social contributions by employees and employers, subsequent reforms signaled a move toward new approaches to both financing and provision of health care.

This research will return briefly to the ideas in health policy competing during the 1980s but will concentrate mainly on a period of more pointed reform discussions from the
early 1990s until 2010. In general, a number of developments have altered the governance (both financing and delivery) of French health. The main elements include a partial conversion from social contributions to tax-financing, the retreat of the social partners from administration of the health funds, a greater role for the government in decision-making and controls, increased participation of complementary insurers and shifting risk back to the individual through higher out-of-pocket costs, and innovations like the gatekeeper treating physician, the personal medical file and new forms of doctor payment.

In the interest of analytical potency, policies are not examined in chronological order but rather under thematic categories related to the repertoire of ideas used in framing the health reform debate. Chapter 2 is devoted to a discussion of constructivist institutionalism and its application to political economy and will lay out the ideational and discursive framework to study health policy and politics in France. Chapter 3 will present the contest between grand paradigms in French politics, economy and society underlying the debates over social protection and health provision. Chapter 4 will give a brief introduction to the history of the guiding principles of the French health care system and to show how French policy makers have been influenced by ideas and discourse from the international policy community. Next, the politics and policy reform efforts of the last two decades will be analyzed regarding finance, access and coverage in chapter 5 and the delivery system in chapter 6. Finally, chapter 7 will conclude by assessing the link between ideational and discursive processes—the construction of the political economy of health—and policy making regarding health insurance and health care in France.
CHAPTER 2 - The New Constructivist Institutionalism: Conceptual Tools for the Study of Discourse and Ideas in the French Health Care System

2.1 Introduction

Surprisingly, in the age of spin and the flourishing media culture, few political economists have taken up the social construction of commonly-held, taken-for-granted notions about the broader economy, labor markets and the welfare state. The constructivist turn in comparative political economy has had little application to social protection and health provision, nor have the methods of this constructivist movement, whether ideational or discursive—been systematically applied to French social policy or notably to health policy and politics. A constructivist analysis of the political economy of health should examine how ideological assumptions, norms, beliefs and perceptions shape policy battles and outcomes.

To avoid the pitfalls of a strictly interpretive idea-focused explanation, it is necessary to assess how and why ideas become institutionalized and the processes mobilizing actors in these cognitive and normative mechanisms. In this way, human agency also plays a fundamental role, choices being constrained by institutional structures and shaped by and filtered through cognitive and normative paradigms. Consequently, the epistemological assumptions of this approach allow for multiple factors of causation and a role for history and culture. Actors assert their interests (as they perceive them) in a world of bounded rationality wherein cultural precepts and beliefs factor into the creation of preferences. Although opting for an ideational emphasis, this approach will not, therefore, neglect the role of institutions or interests but will develop a line of reasoning that is more conciliatory in nature, eschewing a crude opposition of the three Is which has fallen out of favor of late. An explanation of reforms in social protection must show the links between strategic, institutional and intellectual
dynamics (Palier and Surel 2005, 26). In other words, a thorough appraisal of the reform process must take into account the strategic actions of concerned interests, the constraints and opportunities associated with institutional structures and the interplay of ideas and ways of thinking and interacting.

From welfare state studies and historical institutionalism, the rise of ideas provided novel ways of examining policy change but focused mostly on identifying different kinds or means of change. One aim of this research is to show the link between how and why change happens. Incremental, evolutionary processes—how reforms have been achieved—are often inextricably linked with the ideational processes underlying them. Although some scholars have made some initial forays in this direction, they have not thoroughly developed this relationship between ideas and incrementalism. Ideas and interests are mutually constituted in the process of the construction of crises, policy failures, problems and solutions and the paradigm that they imply. In turn, this process either sustains or changes institutions. It is reasonable to assume that, observing the same situation, historicists, who focus more on institutions, would tend to discern more continuity and that constructivists, who focus on ideas, are more apt to detect change. In part, this can be explained by the probability that “the process of institutional change following a period of crisis is likely to be slower than the process by which the ideas animating and informing policy may change” (Hay 2001, 206). In the same way, institutional change through an incremental, layering process may seem slower and less visible to the observer if the ideas animating that change have not been widely proclaimed and legitimized in the public discourse.

To explore the relevance of evolutionary, ideational and discursive processes involved in health policy making, first it is valuable to turn to the new social constructivism in political economy and to show how this relates to assumptions about health spending and demographic pressures. Next, it is important to highlight the advantages of agent-centered
constructivism developing in the field of political economy with similarities to the référentiel approach, the study of policy narratives and other approaches, all of which contain a power dimension and bring ideology back into institutional and policy analysis. Founded in the same basic notions, these approaches focus more or less on ideational content or on the discursive interaction between actors. Parts three and four will examine the tools for policy analysis provided by various ideational and discursive approaches. The final section lays out a program for studying ideas and discourse in French health policy and politics.

2.2 Constructivist Institutionalism’s New Terrain in Political Economy

Concomitant to the growing interest in ideas elsewhere, a new strain of institutionalism was developing in comparative political economy, originally mostly as an outgrowth of historical institutionalism (Blyth 2002; Campbell 1998, 2002, 2004; Campbell and Pedersen 2001c; Schmidt 2000, 2001, 2002a, 2002b). Adopting a more singular emphasis on ideas and discourse, a broader constructivist turn in political science has been called alternatively discursive institutionalism (Schmidt 2002b, 2008), ideational institutionalism (Hay 2001) or constructivist institutionalism (Hay 2006). Broadly speaking, economic constructivism addresses the influence of ideas, norms, perceptions, identities, narratives and ideologies on economic behavior. For the better part of a decade, a group of junior scholars has been building the case for a constructivist political economy and for theoretical engagement with non-constructivists (Abdelal, Blyth, and Parsons 2010; Blyth 1997; Blyth 2002; Hay 2001; Hay and Rosamond 2002; Hay 2006; Parsons 2003, 2009).

An emerging second movement in institutional analysis has cultivated efforts at cross-fertilization and seeking out middle-ground explanations, following the long-standing divisions among institutionalisms (Campbell and Pedersen 2001b). Both historical
institutionalism and discursive institutionalism have recognized a dynamic, dialectic and iterative relationship between ideas, interests and institutions (Rothstein and Steinmo 2002). Blazing the trail for constructivism, historical institutionalists were among the first to suggest that interests are established through a process of interpretation via political discourse and struggle, that politics is not only a contest for power, but also a struggle for the interpretation of interests (Hall 1997, 197).

Applied to international political economy, constructivism reexamines taken-for-granted notions such as GDP or national income accounting (Blyth 2005). These seem to be simple material quantifiable objects; when in fact, they are social constructions. The same, therefore, can be said of measuring health spending as a portion of GDP. Most discussions of financial strains on health systems tend to focus crudely on health as a percentage of GDP, implicitly contributing to the construction of the problem and the prescribed solution. It is often economic theory or the belief in certain economic precepts, not the objective economic facts themselves that cause economic actors to choose particular actions (i.e. the assumption that health spending should not exceed a certain portion of GDP). There is no economic law that determines an optimal level of health spending in a given economy. Blyth (ibid.) points out that this is why many predictions held to be self-evident about the impact of globalization have not been realized. In defiance of the neoliberal consensus, the small, open social democratic welfare states, with high levels of taxation and social spending, have thrived in the global economy. Many beliefs about what happens in a situation of global competition, propagated by the Washington consensus, have not always held to be universally true. Yet many actors in the economy act “as if” there is no alternative paradigm.

A major assumption of constructivism is a dynamic rather than static world (ibid.). Stability in itself is, in fact, a social construction. Agents construct stability through ideas, norms and meanings. Blyth clearly demonstrates how actors follow conventions to ensure
stability. Agents continually generate shared ideas and norms in order to coordinate expectation. In the political economy of nations, the beliefs sustaining these conventions are constitutive of the economic outcome and in so doing are self-reinforcing and self-fulfilling. In other words, “intersubjective beliefs [are] enshrined in conventions and reconstituted in practice” (Abdelal, Blyth, and Parsons 2005, 22).

In his formative text of reference for constructivist international political economy, Blyth (2002) aims to correct for the neglect of economic ideas in explanations of institutional change—in the case of the rise and decline of embedded liberalism. The crux of his thesis is that ideas both give substance to interests and help to determine the form and content of new institutions. First, one set of ideas were institutionalized as embedded liberalism. Then, in the economic crisis of the 1970s, embedded liberal institutions (such as the dependent central bank and active fiscal policy) were delegitimized and thereafter considered to be part of the problem. Business groups and their political allies used monetarist and “neoclassical” ideas to shift the political economy from the post-war Keynesian consensus about redistribution and economic growth. In the new neoliberal order, priority was given then to inflation control and monetary stability. This neoliberalism was a reaction to a perceived “failure” but “such ‘failures’ are not self-apparent phenomena obvious to agents on the ground that demand obvious solutions” (ibid., 8). Failures, themselves, can be manipulated and instrumentalized to further political and ideological ends. As Hay intimated above, crises should be seen as moments of perceived major failure and consequently of open political contestation and debate.

Initially, Blyth viewed failure as an exogenous shock that opened a window of opportunity for change. In this sense, exogenous shocks or changes explained why an order would become unstable, but not how or why the new order would emerge as it did. Ideas explained the transformative process producing new institutions after the moment of failure/crisis/problem discernment. Still, the crisis moment generating this search for new
ideas was taken as an exogenous force with unspecified (material) origins. Blyth did recognize that crises “need to be narrated and explained” and that they are not “self-apparent phenomena” (ibid.). In other words, his original position was that the ideas intervened to define a structural crisis, which was indeterminate and uncertain, but nonetheless existed. In subsequent work, Blyth, among others, came rather to understand this initial impetus for change as endogenously generated (Widmaier, Blyth, and Seabrooke 2007). This developing crisis construction literature has posited that the construction or the creation of a crisis is an endogenous phenomenon that is not the mere reflection of an objective exogenous shock to the system.

In effect, perceptual, ideational, and discursive factors are eminently endogenous.52 Social policy decisions are based on arguments made about demographic pressures, international competition, the non-wage cost of labor, the need for budgetary austerity and the effects of globalization, assumed to be exogenous factors, as causes of the need for reform. Are these claims based on an independent reality of causation or are the beliefs in these claims more determinant than the objective reality they purport to describe? Evidence is emerging, for example, that squarely contradicts the conventional wisdom about the demographic effects of ageing (seemingly the exogenous effect par excellence) on health spending (Dormont, Grignon, and Huber 2006). Are demographic consequences merely exogenous shocks or are they endogenous constructions? Does the non-wage cost of labor dampen competitiveness in France or does a fear or belief in its effects cause economic actors to behave “as if?” Moreover, how do certain actors—such as business and political elites—arrive at basic shared economic assumptions? In sum, how much does social construction matter in the propagation of these taken-for-granted notions about policy failures?

52 For a discussion on how ideas are endogenous to the policy process, see Campbell (1998, 380). Genieys and Smyrl (2008b, 42-45) also describe the competition for legitimate authority as an endogenous ideational process in French policy making.
and problems related to the financing of social protection and health spending? And how much does the construction of a narrative of crisis (or the specter of future crisis) open the way for change?

Much of the constructivist scholarship in political economy concentrates on major crises or major moments of change as its object of study. Yet, just as stability is constructed, so then is instability constructed as well. This limitation in the existing literature has tended to overemphasize the need for a major event to open the way for policy innovation. Pushing constructivism to its logical limits, the perception of “crisis” can be created simply by the dramatization of events. The same could be said of how lesser “problems” and “issues” are constructed and placed on the agenda. Since objectively a “real” crisis, by definition, is more dramatic than a simple policy or social problem, it is counterintuitive that a major event need be more socially constructed than a run-of-the-mill policy problem. The construction of an ongoing social problem (absent a crisis) would require more dramatization to be thrust to the fore of the policy making agenda than would “real war” or “real crisis.”

Ideas, then, are not only significant in times of crisis. Once internalized and unquestioned, once institutionalized, ideas continue to affect behavior (Hay 2006, 70). About crisis, Blyth asserts, “agents must argue over, diagnose, proselytize, and impose on others their notion of what a crisis actually is before collective action to resolve the uncertainty facing them can take any meaningful institutional form” (2002, 9). Where Blyth says crisis, one can read problem and his theoretical account likewise holds up. Just as for a crisis, agents must define, contest and debate what a problem actually is, as part of the quest to reduce uncertainty, to engage in collective action and coalition building and eventually to construct new institutions. 53 Blyth’s insights pertaining to the process of social constructions in the

53 In his study of how ideas precede and produce institutions, Blyth (2002) identifies a sequential process in five phases: ideas 1) reduce uncertainty, 2) make collective action
political economy can be applied to all policy issues and problems. Some prominent researchers have been engaged in this type of constructivist analysis with regard to ordinary policy making (Faure, Pollet, and Warin 1995; Muller 2000; Radaelli 1999; Schmidt 2001). An effort should be made to conduct this sort of constructivist analysis to decision-making in ordinary times—whether of continuity or of methodical incremental change—as well as times of (perceived) crisis.

2.3 Agent-centered Constructivist Approaches

Some of these scholars have endeavored to synthesize and build bridges among the three classical schools of institutionalism: rational choice, organizational (sociological), and historical (Campbell 1998, 2004; Campbell and Pedersen 2001b); while others wish to bury the hatchet and to declare peace among them (Schmidt 2006). As a means to this end, the discursive approach has developed, with the potential of integrating diverse institutional analyses of change and reconciling competing methodologies. An agent-centered constructivism logically points to text and discourse analysis. In particular, the dialectic between ideas and interests is best captured in discursive institutionalism. Moreover, interests do not merely wield influence and exert power in the policy process; they acquire power by way of political discourse. Mainly, agent-centered approaches like the référentiel approach and discourse analysis hold great promise, because they occupy a middle ground between structuralism and methodological individualism.

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54 Powering and puzzling go hand in hand. For a discussion on this argument, see Hall (2008).
55 For a discussion of the référentiel approach in France, see Faure, Pollet and Warin (1995).
One of the main premises of constructivism is that ideas and interests are mutually constituted. Interests are not objectively given, nor are they derived from material or structural conditions. “Desires, preferences, and motivations are not a contextually given fact—a reflection of material or even social circumstances—but are irredeemably ideational, reflecting a normative (indeed moral, ethical, and political) orientation towards the context in which they will have to be realized” (Hay 2006, 63-64). However, by constituting together a particular interpretation of the world, agents engage in a dynamic process of social construction of ideas and interests. “The core claim of constructivism is not that people operate via certain norms or ideas that impart meaning to their action, but that the particular meanings they employ are socially constructed” (Parsons 2009, 3). Through a social process that results in naturalizing phenomena, people function based on a positivist myth, as if they are describing an objective, material reality, when they are, in fact, constructing that reality. Agents act upon intersubjective understandings of material conditions and not their “materi ally telegraphed interests” (Widmaier, Blyth, and Seabrooke 2007, 748). In this view of social behavior, everything is mediated and everything is interpreted. The subject cannot be extricated from the object. In a constant dynamic of intersubjectivity, the act of thinking about the economy (or any other social reality), for example, has an impact on what happens in the economy (or that social reality). 56

Agent-centered constructivism “stresses the contingent nature of outcomes by examining how agents frame such uncertain moments to make persuasive claims concerning the need for change, while also recognizing that frames can take on ‘lives of their own’ in generating future uncertainty” (ibid., 750). These authors promote an agent-centered constructivism that concentrates on the mechanism of persuasion, “as intersubjective contestation among both elite and mass public agents” (ibid., 754). Their “approach casts

56 On the process of how social reality is constructed in this sense, see Searle (1995).
political struggles as arguments over the meaning of events, over how they should be framed and interpreted…” (ibid., 756). In this way, mass publics can reject elite attempts to legitimate change. Constructivists further assume that such shared cognitive models “must be sustained and/or transformed through interaction, via explicitly expressive, communicative, or rhetorical practices” (ibid., 750). An agent-centered constructivism accords an important role to ideational leadership, mediation, and idea and norm entrepreneurs. Entrepreneurs frame events, put the spotlight on issues, or even create or constitute issues through interpretation, dramatization, even spin, in an environment of competing norms and perceptions of interest.

The new constructivist political economy shares much in common with the French référentiel approach, which has garnered little attention in US scholarship but possibly enjoys a decade’s advantage in the area of agent-centered constructivism. As a moderate constructivism, it accords an important role accorded to the interaction between actors and the process of mediation. The référentiel emerges as the result of interaction between the relative power of interests and their ideas. Albeit not identical, référentiels are very similar to paradigms, narratives and discourse. A major insight of this approach is that a référentiel is not merely ideas or discourse, but should be seen as “ideas in action.” Actors (as mediators) have a cognitive and normative function and the référentiel that they construct produces identities and power (Muller 1995, 161-166). In a circular relation, actors produce meaning and appropriate power. Public policy action and change can only be explained by such an actor-centered cognitive approach that accounts for both a structural dimension (institutionalized cognitive and normative frameworks) and a certain amount of strategic autonomy that allows actors to produce ideas and discourse as a way of acting upon structure (Muller 2005).

57 For Muller, mediators are usually either advocates or brokers.
While the *référentiel* has been criticized for overemphasizing the normative power of elites to fashion social representations (Warin 1995, 86-88), Muller views mediation as both an elite and a mass process (1995, 162). As with the paradigm, doubts persist about the hegemony of one *référentiel* over all others and about the assumed coherence and homogeneity of the *référentiel global* (the dominant paradigm). Certainly, tensions and even contradictions exist; and actors interpret and understand *référentiels* in different ways. These criticisms point to a need for greater understanding of the dynamics between competing social constructions. By thinking in these terms, though, the observer may grasp how participants use the policy making process to define themselves (and others) and their goals.

As demonstrated above, in the paradigm approach, one assumes that public policies resolve problems through a process of *social learning*. By contrast, other constructivist theorists, like those using the *référentiel*, emphasize the role of agents (and power) in the delegitimation of the dominant way of thinking and the validation of another. Because the *référentiel* accords a major role to mediation in public policy formulation, it avoids falling into the kind of functionalism that assumes policy to be rational solutions to societal problems. *Whereas social learning* is the process that invalidates a paradigm, a shift in *référentiel* results from a transformation in the actors’ belief system (Muller 2000, 194). In the case of economic policy, neoliberalism gained traction, because Keynesian practices were *believed* to be inadequate for what was presented as a new set of problems. Moreover, they were deemed to be the cause of these problems. In such cases, agents must seize upon events to recast the old paradigm in a new light, creating a narrative to discredit the old paradigm and promoting new paradigms to resolve current problems. Often, old paradigms predate these problems that allegedly only they can resolve and are waiting on the shelf to be trotted out at an opportune moment (i.e. neoclassicism throughout the post-war period).
Other agent-centered discursive researchers have opted for a focus solely on narratives as causal stories with a coherent plot carrying implications for a particular course of action. The analysis of policy narratives enables the researcher to study the dynamics of belief systems (Radaelli 1999, 101). Narratives serve to stabilize, underwrite and certify assumptions (ibid., 99). With this in mind, “the consideration of ideational variables is a methodology for the empirical study of power” (ibid., 100). In French social, and by extension, health policy, several narratives are employed as instruments to affect policy making. The narrative of the trou de la sécu, the narrative of the burden of non-wage costs of labor (charges sociales), the narrative of tax competition in Europe and beyond, the narrative of social exclusion—these are all examples of highly salient narratives in the French social policy discourse mobilized by various actors to political ends. In this sense, they are resources—ideas fashioned into narratives by entrepreneurial actors. In turn, they become the structure within which action is embedded. Once a narrative gains momentum, it becomes the cognitive framework guiding action. Once again, structure and agency are thus in a process of mutual constitution. Actors compete to establish a dominant policy narrative in order to influence the range of policy options available to policy-makers.

Scholars applying the historical institutionalist or paradigm approaches to French social policy in particular have focused mainly on institutional and paradigm changes (Palier and Bonoli 1999) with scarce attention to the political aspects of ideological competition or the way that “elites and other actors deliberately package and frame policy ideas to convince each other as well as the general public that certain proposals constitute plausible and acceptable solutions to pressing problems” (Campbell 1998, 380). The sanitized language of the policy paradigm veils the political nature of ideas themselves and the role of ideology. In the paradigm approach, a determinant role was often accorded to a narrow technocratic policy community made of ostensibly apolitical experts. By contrast, in more actor-centered
constructivist approaches, “ideas have a power because they are embodied in actors defining their identity and interests and orienting action” (Nahrath 1999, 49). By emphasizing the power-seeking function of ideas, bringing ideology back in can bolster the usefulness of the policy paradigm if, by definition, a policy blueprint is thought of as a set of ideas steeped in some form of ideology.

2.4 Ideational Processes in Policy Making

Ideas serve various functions in the public policy process. Broadly speaking, ideas are cognitive and normative frameworks—alternatively referred to in the public policy literature as worldviews, paradigms, public philosophies, belief systems or référentiels—indicating the way the world does and ought to work. Regardless of the appellation, all of these consist of the deep structures and frames that contain basic ontological and normative beliefs. Furthermore, ideas act as discursive practices—arguments and justifications in the communication process. Finally, they can be seen as instruments around which and with which actors position themselves in the power-seeking process. These ideas can be blueprints that “provide political actors with a model for reform” around which “actors coordinate their efforts and build coalitions” or they can “constitute powerful ideological weapons” used to alter power relations and institutional arrangements (Béland 2007, 125). These functions—cognitive and normative, discursive and power-seeking—should not be viewed as separate from each other, but equally integral to the overall, interwoven fabric of ideas in a complex and overlapping policy making process.

58 For a discussion of these related approaches, see Surel (2000). While the normative element implies a role for ideology, the relationship between ideology and these frameworks is little explored in the literature.
Table 2.1 Three functions of ideas in policy making

<table>
<thead>
<tr>
<th>Cognitive and normative functions</th>
<th>Cognitive and normative frameworks, paradigms, belief systems, worldviews, référentiels, ideology, narratives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discursive functions</td>
<td>Frames, arguments, justifications, construction of the need for ...., narratives</td>
</tr>
<tr>
<td>Power seeking/ power exertion</td>
<td>Ideological and power struggles, positioning in policy discussions and negotiations, ideas as political resources</td>
</tr>
</tbody>
</table>

According to Béland (2005a), the ideational process in policy making consists, thus, of two distinct, albeit related, components—the applied policy idea/paradigm component and the ideological framing/discursive component. First, “the term policy idea refers to specific policy alternatives […] as well as the organized principles and causal beliefs in which these proposals are embedded” (ibid., 2). In effect, these applied policy ideas, or alternatives, are rooted in policy paradigms that suggest certain policy actions for experts and policy makers. Second, the ideological frames or discourse about these alternatives are designed by these actors (drawing on cultural and ideological repertoires) to persuade others to support them. In other words, policy alternatives, surface-level ideas, contain within them underlying assumptions from a broader paradigm—a deep structure, worldview or ideology—about the way the world does or should work (cognitive and normative elements). These policy and paradigm ideas are reinforced by the justificatory discourse and ideological frame intended to convince others of the validity or legitimacy of the policy action and/or to change their mindset about the larger paradigm.

In a more integrated approach, first, a surface-level policy idea should be studied in light of its embeddedness in the paradigm or deep structure. Next, the framing discourse for

59 Campbell defines frames as the “normative and sometimes cognitive ideas that are located in the foreground of policy debates” (2002, 26).
both the specific policy alternative and the corresponding paradigm should be assessed with attention to relevant actors, the expression of their interests and the ideological argumentation and justification process leading to policy action or inaction. As Béland stresses, “the ability to successfully frame policy alternatives can become a decisive aspect of the policy process” (2007, 1). The most promising avenue for linking ideas (both policy and paradigm) to interests, concentrating on the ideological framing of problems and solutions provides ideational theory the potential to capture the power-seeking aspects of political discourse and their reverberations throughout the entire policy making process. The question becomes how are these frames mobilized, diffused and instrumentalized.

Table 2.2 Two-pronged ideational process in policy making

<table>
<thead>
<tr>
<th>Applied policy ideas and paradigms</th>
<th>Ideological Framing/Discourse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy alternatives embedded in paradigms, worldviews, ideologies</td>
<td></td>
</tr>
<tr>
<td>Ideas include both surface-level policy options and principles and beliefs</td>
<td></td>
</tr>
<tr>
<td>Also taken for granted, underlying assumptions from deep structure</td>
<td></td>
</tr>
<tr>
<td>Social constructions naturalized in policy paradigms</td>
<td></td>
</tr>
<tr>
<td>- Used for persuasion to sell policy alternatives in public space</td>
<td></td>
</tr>
<tr>
<td>- Creates categories and identities and influences preferences</td>
<td></td>
</tr>
<tr>
<td>- Conscious political framing</td>
<td></td>
</tr>
<tr>
<td>- Political and social construction of policy failure and the need for reform</td>
<td></td>
</tr>
<tr>
<td>- Argumentation and justification</td>
<td></td>
</tr>
<tr>
<td>- Draws on cultural and ideological repertoire</td>
<td></td>
</tr>
<tr>
<td>- Frames links ideas and interests</td>
<td></td>
</tr>
</tbody>
</table>

Braun suggests another analytical tool for making sense of ideas in policy making. He argues for ideational analysis based on a “two-level game” wherein ideas and interests exhibit a different relationship to each other at each level. Derived from the terminology of Jobert, the arena encompasses the space where negotiation and power seeking take place between
interest groups and policy makers over a small number of options. Alternatively, the *forum* is the space where public policy debate takes place and comprises all who are involved broadly in general political matters (Jobert 1995, 19). Public forums include, among others, the legislative domain, the courts, public commissions, advisors to government and political parties, think tanks, academia and the media. Drawing on this distinction, Braun submits that “the analytical relationship between ‘ideas’ and ‘interests’ differs according to the two sides characterizing political decision-making: the negotiations in the political arena and the deliberation processes in the public forum (1999, 12).

Although these should not be conceived as entirely separate spaces, ideas serve more of a power-seeking function in the political arena and they serve primarily an argumentation function in the debates taking place in larger forums. However, using such analytical categories should not be allowed to artificially limit the way one views the range of actions taken by actors in the process. Both realms are interconnected and equally important in policy analysis and, of course, many actions participate in both the arena and the forum. For this reason, it is arguably more apt to view policy making as occurring in two conceptually different, although sometimes concurrent and often intersecting, political spheres and to show how and at which points these two spheres overlap with each other.

To show this rapport, Braun proposes the adoption of “ideas as benchmarks” used by actors in negotiations to further their perceived interests in the political arena. As he elaborates, “ideas, story-lines or narratives which become hegemonic in a negotiation context are more and more seen as the ‘benchmark’ all actors use to define and legitimate their interests” (ibid., 27). An example of this type of benchmark in French social policy is the notion of the “trou de la sécu,” tending to structure much of the debate concerning the financing of social protection including the health care system. Another similar benchmark idea is the concept of “charges indues,” the notion put forth by trade unions questioning the legitimacy of
social contributions (by employers and employees) being used to fund the social safety net benefits that, they contend, better fall under a tax-based national solidarity scheme.

Concurrent and parallel to negotiations in the arena, other processes occur which also influence which ideas prevail. At this level, “general visions about the public interest are the ‘meta-norms’, the worldviews, the frames which inform the construction of specific policy ideas” (ibid.). To further demonstrate the relationship between these two levels or spheres, Braun asserts that, although interests are the “ultimate screen of actors,” frames which are forged in the general debate eventually get injected into the negotiation level in the form of a benchmark idea. “In the public forum, general visions of the public interest and on the nature of the political community are discussed which in turn ‘frame’ the developments of benchmarks within the negotiation system” (ibid., 29).

Table 2.3 Two political spheres of policy making

<table>
<thead>
<tr>
<th>THE ARENA – the space where policy negotiations take place between interests and decision makers</th>
<th>THE FORUM – the wider multiple public spaces where public interest is debated and defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideas serve power-seeking function</td>
<td>Ideas serve mostly argumentation function</td>
</tr>
<tr>
<td>Actors viewed as vested interests</td>
<td>Actors viewed as advocates</td>
</tr>
<tr>
<td>Where negotiation and deliberation take place over which policy alternative to choose</td>
<td>Where ideas produced and contested and different alternatives emerge</td>
</tr>
<tr>
<td>Discussions from forums forge frames or ideas as benchmarks <em>point of intersection of two spheres</em> ↔</td>
<td>General paradigms and frames about the public interest influence policy ideas and benchmarks become part of the general public discourse ↔ <em>point of intersection of two spheres</em></td>
</tr>
</tbody>
</table>

In this circular process, advocates use argumentation and political communication in defense of their worldview or ideology in the public forum, while interests engage in power-seeking battles around established benchmarks in the arena. Hence, to fully assess the
role of ideas in policy making, it is important to examine this point of intersection—where the framing of issues in the public debate develop into benchmarks for actors in the negotiation process and where benchmark ideas feedback into the general policy discussion. Sometimes, a policy idea or a new benchmark and the underlying assumptions suffice to reorient the existing broad paradigm without a complete public reframing of the issues.

As opposed to the simple aggregation of interests, "beliefs, world-views and cognition become the constitutive components of ideas and one of the principle questions becomes how and why certain ideas prevail at a given moment of time and others do not" (ibid., 27). It is imperative to focus on the political and policy processes involved in the framing of an issue—the diagnosis and remedy—in order to learn how and why a particular notion has triumphed over all others. Mostly, it is the framing discourse about the need for policies that is intended to shift a polity’s understanding of the desirable paradigm.

Because this framing discourse functions as the primary instrument used by political entrepreneurs to make an action palatable and ultimately achievable, often the existing ideological repertoire can be deployed as a justification for change. Moreover, even when urging the preservation of an existing social program, reformers introduce what they proclaim to be salutary measures that tend, in fact, to work against the previous logic of that same system or else to stretch the meaning of commonly held notions. 60 While partisans of a policy alternative often blatantly state their allegiance to a particular paradigm, it is also the case, sometimes, that the underlying worldview is cleverly camouflaged by use of the existing

60 When this type of framing of change occurs, Cox (2004) refers to it as “concept stretching,” a process underpinning “the path dependency of an idea.” Concept stretching becomes an option as a way of justifying change by adapting robust foundational principles to new conditions or to new policy ideas.
ideological repertoire (new wine in old bottles) to an unwitting public that does not perceive a shift in logic of a particular policy action.  

An example of this is the notion of universal health coverage in France that was enacted as part of the program against social exclusion, another benchmark notion guiding recent social policy. While the couverture maladie universelle (the CMU) implies the same coverage for all and its implementation represents an improvement in coverage for its beneficiaries, this means-tested program (a breach in the social insurance logic) has been repeatedly criticized for its tendency toward stigmatization of the “CMUistes” and the corollary refusal to treat them by private practice doctors (mostly specialists) (see chapter 5). It is widely documented that CMU recipients opt more often for hospital and emergency room care while those with better insurance coverage have greater access to all types of practitioners, the end result of which being a problem of unequal access and dualization of health care provision. Hence, a measure developed around this new policy benchmark, yet appealing to the existing ideological repertoire of universalism, equality and solidarity, has contributed to the dualization or splintering process and runs the long-term risk of undermining the widespread French sentiment in favor of health care solidarity.  

Along similar lines, employing what he dubs an amended historical institutionalist approach, Béland explores the relationship between ideas and institutions in policy making to explain the recent debates over US Social Security reform. Ironically, at antipodes to the French case, “because the American ideological repertoire is centered on individualism and self-reliance, there is little room for discourse about social solidarity in the field of social policy reform” (2005b, 3). And yet an analogous process can be observed in both countries. Béland  

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61 This phenomenon can be associated with change by stealth.  
62 In effect, different sets of ideas can be institutionalized by the same measure as in the case of the CMU where universalism based on national solidarity (the republican ideal) coexist with means-testing and stigmatization leading to unequal treatment.
found that rhetoric used by recent critics of the system oddly resembled the language of those who advocated the notion of federal social insurance at the time of the creation of Social Security. Just as American policy-makers tap the foundational well of individualism and self-reliance, the French reformers draw from the Republican well of equality and solidarity.

However, when openly advocating change becomes a politically untenable position and the legitimizing discourse proves politically impossible to frame directly by use of either the existing repertoire or new ideological precepts, change agents can pursue other strategies such as blame avoidance or protest avoidance (Pierson 1994, 1996, 2001; Béland and Marier 2006). Drawing from both historical and ideational precepts, Béland has suggested that because welfare states have produced large constituencies and veto points, framing has become even more important. “Because politicians willing to impose unpopular measures have to make constant efforts to avoid blame and justify the need to reform, frames have become even more central under the current ‘new politics of welfare state’” (2005a, 13). Paradoxically, this might lead some politicians to use powerful discourse and frames from the neoliberal paradigm, even invoking impending financial disaster as a strategy to impose reforms, when those same politicians are not whole-hearted neoliberals.

2.5 Discursive Processes in Policy Making

The most elaborate discursive approach has been developed by Vivien Schmidt (2002b), offering a framework for research and analysis. Whereas other constructivist approaches focus mainly on the content of policy ideas, Schmidt emphasizes the interactive component of discourse and theorizes the discursive process in detail. As she says, discourse and ideas are analytically separable. Discourse should not be conflated with the ideas, beliefs and perceptions underlying it. The analytical separation of ideas and discourse
“underscores the ability of policy discourse to affect values rather than simply reflect them, to change the underlying structures of perception and belief as it influences the course of events through words as well as through the actions those words promote” (ibid., 216).

Discourse should be understood in simple terms as “whatever policy actors say to one another and to the public in their efforts to generate and legitimize a policy programme” (ibid., 210). Yet, discursive analysis comprises both 1) policy ideas and values (the ideational dimension) and 2) the process of policy construction and communication (the interactive dimension). The ideational dimension contains both cognitive and normative elements. The cognitive element of policy ideas speaks to the logic of necessity; the normative element must appeal to the logic of appropriateness. In other words, ideally policy ideas seem both functionally apt and culturally legitimate. The interactive (or discursive) dimension includes what Schmidt calls the coordinative and the communicative. The coordinative function provides a common language and framework for policy actors in order to construct a policy

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63 This analytical separation allows up to grapple with the dynamic process of how policy discourse can affect values rather then simply reflect them. As Schmidt says, “the policy discourse, along with the policy programme it promotes, can be an impetus to change in the ideas and values of the polity” (2002b, 216). Policy ideas implemented without an explicit discourse can also affect values and perceptions. This is why it is important to distinguish between the cognitive and the normative. An argument for the necessity of policy that clashes with existing values may prevail and eventually alter them. At times, a policy that is only coordinated in a narrow policy community may eventually begin to affect the underlying norms and values of the polity without an explicit public discourse. An example of this is the gradual introduction of case-based pricing and competition in the hospital system (see chapter 6).

64 Operating according to the logic of necessity, cognitive elements include “paradigms, taken-for-granted descriptions and theoretical analyses that specify cause and effect relationships that reside in the background of policy debates and that limit the range of alternatives policy makers are likely to perceive as useful.” Answering to the logic of appropriateness, “normative ideas consist of taken-for-granted assumptions about values, attitudes, identities...[that] also lie in the background of policy debates but constrain action by limiting the range of alternatives that elites are likely to perceive as acceptable and legitimate” (Campbell 2002, 22, 23).
program and to reach agreement on policy. The communicative function allows political actors to convey the policy program to convince the public of its necessity and legitimacy.\textsuperscript{65}

Discursive institutionalism differs from other institutionalisms in that it illustrates how actors possess agency even within culturally-informed institutions. Through coordinative and communicative action, policy and political actors are not bound entirely by cultural constraints; they can overcome institutional rules and norms by recasting and reshaping them while still tapping into the deep core values of the polity and drawing from the existing cultural and ideological repertoires.\textsuperscript{66} It is within communication and discourse—sharing, transmitting, persuading—that policy actors either perpetuate existing perceptions of interests or reconceptualized them to effect change. Discourse is a means by which actors can change preferences “by altering perceptions of economic vulnerabilities and policy legacies and thereby enhance political institutional capacity to impose or negotiate change” (Schmidt 2002b, 62). In other words, institutional capacities are not fixed or predetermined; they can be augmented or diminished by discourse using compelling cognitive and normative arguments.

Schmidt argues that, while possessing the institutional capacity to impose public service and welfare sector reforms, French governments had difficulty until the late 1990s, because they could not find a legitimating discourse, until Prime Minister Lionel Jospin spoke of the need to balance “equity” and “efficiency.”\textsuperscript{67} As she asserts, deregulation and privatization of certain sectors clashed with the public service ethos of the Republic, and

\textsuperscript{65} This distinction can be overlaid on Jobert’s discussion of the public arena where coordinative deliberation and negotiations take place where policy actors (government officials, civil servants, experts, unions, interest groups, etc.) argue, negotiate and bargain and the public forum where argumentation and justification to the general public occurs.

\textsuperscript{66} The logic of appropriateness—the normative aspect—reflects the deep core values that place moral framing at the heart of political behavior. Lakoff (2002) has shown, however, both conservative and progressive models coexist in most people’s minds and therefore either can be activated with effective framing.

\textsuperscript{67} It is debatable whether the Jospin government was that much more successful at the discourse. By the end of Jospin’s five-year term (1997-2002), the Socialist Party and Lionel Jospin were mistrusted and viewed as having simply pursued similar policies as the right.
therefore lacked a legitimizing discourse, until Jospin’s equity/efficiency balancing act combined both neoliberal and “social” elements. Earlier monetary and industrial policy changes had been more easily justified through a discourse about globalization and European imperatives necessary to create a rampart against global market forces and neoliberalism. At a certain point, an apparent contradiction emerged between the earlier discourse and the need for structural change in social policy, creating a cognitive dissonance about the necessity for change and a normative dissonance about which goals and values were being served. Perhaps France has only been successful in framing when elites have sought to deflect blame and were able to place reforms in the context of European imperatives and goals. On the other hand, positive/affirmative projects such as sweeping changes in the health system are more difficult to frame publicly. Consequently, elites refrain from widespread public debate and health reforms are largely absent from electoral platforms.

For Schmidt, political institutions within a given country or polity determine the type of discourse that is most important in policy making. In single-actor systems (like the UK and France) with concentrated power, communicative discourse predominates. In theory, governments possessing greater institutional capacity to impose reforms engage in more communication with the public to garner support for their policies, as opposed to multiple actor systems that rely more heavily on coordinative discourse between policy actors. Schmidt’s single-actor/multiple actor distinction in political institutions may be too sharp to account for the role of discourse in certain types of policy change, such as in the highly technical domain of French health policy in what is a decreasingly unitary state system. In health matters, partly due to its highly technical and complex nature, the coordinative actors (including government,

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68 In part, the Jospin government’s discourse used a kind of *bricolage* to recast and give new meaning to the “social.”
civil servants, insurers, social partners, doctors’ unions and experts) may be more important than communication to the public in France.  

Considering the political liability that characterizes social and health reform politics and the resulting tendency toward blame and protest avoidance, it is understandable that French governments have not engaged in a thoroughly developed communicative discourse and have opted for a less obvious incremental process of reform. Another possibility is that the state’s institutional capacities in the social domain are curbed by the existence of an interested and organized opposition as well as a greater need for a publicly accepted legitimizing discourse when the government undertakes a major visible reform. Therefore, not only the overall structure of political institutions, but also the policy domain in question affects what kind of discourse matters or whether it matters at all.

As discussed in chapter 1, change has occurred by stealth without an effective accompanying public discourse. Sometimes policy or programmatic ideas can take hold without being fully consonant with the broadly accepted cognitive and normative paradigm. Policy ideas (though possessing underlying background assumptions) can work through incremental urense, a wearing down, that can occur even when there is robust opposition to the unstated underlying paradigm. In the end, the public might become resigned to what is ostensibly an inevitable evolution, despite the policy’s inability to pass the appropriateness test. Thus change might occur even when it does not seem to fit with existing deep-seated values or without having effectively reconceptualized them. A program may be enacted, while

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69 In the coordinative phase, ambiguous agreements may be reached because different actors may agree on the cognitive aspect of a policy without agreeing on the normative justification. This harks back to Palier’s ambiguous agreements in social policy.

70 As has been pointed out in chapter 1, retrenchment politics carry liabilities that curb state capacities (Vail 1999) and justifications and framing of reforms have become even more important with the new politics of welfare reform (Béland 2005a).

71 Geniéys and Smyrl (2008a; 2008b) make the case that social and health policies are largely the outcome of a process of ideational competition for legitimate authority between what they call programmatic elites—groups inside the state who share a common programmatic goal.
still being contested, but eventually provide the frame or benchmark around which all actors organize.

Arguably, some policy initiatives, such as the health insurance deductible or the introduction of managerial practices in hospitals, do not always reflect a broadly legitimate worldview arrived at through “social learning,” yet they may serve a strategic purpose of chipping away at the dominant paradigm (at least they are often interpreted as such in opponents’ discourse). The surface level frame—the need to make the user more responsive to costs, and thus responsible for his health—activates a deeper frame of individual responsibility and the rejection of health as a collective problem. The responsibility frame conjures two meanings: 1) one is responsible to pay for one’s own health care and 2) one is responsible as the cause of one’s own ill health. There is no need for this deeper frame to be explicit for incremental measures to produce a cumulative effect leading to deeper ideational change. Surface level frames often carry with them deep structure assumptions and premises that do not need to be made explicit to activate a broad cognitive frame not referred to openly in the discourse.

Until now, discursive studies have explored relatively little the cognitive and psychological processes involved in the use of frames. All politics possess moral, mythic and emotional dimensions (Lakoff 2002, 19). Cognitive science and cognitive linguistics study how moral systems are built into unconscious conceptual systems. Policy discourse draws implicitly (if not subconsciously) upon conceptual models that feed into worldviews and societal paradigms. Social and health policy positions are eminently moral. What does a social construction in the form of a policy narrative or frame do? It makes events appear self-evident. It makes people behave “as if” the claims of the frame or narrative are so. It makes the claims seem natural or inevitable. It presents the world as if no alternative vision exists. It sustains
taken-for-granted cognitive and normative shared models infused with this naturalizing effect.\footnote{While constructivism acknowledges the taken-for-granted cognitive and normative frameworks, there has been little theorizing about how the cognitive process works. Lakoff (2002) shows how the cognitive and normative frameworks in politics can be extrapolated to moral models of the family. Political concepts are based on a distinction between a conservative, strict father model and a progressive or liberal (in the American sense) nurturant-parent model of government and political behavior. A most important point is that these models tend to coexist for most people who are biconceptual, possessing both frameworks in their mental background. With biconceptualism, rhetoric can tap into and activate one of the underlying models in order to suppress existing cultural blinders (most likely based on the opposing model), but that people are able to operate within two models at the same time.}

There has been a kind of assumed functionalism derived from expectations about structural or third order change (from Hall’s model). The expectation or assumption of historical institutionalism has been that third order, structural change occurs as the result of structural policy failure and crisis opening up space for a new explanatory discourse—a new narrative of the problem and potential solutions. Instead, discursive analysis acknowledges the constructed nature of policy problems and crisis. Discourse plays a central role in creating the belief in structural failure. What then is the relationship between the perception of crisis or of the existence of a social or policy problem, strategic learning, framing and incremental change in the contest over French social policy (and health in particular)? Both incremental and paradigmatic changes are predicated on some form of strategic ideational struggle (whether implicit or explicit). However, structural, and hence paradigmatic, change may also occur through an accumulation of incremental steps, without a coherent ideological framing to the public. This does not mean that the ideological frame stands unaffected or that ideology does not motivate the strategy of incrementalism. Constructivist analysis tracing these processes will likely elucidate this puzzle.

The French case is puzzling because it is a situation in which a social policy paradigm shift is not publicly perceptible despite some potentially significant changes in institutions. One
puzzle of discursive analysis is to determine why the public discourse or public sentiment does not align with the underlying worldview whose ideas are being institutionalized. Given the assumptions of constructivist institutionalism, what are the ideational and discursive processes that permit change without a wholesale shift in thinking? One hypothesis might be that when discourse is not explicit, change is mostly incremental (and/or by stealth) and constitutes a layering process. When discourse is explicit, the population is more likely to experience reform as radical structural change, because ideas have been more openly contested and have been more readily accepted. Put another way, if delegitimation and open contestation do not occur, layering or other institutional processes may be pursued as a reform strategy.

2.6 Ideas and Discourse in French Health Politics and Policy

Scant attention has been paid to ideas and discourse in French health politics and policy. Recent U.S. scholarship has not explored how old ideas persist or how new ideas regarding the governance, financing and delivery of health have been crafted and mobilized. Retrenchment studies have not taken into account the intellectual assault on the welfare state, the framing of debates, how initiatives are blocked or how actors shape and restrict the agenda (Hacker 2006b). Most analyses do not question the conventional wisdom on the

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Hacker states, “perhaps most important, in emphasizing affirmative decisions, the retrenchment literature also excludes from consideration a wide range of agenda-setting and blocking activities that may well be quite crucial in shaping the welfare state’s long-term evolution (2006b, 397). Rather than only studying actions taken in policy making, it is also important to consider how successful certain groups have been in restricting the agenda. Initially in 1995, the Juppé government wanted to pursue the harmonization of the French system into a single uniform system of basic benefits, called assurance maladie universelle. This notion was removed from the agenda and the failure to achieve a harmonized benefit regime for all is a non-event that has not received scholarly attention. Finally, in 2000, the idea
political economy of the welfare state, nor do they address the role that ideology and propaganda play in these matters. Some French scholars, on the other hand, have turned to ideas in health policy by studying international policy transfer (Serré and Palier 2004; Serré and Pierru 2001) and the influence of U.S. paradigms on French experts and health economists (Benamouzig 2005). Other works have underscored the role of experts and their ideas in health care reform in France and the spread of neoliberal ideas in the health sector in France (Benamouzig 2005; Pierru 2007; Serré 1999).

This study draws on constructivist institutionalism, recognizing agency and aiming to address how persistent and changing ideas relate to the relative power of interests and actors. It will consider interests’ ability to mobilize political resources to advance a worldview and to have it embodied in policy and institutions—how agents use ideas to shape and influence institutions in the policy arena or the public forum. Without opposing ideas and interests, it will examine the ability of actors, not to maximize their interest, but to maximize their influence, and in turn, their values. It does not assume rational awareness of interest but actions based on perceptions of interest. Therefore, it is concerned not only with material and tactical advantages, but with ideational and discursive prowess.

Although seemingly weakened by the state’s greater oversight over health financing, doctors have thwarted the implementation of some reforms and stand as an obstacle to attempts at more ambitious reforms, all in the name of la médecine libérale. Rochaix and Wilsford (2005) argue that the state has been stymied in its efforts to control costs since the 1970s, due to the immobile configuration of interests in ambulatory care. Nevertheless,
Genieys and Hassenteufel (2001) describe an increasingly involved Welfare Elite. Through an intra-state ideological turf battle with economic policy elites at the Finance Ministry, social policy elites conquered the social sphere, coalescing around a program according the state a large role in the social domain (Genieys and Smyrl 2008a; Genieys and Smyrl 2008b).

Whereas Genieys and Smyrl focus on the role of these state programmatic elites, this present research is devoted to the ideas and discourse of a broader (however state-centered) policy network comprised of experts, economists, business elites, doctors’ unions, the media as well as public opinion. Major policy reforms provoke great discord among different actors in the system, including health professionals, political representatives, civil servants, insurers and patients’ groups, constituting an apparent contradiction in need of explanation. Paradoxically, most reforms have been undertaken in the name of preserving solidarity; yet opponents to these reforms decry the new measures as a dismantling of the post-war system of solidarity. In order to understand these paradoxes, it is essential to retrace the expert and public debates over reform efforts.

One potential explanation of this paradox lies in the notion of change by stealth and the rhetoric/reality gap. While many recent reforms have been enacted in the name of solidarity, the term “solidarity” contains multiple meanings. It is a broad and vague enough notion that can couch “subterranean” efforts to alter the system. When institutional change occurs through conversion of state activities and layering of new social protections, ideas aid in the production of new wine, albeit in old bottles. This type of change by stealth in old packaging relates to both ideas and framing. Health system reforms often reflect new policy ideas coming out of elite policy processes presented to the public as a means of saving the old system and preserving its basic principles.

The main question to be answered is what explains the way the health care system has evolved in recent decades. Despite institutional and ideational stickiness, incremental
evolutionary change has been the normal state, while some major structural change has also
been proposed and pursued. This research will examine incremental trends as well as major
reforms dealing with governance and finance (the Juppé ordinances), access and coverage
(the creation of the CMU), ambulatory care (the Douste-Blazy Law) and the hospital system
(the T2A financing reform and the Bachelot Law). Unlike in the approach of Rochaix and
Wilsford (2005), the health policy universe will not be considered one of sticky stasis subject to
exogenous shocks but one of punctuated evolution subject to endogenous ideational and
discursive processes. Shocks such as the fiscal imperative are viewed as constructions of the
discursive process, not as exogenous phenomena. While medical inflation and demographic
change may be independent objective realities, the way interests react to them and construct
them as problems is of utmost importance to the constructivist.

Ideas and discourse can explain both continuity and change. “Discursive
institutionalism works best at explaining the dynamics of change (but also continuity) through
its attention to ideas and discursive interactions, new or continuous” (Schmidt 2005, 113). In
order to assess both continuity and change, ideas and discourse will be analyzed on three
levels. The broadest level is the deep structure grand paradigm level, known in the literature
as the societal paradigms, public philosophies, the deep core, public sentiments, worldviews,
global référentiels, broad cognitive and normative frameworks and systemic frameworks. The
grand societal paradigms undergird sectoral paradigms and applied policy. They are the
cognitive and normative ideas, values and norms that reside in the background. At the second
level are sectoral policy paradigms, known as the policy core, sectoral référentiels, general
programs, narratives, programmatic beliefs between worldviews and policy ideas. This level
brings cognitive and normative ideas to the foreground linking the deep core paradigms and
worldviews to policy ideas. The policy paradigm defines problems and sets the agenda for
what should be considered and the goals to be achieved. The third level consists of the
applied policy ideas in the foreground—the policy solutions providing the means and instruments to reach the goals of the policy paradigm. The policy paradigm expresses what is to be done and why. The applied policy ideas express how this will be done.

Table 2.4 Three Levels of Ideas and Discourse

<table>
<thead>
<tr>
<th>Grand paradigms</th>
<th>Societal paradigms, public philosophies, deep core, public sentiments, worldviews, référentiels global</th>
<th>The cognitive and normative basis for policies and programs in the background:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector-based Policy Paradigms</td>
<td>The policy core, référentiels sectories, general programs, narratives, programmatic beliefs between worldviews and policy ideas, benchmark ideas</td>
<td>Cognitive and normative ideas in the foreground linking policy to the deep core structures, showing what should be done and why, defining problems, setting the agenda and goals.</td>
</tr>
<tr>
<td>Applied policy ideas</td>
<td>Policy solutions</td>
<td>Policy solutions, cognitive and normative ideas in the foreground about the means and instruments to achieve the policy paradigm goals.</td>
</tr>
</tbody>
</table>

Through the tracing of ideational and discursive processes, the aim of this study is to show how ideas and/or discourse matter in policy making. Agent-centered in its approach, it requires identification of actors who seek to influence policy, the carriers of ideas, discourse, narratives and frames—the mediators, advocates, entrepreneurs engaged in contestation, persuasion and diffusion. Ideational process tracing includes the “archeology of textual materials” (Campbell and Pedersen 2001a, 12) reading policy documents, alternative proposals, press accounts, etc. for the policy paradigms shared by experts and policy makers. Discursive process tracing focuses on the ideas, notions and frames advanced to justify policy continuity or change. "Policy discourse is the sum of policy and political actors' accounts of a
policy programme’s purposes, objectives, and ideas which serve as a guide to action by defining the concepts and norms to be applied, identifying the problems to be solved, explaining the methods to be followed, developing the policy instruments to be used, and, all in all, framing the national policy discussion within a given policy arena” (Schmidt 2002b, 214).

The study of policy discourse reads for arguments and justifications, for narratives about causes of problems and their suggested remedies, and for frames, slogans and recurring images and evocative phrases expressed in both expert and political communication. Discourse analysis accords a prominent role to language and rhetoric in the media and to the legitimization function of communicative discourse, and therefore should attempt to link public debates with policy content.
CHAPTER 3 - Grand Paradigms and Deep Structure Framing: Market Liberalism vs. Solidarity?

3.1 Introduction

Despite the perception of immobility in French social protection, a multitude of factors have led to changes that have gradually, and sometimes explicitly, breached the logic of the post-war social protection regime. Observers had earlier concluded that the French welfare state persisted due to a strong and broad national consensus (Ambler 1993). However, during the 1990s, a new focus on pressures such as unemployment and the EMU convergence criteria raised questions about the structural inadequacies of the French system of social protection (Gueldry 2001; Levy 2001b; Palier 2002a, 2002c, 2005). European imperatives (political commitments and legal constraints) and globalization (real or perceived economic pressures) were often advanced as the main causes of the need for structural reform. Constructivist analysis questions these factors as unavoidable exogenous shocks and maintains that the socially-constructed belief in them is causally significant.

Grand paradigms and beliefs about structural factors are socially-constructed and invoked to build momentum around the definition of the problem and the need to change. Health policy and political discussions are influenced by these economic, social and political frameworks in the cognitive and normative background. Social protection and health are embedded in the larger regime of political economy. Deep structure ideas residing in the cultural and ideological repertoire are deployed in the discourse in relation to both finance and delivery paradigms as well as applied policy ideas. This chapter will review ideas and

\[76\] The construction of the notion of an exogenous threat is an endogenous factor.
discourse from macroeconomic paradigms, the French republican paradigm and social democracy in the cognitive and normative background of policy discussions and will assess the role they have played in debates over health system reforms.

First, this chapter will explore how the conventional wisdom about exogenous factors such as globalization and Europeanization was used to build arguments in favor of neoliberal measures and market-making. Exogenous frames were often advanced to deflect attention away from endogenous processes including hardly inevitable political choices made by French governments and the spread of neoliberal and market-promoting ideas within the governing elite. Next, it will show how the neoliberal narrative constructed the welfare state crisis and the corollary need to reform. Eventually, arguments about the structural rigidities of the French welfare state predominated and became part of a Left-Right consensus regarding what should be done with obvious ramifications for health policy. Meanwhile, the solidarity narrative, with broad support across the political spectrum also served both those resistant to change as well as the reform-minded. With its ambiguous and plural nature, the concept of solidarity, a powerful tool in the cultural and ideological repertoire, has been revived and recast—a case of new wine in old bottles. Finally, French governments have adopted a moderate or pragmatic liberalism that accommodates both old and new concepts. This chapter will show that, rather than being rigid clashing paradigms, neoliberalism and republican solidarity should be understood as malleable discursive tools used in endogenous processes to various justificatory ends.

3.2 Exogenous Structural Frames, Neoliberalism and the Market

A thriving comparative political economy literature continued to dispute the nature of French capitalism after the demise of dirigisme and the turn towards the market (Clift 2004;
Hall and Soskice 2001; Levy, Miura, and Park 2006; Schmidt 2002b). While there was agreement that France has become more market-oriented, the literature was discordant over the role of the state and how much French financial capitalism had come to resemble an Anglo-Saxon shareholder-dominant liberal market economy (LME). Many agreed that the new political economy in France was characterized by a diminished direct intervention by the state in the economy, but that the state had turned its concentration to “offering a social policy framework which furthers economic restructuring and competitiveness” (Hancké 2001, 334; Levy 2005a, 2005b; Levy, Miura, and Park 2006). In other words, market-making became a primary state activity and economic liberalization the impetus for new kinds of state involvement in social policy.

Institutionally, France’s redeployed state capacities can be linked to the neoliberal turn even though liberalization was part of a pragmatic rather than ideological program. However, Levy’s account (2005b) implied that redeployment of the state responded to a structural need for new interventions caused by the 1983 U-turn and the repudiation of *dirigisme*, leaving untouched the question of the existence of alternatives, how they may have been framed or if and why they were omitted from framing. Structural explanations tend to accept the official discourse that exogenous forces like global and European imperatives caused a need for new state activities instead of explicitly examining the endogenous process whereby policy actors produce and adhere to these beliefs. While exogenous events may or may not be inescapable, the way they are defined and perceived is contingent upon the actions of those who decide to seize upon them. While the events that are deemed to be a crisis or failure may be objectively real, the explanation for why they have happened and what should be done to resolve them are not self-evident.

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77 Many of the structural explanations claiming that exogenous pressures were the cause of institutional change tend to repeat the official neoliberal argument and diagnosis.
The turn to neoliberal ideas and the market coincided with discourses about a globalizing economy and the integration project of the European Union. It is widely held that monetarist inflation-fighting rigor in France was largely a by-product of European integration (Fourcade-Gourinchas and Babb 2002, 5).\textsuperscript{78} The 1983 U-turn was the watershed moment in making Europe the new frame of reference. However, the “neoliberal” turn was an \textit{a posteriori} consequence of political objectives that provided the French financial and economic elite fertile ground to consolidate their pro-market orientation. After the shift to monetarism in pursuit of monetary union, the autonomization of financial policy became an end in itself (Jobert 2003, 470). In some ways, for the governing Socialists at the time, Europe was the end, and the market the means; but for French neoliberals—many of whom were economists at the Finance Ministry, the market was the end, and Europe the means.

This is very similar to what happened at the European level with regard to the adoption of free markets. Contrary to conventional thinking, even the European single market was not a simple product of doctrinaire neoliberals (Jabko 2006). A purposefully inclusive vision of the market was chosen by the advocates of Europe as a conveniently broad enough banner to build a coalition in favor of integration. In defiance of the globalization thesis and the structuralist interpretations of the pressures to liberalize the European economies, Jabko argues that the market was not “a driving factor or ideology of change but […] a strategic repertoire of ideas” (ibid., 5). Furthermore, the European Union built a substantial regulatory framework in order to make a well-functioning market. The idea of the market was employed by creative political actors as a strategy to pursue integration and build Europe. The market, like neoliberalism, “has been endowed with a variety of meanings” (Jabko 2008, 106) and is a

\textsuperscript{78} In the post-war period, budget austerity was firmly within the traditional fiscal conservatism of the French Ministry of Finance which outperformed other countries on this front until the mid-1970s (Fourcade-Gourinchas and Babb 2002, 563).
vague enough concept to be used to various strategic ends and to be subsumed in or reconciled with a wide array of national economic, social and political paradigms.

Furthermore, the globalization and European discourses were often deployed to exact concessions from the French public and to avoid blame. In her comparison of welfare reform framing, Ross (2000) found that leaders in all countries resorted to exogenous frames and presented reform as inevitable in the face of international economic competition. The globalized economy itself was “perceived as exogenous—and therefore relatively uncontrollable” (Fourcade-Gourinchas and Babb 2002, 535). However, French reform discourse exhibited the tendency of continental European welfare regimes to use an exogenous-defensive frame to justify reforms. In other words, the justificatory discourse made the claim that reform was the only means to preserve social protection in the face of unavoidable exogenous events. Continental regimes “emphasized the need to defend existing programs and protect social rights to the greatest extent that exogenous pressures [would] permit” (Ross 2000, 177). It is important to remember that while the frames evoked exogenous pressures, the act of framing should be viewed as part of the endogenous discursive process. Initially, the debate in France revolved around the need to adapt in order to preserve social rights, and this largely coincided with the social anesthesia strategy. Later, however, the framing shifted towards arguments about France’s own structural problems as a handicap in a competitive international economy and as the cause of social exclusion.

Whereas in the varieties of capitalism literature institutional change results from exogenous pressures, ideational explanations demonstrate that institutional change is the product of endogenous processes pursued by domestic agents. In Blyth’s (2002) study of disembedding liberalism, ideational convergence occurred in part in both Sweden and the

79 For some, Europe and globalization have been scapegoats for actions that were taken for other reasons, and the double speak with regard to globalization and markets have led to a disconnect between discourse and actions (Schmidt 2002b; Meunier 2004).
United States, because liberalism had been part of the ideational repertoire in both countries. This does not mean, however, that the ideas translate into the same policies in all countries and cultures, because “the meaning and identity of neoliberalism is always local” (Kjaer and Pedersen 2001, 242). Rather than seeking to place France into a typology of capitalism, the concern for the multiplicity of meanings in neoliberalism facilitates an understanding of how ideas translate in different contexts and how different cultures produce different readings of the same paradigm. Deep structure ideas contained in a broad paradigm are interpreted through the local “discursive system of meaning.”

Neoliberal doctrine, in the broadest sense, advocates a limited, minimalist role for the state and upholds the virtues of the market. Thus, as a broad paradigm or public philosophy, neoliberalism is not a uniform set of guiding principles. It is “less a coherent totality, as is often assumed, than a loose conglomeration of institutions, ideas and policy prescriptions from which actors pick and choose depending on prevailing political, economic, social, historical, and institutional conditions” (Campbell and Pedersen 2001a, 3). The influence of such a paradigm does not entail the diffusion of a homogeneous set of ideas across countries. Neoliberal ideas in the post-Keynesian period translate differently depending on the country, its existing institutions and its discursive system. Jobert and Théret (1995) also suggested that the neoliberal turn took a different course in each country. In the case of France, a group

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80 “Discourse is a system of meaning that orders the production of conceptions and interpretations of the social world in a particular context. In this view, ideas are always embedded in discourses and become meaningful only by being interpreted as part of a particular discursive system of meaning” (Kjaer and Pedersen 2001, 220).

81 For an example of a discursive analysis of the translation of neoliberalism in the Danish case, see Kjaer and Pedersen (2001). As the authors explain, translation differs from diffusion. Hence, “the story of neoliberalism should be analyzed as a process in which actors within a particular national context select various relevant neoliberal concepts and conceptions from ideas available to them and use them in ways that displace the existing order of interpretation and action and trigger a shift in policy attention, preferred policy models, and opportunities for political action. In contrast to diffusion, in translation, one does not assume a fully developed and easily identifiable idea (or paradigm) that is transferred unchanged over time and from one country to another” (219).
of experts shaped the French version of neoliberalism giving it its own “consécration republique.”

Furthermore, contrary to impressions fostered by recent debates and the framing of neoliberalism as a foreign Anglo-saxon intrusion, neoliberal ideas are not new to France. As Machin reminds us,

…the debates about whether or not the state should partly replace the market, or simply police and complement it, had continued through the nineteenth and twentieth centuries. For such periods as the Second Empire and the inter-war years, however, laissez-faire policies largely predominated. The idea that the public sector (or state dirigisme, or 'industrial policy', at different times) was not only ineffective, but actually held back the economic development of the country and the natural creativeness of its entrepreneurial elites was not an innovation of neoliberals in the 1980s. (2001, 145)

Contrary to the all-too-common rhetoric presenting neoliberalism as imposed from without, a part of the governing and intellectual elite propagated these ideas in France. Neoliberalism became an important minority position in France during the 1970s (Prasad 2005, 2006). The New Economists, with their free-market, anti-statist proclivities, held leadership positions and great sway at the *Ecole Nationale d'Administration* and *Institut d'Etudes Politiques* in Paris.

At the same time, elsewhere in the academy, public life and the pages of *Le Débat* and *Commentaire*, the followers of Raymond Aron revived French liberal thought (Anderson 2004). Between 1976 and 1981, President Valéry Giscard d’Estaing and Prime Minister Raymond Barre constituted a proto-neoliberal government (Prasad 2005). For one French observer, Europe having been mobilized as a legitimizing instrument, the year 1983 marked, not only the conversion to the market of the leftist government but also confirmed the shift to economic liberalism of the Gaullist movement (Denord 2008). Regardless of the political

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82 Prasad also found evidence of a developing skepticism among the elite and professional economists toward state intervention and a public ambivalence about high taxes, nationalization, egalitarianism and the efficacy of the state (2005, 379-380).
discourse railing against liberalism and the denunciation of the *pensée unique*, France pursued liberal reforms, namely privatization, liberalization of key sectors and flexibility of the labor market. Much of the neoliberal turn occurred behind the scenes in technocratic circles and related reforms were often conducted by stealth.

3.3 Constructing the Problem of the French Welfare State: The Neoliberal Narrative, Crisis Rhetoric and the Need to Reform

Although the neoliberal paradigm did not receive a full-scale welcome in France, the neoliberal narrative played a prominent part in the problem stream (Kingdon 1995) and the social construction of imperatives with regard to the welfare state (Cox 2001). From a constructivist perspective, the narrative of a problem is constitutive of the problem. As a central element of the problem stream, the neoliberal narrative about the dysfunction of the welfare state aimed to delegitimize the existing system using crisis rhetoric and presenting the case for the need to reform. As Kuipers (2006) states, “reform is the product of the deliberate construction of an imperative for change by change-oriented politicians” (10). Imperatives are constructed through crisis rhetoric; the narrative attributes blame to system failures that are believed to have caused a crisis and prompted the need for change.

...Economic ideas make...institutional resolution possible by providing the authoritative diagnosis as to what a crisis actually is and when a given situation actually constitutes a crisis. They diagnose ‘what has gone wrong’ and thus ‘what is to be done.’...Instead, the diagnosis of a situation as a ‘crisis’ by a particular set of ideas is a construction that makes the uncertainty

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83 Kingdon (1995, 88) asserts that the problem, policy and political streams operate independently of one another. Similar to Blyth, he states that solutions are often devised regardless of whether they respond to a particular problem.

84 Kuipers (2006) compares the crisis rhetoric in Belgium and the Netherlands in the early 1990s. Kuipers, however, is concerned with how successful crisis rhetoric results in non-incremental change. Crisis rhetoric can also be successfully employed to justify incremental, yet fundamental, transformative change over time.
that agents perceive explicable, manageable, and indeed, actionable….(Blyth 2002, 10)

Thus, in uncertain times, ideas define and give shape to failures and crisis. They are used to diagnose and construct moments of uncertainty allowing actors to provide causal explanations for what appears to be an accumulation of institutional failures. Crisis narratives use simplification and hyperbole and usually call for urgent, drastic action. The objective of a crisis narrative is usually to discredit and delegitimize an existing system and to garner support for change. Internationally, the “welfare state crisis” has been used as a rhetorical device, an alarmist discourse “instrumental in weakening the intellectual legitimacy of welfare systems” (Boyer 2002, 12).

Not only in the US and Sweden, inflation and taxation became the central issues around which monetarism, supply-side economics and rational and public choice theories coalesced in order to discredit government intervention in the economy. Yet these ideas had been waiting in the wings for decades and were reminiscent of nineteenth century thinking. "The ideas used to disembed liberalism were, in many cases, simply a warmed-over version of the ideas that embedded liberalism had seemingly defeated back in the 1930s” (Blyth 2002, 85).

Hay argues for making a distinction between contradiction and failure (defined as an accumulation of contradictions) and crisis. He states: “if it is narratives of crisis that are responded to and not the contradictions themselves, we cannot in any sense (theoretical or otherwise) derive the response to crisis from a static analysis of the contradictions of the existing system. A given constellation of contradictions can sustain a multitude of differing and incommensurate conceptions of crisis, apportioning responsibility and culpability very differently and calling forth wildly divergent decisive interventions. Moreover, crisis narratives do not compete in terms of the sophistication or indeed accuracy of their understanding of the crisis context. Indeed their ‘success’ as narratives generally resides in their ability to provide a simplified account sufficiently flexible to ‘narrate’ a great variety of morbid symptoms while unambiguously apportioning blame. To become sufficiently ascendant to alter the trajectory of institutional change in the ‘postcrisis’ world, crisis must make sense to individuals of their experience of the crisis (whether direct or mediated); they must also be sufficiently general and simple to identify clear paths of responsibility and an unambiguous sense of the response that must be made if catastrophe is to be averted” (2001, 204).
In the global economic environment of the 1970s and early 1980s, ideas in search of a problem met a “crisis” in search of a narrative.

The economic downturn of the 1970s and early 1980s witnessed a counter double movement away from these embedded liberal ideas as states began to experience problems such as stagflation that existing ideas and institutions seemed unable to address. In this situation, those institutions that had served as the basis of the embedded liberal order themselves became objects of critique and contestation. Institutions and instruments such as dependent central banks and active fiscal policies were now diagnosed as ‘part of the problem’ rather than as ‘part of the solution’ to the downturn of the period and were systematically delegitimated and dismantled. (Blyth 2002, 5)

Existing theories were deployed to provide a diagnosis for the causes of the crisis of stagflation in the US and elsewhere, including France. Monetarism called for the tightening of money, while supply-side theories provided the argument for tax cuts. In addition, public choice theorists helped to make the case that governments were causing inflation due to the incentives built into electoral politics. In sum, a combination of beliefs and theories about inflation set policy makers on the road to disembedding liberalism. While a naturalizing effect occurs when actors’ assert these paradigmatic beliefs, in fact, the mutually reinforcing socially-constructed paradigmatic framework is not based on fundamental laws of economics, but on social conventions. Helping to define actors and their interests, these beliefs served to reduce uncertainty by giving these actors causal explanations for inflation around which

86 The characteristics of both classical liberalism and neoliberalism are “high capital mobility, large private capital flows, market-conforming tools of macroeconomic management, a willingness to ride out balance of payments and other disequilibria by deflation, and a view of the rate of employment as dependent upon the market-clearing price of labor” (Blyth 2002, 6).

87 As Blyth (2005) points out and studies show, public perceptions of inflation often do not coincide with official data.

88 This social construction of economic imperatives is an intersubjective dynamic in which the actors’ beliefs and thinking about social realities bear an impact on those realities such that paradigmatic beliefs can become self-fulfilling. “Ideas that agents have about the impacts of their actions, and those of others, shape outcomes themselves” (Blyth 2002, 33). In the neoliberal paradigm, for example, actors believe that deficits cause inflation; consequently, deficits will cause inflation because all of the relevant actors make decisions based on the widely accepted premise.
they could rally, organize and assert their interests. This gave business interests and the 
intellectual and political elite and ideational arsenal and an opportunity to use monetarist and 
neoclassical ideas to shift the political economy away from the Keynesian focus on 
redistribution and growth towards controlling inflation and maintaining monetary stability.

The neoliberal diagnosis and program to disembed liberalism was a reaction to the 
perceived failures of Keynesianism. Since the early 1980s, crisis has been a perennial theme 
with regard to the French welfare state and the broader social model (Boyer 2002; Lefebvre 
and Meda 2006; Lesourne 1998; Marseille 2005; Renaut 2006; Rosanvallon 1981; Smith 
2004). Just as in the embedding and disembedding of liberalism in the U.S. and Sweden, the 
narrative of crisis and the need for reform has played a major role in the liberalization of the 
economy and the transformation of social protection in France. While what might be 
considered neoliberal solutions have not always been pursued, the neoliberal diagnosis has 
been paramount in identifying problems and setting the reform agenda.

As intimated above, (perceived) crises and failures need to be narrated and 
explained; the need to reform must be constructed. “If the idea of the welfare state is socially 
constructed, so is the need to reform it” (Cox 2001). In effect, the French social model and 
welfare state have long been portrayed as being in a perpetual state of crisis, just as the idea 
of French decline recurs frequently. As early as the 1950s, the French model was accused 
of inflationary tendencies and harming economic growth (Savidan 2005). During the 1970s, a 
new discourse arose about the problems of social exclusion and the new poverty placing in 
question some basic assumptions about the post-war economic and social model and 
Bismarckian social protections (Lenoir 1974; Stoleru 1974). In October 1980, the OECD held 
its landmark conference on the Welfare State in Crisis; the Rosanvallon (1981) work on the 

For Genieys and Smyrl, elite competition for legitimate authority drives actors to constantly 
seek alternatives and change. Therefore, “the inherent desire for change leads to the 
discovery (or outright manufacture) of ‘crises,’ not the other way around” (2008b, 31).
subject soon followed, which echoed the diagnosis while seeking alternative solutions. In the 1990s, the discourse shifted to the looming crisis caused by globalization and demographic pressures, assuming an insatiable growing demand and a diminished ability to meet this demand due to the international economic environment.

As part of the delegitimization of big government and Keynesian economics, welfare systems were eventually depicted as the cause of economic crises, and no longer the solution (Palier 2002, 2005), in echo of Ronald Reagan’s famous refrain with global reverberations, “government is not the solution to our problem; government is the problem.” In Keynesian economics, social spending was a fundamental aspect of the overall objective to sustain economic growth. In the post-Keynesian supply-side economy, social spending was increasingly portrayed and perceived as a burden on the economy.

This neoliberal diagnosis held that protection itself was the problem and paved the road for path-breaking changes in the 2000s. A Left-Right consensus on French sécurité sociale eventually emerged that the perennial “crisis” was structural and due to the rigidity of social policy (Gueldry 2001, 96). By the mid 2000s in France, a flurry of publications from both the Left and Right addressed the widely-decried and broken French social model (Baverez 2006; Duval 2005; Fontanel, Grivel, and Saintoyant 2007; Godet 2005; Julliard 2005; Laine 2006; Renaut 2006). A great public debate ensued between mostly self-avowed anti-statist “déclinologues” depicting an immobile France not only in crisis but in decline (Baverez 2003, 2005) and the defenders of certain aspects of the French social and economic model (Maris 2005; Meunier 2004) or those wishing to move towards a more Nordic-style system (Lefebvre and Meda 2006). Across the political spectrum, over several decades, a consensus emerged

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90 Castles demonstrates that “the initial crisis warnings of the 1970s and 1980s were falsified by events, their mythicial status revealed by measuring the actual experience of social policy development against the predictions of those forecasting doom” (2004, 1-2).
91 “The ideological purpose of declinism [was] to create the conditions for a radical neoliberal reform” (Meunier 2004, 104).
that the French social model was malfunctioning with regard to employment and inequalities in comparison to its Nordic or Anglo-Saxon counterparts.

Influenced by neoclassical economics and methodological individualism, much of the neoliberal reform rhetoric and discourse attacked the perverse incentives of the welfare state and were concerned with such issues as moral hazard (framed as the willingness to abuse or overutilize benefits).\(^2\) A devotee of the Reagan and Thatcher programs, Baverez (2003) argued that the high fiscal and social burden of a welfare-statist model discouraged high value-added production and that it was a primary cause of France's imminent decline. For this discussion, the most salient arguments in support of the neoliberal thesis and propagated internationally included the idea that employment-based social insurance exacerbated social exclusion, that high social charges dampened competitiveness and caused unemployment, and that social and labor protections in themselves were rigidities that thwarted the dynamism of the economy.

3.4 Solidarity in the French Social Model: New Wine in Old Bottles

Solidarity, just as neoliberalism, is a plural object. For that matter, likewise is the abstract notion of French Republicanism (Levy, Cole, and Le Galès 2005) in which solidarity is rooted, originally theorized extensively by Prime Minister Léon Bourgeois in his 1912 *Solidarité*. A secular middle-class Republican, Bourgeois endeavored to synthesize (ostensibly) competing ideas and to find a middle path between liberalism and socialism. Based on Durkheimian notions of the division of labor and interdependence, he developed a theory of society based on solidarity between freely consenting individuals who have both rights and obligations in society (Bourgeois 1998; Stjernø 2005). From the outset, defenders

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\(^2\) As Cox (2001) has shown, even in social democratic Denmark, reform rhetoric and subsequent reforms placed more responsibility on the individual.
of solidarity have grappled with whether solidarity and freedom are contradictory or complementary. For Bourgeois, solidarity recognized both individual and collective responsibility.

In France, the first forms of worker solidarity were based on the principles of voluntarist mutual aid (Gibaud 1995). The mutualist movement was long reticent to accept mandatory social insurance, due to its concern for both liberty and solidarity. The first mandatory social insurance laws in France in 1928 and 1930 guaranteed the freedom of choice of insurer to the workers. In the post-war period of the French welfare state, a Bismarckian system of occupational social insurance was instituted. When this system came into question during the 1980s, solidarity was rekindled in the public discourse, redefined and redeployed in new ways to justify social policy reforms (Béland 2009b). The history of the organizing principle of solidarity in France can, thus, be understood as a case of concept stretching—essentially new wine in old bottles. Solidarity has been invoked to justify different types of protection and has passed through the phases of voluntarist mutualism, obligatory occupational forms and finally to national conceptions of social citizenship.

The revival of liberal ideas in France prompted a reinterpretation of the welfare state that played on its complexity and the multiple meanings of its founding principles, thus allowing profound changes behind the shelter of an unchanged veneer (Jobert and Théret 1995, 72). Jobert and Théret (1995) affirmed that political discourse revived the republican rhetoric of solidarity in order to legitimize the shift to neoliberal policies. At the same time as

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93 Cox (2004) has found that the Scandinavian model had a sticky reputation despite fundamental reform in the 1990s. He asserts that the model itself is an idea with broad and even contradictory core characteristics, namely universalism, solidarity and decommodification. Just as in France, the broad attachment to the idea of the model gives it its sticky reputation. In order to preserve the values of the model, concepts are stretched to accommodate the new policy reality. Thus, there is not institutional path dependency, but rather ideational path dependency, and concepts are stretched to accommodate institutional change.
neoliberal macroeconomic policies were being enacted, republican solidarity was being recast, in effect infusing new meaning into the old ideological repertoire. As Ross (2000) underscores, framing often entails reframing or reworking extant frames. In effect, neoliberal policies in France owe their success in part to the malleability of republican solidarity. Just as Bourgeois had done in the nineteenth century, the French political elite sought to reconcile liberalism with republican notions of solidarity.

“Managerial neoliberalism [was] legitimized by the substitution of republican solidarity for reduction of social inequalities as the guiding principle of the social [welfare] state” (Jobert and Théret 1995, 23). Unlike in social democracy where equality remains pivotal, national solidarity accompanies the market, almost as an afterthought to compensate those who are excluded from participation in the labor market and the productive economy. In effect, solidarity replaces equality as the stated purpose of social policy. Ironically, neoliberalism and solidarity narratives in France have been two sides of the same coin. By claiming to mitigate the effects of liberal policies, the solidarity narrative made income and social inequalities more acceptable. The solidarity narrative has underwritten the dualization of social protections into employment-based occupational social insurance and national tax-based benefits and has been used in the service of institutional change by layering minimal protections onto the old Bismarkian arrangement.

Nevertheless, some scholars persist in a view of France as unwilling to change, a public unwittingly clinging to old notions of solidarity that only serve privileged, insider groups. Despite signs of change, Smith (2004) depicted a France in Crisis as part of a frozen landscape defined by the insider/outsider problem, contending not only that the rhetoric of solidarity masked inequalities, but also that social spending redistributed from the poor to the
Echoing the stasis narrative, he attributed France’s problems to the corporatist nature of social protection. He proclaimed that “policy cannot remain ossified in tradition as politicians denounce changing global economic dynamics…. France must stop blaming outside forces for its problems and it musts also stop equating reform with the unattractively inegalitarian US and British economic paths” (2004, viii-ix). The crux of Smith’s argument is that the social protection system has been the major source of inequality in France. In his view, social policy, purported to enhance solidarity with outsiders, tends instead to further exclude them.

Arguing that France’s problems were endogenous, home-grown and structural, he recounts a path-dependent story in which both ideas and institutions remained fixed in the left-wing ideology of solidarity—the “solidaristic catechism” (ibid., 9). For Smith, the ideology of solidarity, used to defend vested interests (mainly in the public sector) while invoking globalization as the cause of France’s economic problems, was the main impediment to change. Blaming globalization for France’s economic and social woes, the French far-Left fueled the myth of solidarity and deflected attention off of France’s own homegrown problems.

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94 This is known as the Matthew effect. For more on the reverse redistributive aspect of the French welfare state, see Prasad (2005).
95 While it is true that the discourse often cites external forces as the reason for the need for reform, it is difficult for the French to not equate reform with the US and UK models, for in their experience, most policy responses since the 1980s have been neoliberal. Attempts that have been made by the Left at more consensual social democratic reforms have enjoyed limited success. In the end, it might be said that the French social repertoire draw more easily from economic liberalism (even in its newest form), than from any Nordic-style social democratic model.
96 Perhaps the French people conflate the professional and the national do not really make the same distinction as do the experts, possibly due to the legacy of a system trying to meet the goals of Beveridge with the tools of Bismarck. National solidarity carries meaning even though the system had long been employment-based.
97 While Smith presents with incisive poignancy the insider’s privilege, he often falls into stereotypes while reproducing neoliberal assumptions about market efficiencies. Although coming from a self-avowed social democrat, his demonstration resembles arguments by those on the Right calling for social cutbacks. His critique is mainly of the Left, and most notably of the extreme or alternative anti-globalization Left’s discourse, in complete neglect of the
By definition, a Bismarckian social insurance model is conceived as a way to protect against social risks and does not seek vertical redistribution. Smith himself notes “income redistribution is not the guiding principle of corporatist/continental welfare states even if the rhetoric of redistribution is commonly heard” (2004, 21). If Smith accurately highlights the problems of social and income inequalities in France, effectively critiquing the shortcomings of the corporatist system, he may place too much emphasis on social policy as the primary cause of these problems, thus remaining trapped in the prevailing neoliberal discourse. The corporatist system in its original form may have simply been ill-equipped to resolve these problems, but this does not preclude adaptation. Just because the broad ideology of solidarity has not changed does not mean that some institutions or policies have not. Perceptions are sticky, while change occurs by stealth, the repertoire often being exploited to new ends.

Much of the discourse has mixed the specter of lagging behind in a global economy and the need for the European Union as a rampart against Anglo-american neoliberalism. Both corporatist goals and neoliberal reforms have been pursued in the name of solidarity, in turn, contributing to dualization. Where Smith's interpretation views the rhetoric of solidarity as an obstacle to change, others perceive it as a way of stretching a concept in order to introduce change through the existing social repertoire—the path dependency of an idea but not of institutions. Smith’s analysis neglects the degree to which France changed both openly and by stealth and that both neoliberal-style reforms in the macro-economy combined with the lack of generous, vertical, redistributive solidarity in welfare spending have worsened the situation for neoliberal analysis propagated by the Right. He fails to give due attention to how the business class and right-wing used the globalization discourse to make the case in favor of neoliberal reforms. Moreover, he indicted the middle class and public sector workers as the privileged class with little, if any, mention of the business class. He lays most of the blame on the privileges enjoyed by the public sector workers (as has much of the employer and right-wing rhetoric in recent decades). He also falls short on his critique of the reforms that have departed from the social insurance paradigm and given rise to resistance against neoliberalism, neglecting to mention pension or health reforms since the 1990s.
outsiders. By serving the goals of financial capitalism, social anesthesia layered neoliberal measures atop a shrinking social insurance model.

Smith (2004) emphasized how the Anglo-Saxon model is often brandished as the sole alternative to the existing French system. “The operating principle of the French Socialist party today—national (or European) ‘solidarity’ versus global ‘neoliberalism’—is a false choice” (14). Although often presented as such, liberalism is not a foreign import to France, but a part of the historical, social repertoire. It has often been promoted from within by the Right and the *patronat*. Treating it as a foreign intrusion, the Left uses the specter of Anglo-American liberalism to discredit it in the eyes of the public, by making it (and its proponents) appear to betray essential principles of the French Republic. Ideationally, the post-war consensus regarding a universalist, solidarity paradigm may not have been as historically consolidated as once thought. In the age of austerity, employers took advantage of windows of opportunity to construct problems as they had often seen them (the theme of social contributions being a drag on the economy is not a new one).

In stark contrast, Palier (2002a) has argued that the majority of the political and administrative actors involved had come to accept the insider/outsider thesis by the 1990s and saw the need to make a break with a purely social insurance model. The basic narrative by the end of the 1980s included an outright critique of social insurance as flawed. An employment-based system not only produced social exclusion, but its financing drained business competitiveness and job creation while the social partners blocked necessary adaptation to new conditions. In sum, social protection had been a source of problems, but not only because of the persistence of the solidarity rhetoric in defense of the old. The chosen reform path, providing only minimal passive protections for the socially excluded and most

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99 Smith’s account does not acknowledge the degree to which the socialists have gone along with neoliberal reforms. The governing elite in France adheres to the belief (as in the US and UK) in the structural trade off between state spending and employment.
vulnerable, exacerbated the insider/outsider dilemma. Problems (and their definition) were homegrown, because the political class had adopted neoliberal frames, ideas and policy prescriptions, often even while publicly decrying them. The contrast of these two scholars highlights the ongoing tension between liberalism and solidarity and the two sets of référentiels that exist endogenously in the French cultural and ideological repertoire. From the same events, emerge differing narratives. In the end, this underscores the struggle to control narratives and the effect that ideas and perceptions can have on political outcomes.

3.5 An Ambivalent Master Discourse: The Flexibility of Moderate Liberalism

Exploring the ideas put forth by various interests in health care politics, this study does not posit a full-fledged turn to neoliberalism as a widely accepted public philosophy. While the neoliberal paradigm has not been fully embraced in all policy circles or by public opinion, it has still played a preeminent role in public debates and in policy decisions. As Levy (2005b, 122) blithely asserts, “politically, France has been a case of liberalization without liberals.” In part, this ambivalent relationship with neoliberalism is due to the perceived conflict with competing aspects of the French cultural and ideological tradition, namely the republican ideals of equality and (certain conceptions of) solidarity. In France, as in most advanced political economies, the underlying debate often depicts a dichotomy opposing social democratic ideals of equality with neoliberal notions of liberty. Yet, France inherited a dual cultural legacy from the 19th century—both liberal individualist values and public and private protections in the name of solidarity (Godt 1985). However, liberalism and solidarity have been portrayed as both conflicting goals but also as complementary reconcilable notions. The ambiguity and tension between differing views of the relationship between solidarity and liberalism often
allows decision-makers more latitude to legitimate policy measures by invoking one or the other.

Despite the ostensibly irreducible opposition between liberalism and solidarity, the cultural and ideological repertoire has long contained both the liberal and the social. Several frames and paradigms are able to operate at once. While there may be consensus about the existence of a problem or the need for reform, a clear-cut dominant paradigm does not tend to emerge. Instead, a “pragmatic neoliberalism” (Fourcade-Gourinchas and Babb 2002; Prasad 2005, 2006) or a “moderate form of economic liberalism” (Béland 2007; Schmidt 2002b) can accommodate both social democratic and neoliberal frames (which can be either competing or complementary).” Despite the fact that some structural changes have occurred, this does not signify the complete abandonment of the old paradigm. The assumption of a fully hegemonic paradigm excludes the possibility of ostensibly contradictory notions, such as neoliberalism and solidarity as the basis for the same policy paradigm or program.100 Both neoliberalism and solidarity are ambiguous terms with multiple meanings that can be squeezed or stretched as policy and political actors see fit.

100 Lakoff’s (2002) notion of biconceptualism can help to explain how dichotomous ideas might coexist within the policy setting. The metaphor of the nation as family applied to US political morality by Lakoff can be extrapolated with ease to other liberal democracies such as France. While the players differ and the models translate differently in different cultures, the basic progressive/conservative dichotomy can be found in political discourse in France just as it is in the U.S. Just as progressives in the U.S. view the government’s role as akin to the strong nurturant parent, in a similar fashion, the French state is considered to be the legitimate guarantor of basic needs and fairness for all French citizens. At the same time, the more conservative strict-Father model is also present in the French metaphorical repertoire with themes of moral authority, hierarchy, self-discipline and individual responsibility, laissez-faire and efficient markets. It is reminiscent of the paternalist employers of the nineteenth century and can be associated with neoliberalism. The notion of individual responsibility and the morality of reward and punishment are also evoked at times in France mostly by right-wing pro-American politicians. While the strong providential state dominated in France in the post-war Keynesian period, the laissez-faire model remains a conceptual model upon which to build political, moral frames.
As Schmidt (2002b) has shown, the ambivalent French discourse about economic and social change revealed a tension between macro-economic decisions and the values of Republican solidarity and public service. Changes in macroeconomic policy and thinking about the broader economy sent ripples through other policy sectors, including social and health policy. An implicit acceptance of some of the precepts of supply-side economics and managerial liberalism have contributed to a kind of ideational neoliberal creep, even in the absence of a wholesale adoption of neoliberalism as a paradigm for the finance and delivery of health care.

Budgetary rigor, a basic tenet of the Washington consensus and supply-side economic theory, was integrated into the thinking of the French welfare elite. A programmatic elite prevailed in a struggle between economic and social rationales by importing economic ideas and reconciling them with the state’s defense of the general interest and national solidarity in health. Genieys and Smyrl (2008a) identified key figures in the French civil service such as Bertrand Fragonard, Jean Marmot and Jean Choussat who were instrumental in fashioning a social paradigm. Others, national health insurance fund or hospital administrators, including Gilles Johanet and Jean de Kervasdoué, and public health officials all joined in the counterculture to oppose the prevailing neoliberal orthodoxy. The model they adopted held simply that “in order to preserve the French system of social protection, it must be adapted to meet current financial constraints. This, in turn can be accomplished only by reinforcing the directive role of the state and targeting benefits to the most disadvantaged sectors of society” (ibid., 85). Attached to the founding principles of French social protection, these civil servants criticized the corporatist model and also rejected market solutions. In this case, by asserting the state’s role in budget discipline, they were staving off neoliberal ideology and privatization of the social sector.
This group of civil servants enacted a state-centered program resembling that promoted by the international policy community integrating market and management ideas into state activities. Reflecting the adaptive pragmatism of the French elite, this is effectively a form of what Maarse calls cultural privatization. While the French welfare state elite is certainly of utmost importance in the social and health sectors, Genieys and Smyrl (2005b; 2008a) explain policy outcomes solely by the competition for legitimate authority within the state between a group of high civil servants in Social Affairs and their rivals at the Finance Ministry. In their account, the programmatic elite coalesced around a policy program as a solution to a problem. Their explanation touches upon how the social welfare elite gained autonomy in reaction to the neoliberal ideology of the economists at Bercy. It is, therefore, a by-product of the propagation of ideas (even as a counter-response to them). They call this “pre-emptive adaptation” (Genieys and Smyrl 2008b, 139). Because state intervention was being challenged and contested, the programmatic elites incorporated budgetary rigor into their own state-centered program. In effect, the implication is that budgetary pressure was a pretext—a rationale used by the social welfare elite to shift to state financing and control of the social and health sectors in order for them to prevail in ministry turf wars as part of internal state competition. The agents of change were the policy managers from the social ministry who won out over a competing group of elites (Genieys and Smyrl 2008a, 76). This can also be interpreted as a partial victory for neoliberal and new public management ideas, for even though the social affairs group retained personal control over their sector, they only did so by integrating and recasting the ideas of their competitors under a social state-oriented banner. Even though the social sector eventually became more autonomous through preemptive adaptation, this was nonetheless a reactive posture to the onslaught of the new doctrine espoused by the neoliberal state economists in France.
Yet, this begs an important question. Why were these programs and their ideas more legitimate than rival programs and ideas? Most certainly the social elites’ authority derived in part from the social legitimacy of their ideas or their discursive ability to have them accepted.\textsuperscript{101} If not, what accounts for their success? In this account, state policy making occurs in isolation from other societal factors, according no explanatory power to the role of the polity, societal interests or public opinion, the role of academics, the media, think-tanks, international organizations or politicians.\textsuperscript{102} While this analysis elucidates the plurality of the state and lays to rest the state as unitary actor, policy making and ideational and discursive processes surrounding them cannot be reduced to competition between state elites which is only one element of a larger societal debate. Perhaps the social affairs vs. finance rivalry should be viewed as an incarnation within the state of broader societal debates. In this instance, the social welfare elite were more aligned with public opinion in asserting the state’s role as guarantor of social protection, despite the corporatist history of the system.\textsuperscript{103}

3.6 Conclusion

Despite the influence of business and financial elites in the contest over ideas and power, a competing set of ideas and elite actors in the Social and Health Ministries were able carve out an expanded role for the state in social policy based on the goals of solidarity

\textsuperscript{101} If competition for authority is the sole explanation for the success of the welfare state elite, then it would seem that the ideas themselves are of little or no consequence.
\textsuperscript{102} This is perhaps the bias of a focusing on the sociology of these particular actors as the object of their research. Their research design is deliberately elite-centered and focused on individual actors.
\textsuperscript{103} The French do not feel well-represented by unions in the health system. In a 2007 poll, only 48% of respondents felt that unions were the legitimate representative of patients and users of the health system, compared to 91% for doctors, 86% for patients’ groups, 77% for mutual insurers and 73% for public administrative institutions (health funds and health ministries) (Collectif Interactif Sur la Santé and LH2 Opinion 2007, 18).
Instead of dismantling the state after the 1983 turn, the senior civil servants in the social ministries deliberately augmented state intervention. Contrary to the neoliberal dogma, state action was reinforced and enhanced through a critique of the corporatist system and purposeful incremental change. In a rivalry with the neoliberal “state economists” at the Ministry of Finance, the social welfare elite developed a “social” paradigm that integrated financial concerns and constraints into state social activities. By co-opting the concern for budgetary constraints, they managed to supersede their competitors from the Finance Ministry and to defend, and even expand, the state’s role in social policy. In effect, the welfare elite were able to work liberal principles into their programmatic views.

In the old neoliberalism vs. social democracy dichotomy, efficiency and social justice were viewed as incompatible. Increasingly, the argument has been made for a paradigm that reconciles both economic performance and social solidarity. While some interpret reform trends as a dualization of the French welfare state taking on more liberal, residual characteristics (Palier 2002b), others argue for the potential to strengthen both Bismarckian and Beveridgean protections (Boyer 2002). Understanding the hybrid nature of the French republican paradigm drawing from universalism, corporatism and market-driven models (Révauger 2006) helps to explain the reform path taken in recent decades and the inability to adopt large-scale Nordic style unified coverage and also the outright rejection of neoliberal social protection. The liberal solidaristic traditions have been adapted and deployed in ways

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104 The French school has shunned the notion of a unitary state for decades. “What immediately appears is the diversity of sectoral orientations and segmentation of public actions” (Jobert 2003, 465). Genieys and Smyrl seek to “get once and for all beyond the rather simplistic notion of the ‘strong’ or ‘autonomous’ state seen as a unitary actor in opposition to an undifferentiated ‘society’ or even to plural ‘interests” (2008a, 86) Instead, they have proffered the label of programmatic elites operating in different sectors and often in competition with other elite groups of actors.

105 Genieys and Smyrl express the caveat that, although this programmatic influence was strong for two decades, it has declined since that time (ibid., 89).
that make possible certain kinds of reform—mostly layering, stealth and incrementalism building to structural change—by couching them in these malleable and broad value frames.

On one hand, neoliberal ideas are perceived to be chipping away at a longstanding tradition of solidarity. On the other hand, the notion of solidarity has proven to be robust and malleable. Through concept stretching, many reforms have been justified using a solidarity discourse. While the neoliberal discourse has gained momentum, a range of ideas about health care financing and delivery still reflect the coexistence of multiple visions of society. The French worldview is not monolithic and contains elements from both the individualism and collectivism of the nineteenth century. In many ways, the solidarity tradition has always served to reconcile seemingly contradictory and competing objectives.

The importance of the neoliberal turn for health policy making seems to lie in its propensity to frame the discussion, to propagate narratives, to provide alternate ways of thinking and talking about health matters and to diffuse benchmark ideas around which policy actors positions themselves in expert and public discussions. The driving force of change, these ideas play a paramount role in the debate over the future of the French health system. Relying on an ambivalent master discourse embracing only a moderate neoliberalism with all the attendant caveats, policy makers have been able to engage in incremental reforms and some structural change provided that they were not perceived as a blatant assault on the welfare state and the most cherished of traditional French values, and more importantly if they were able to be cast as reconciling both liberal and social objectives.
CHAPTER 4 - The French Health Policy Paradigm in Flux: Ideational and Discursive Influences in the Age of Managed Competition and Managed Care

4.1 Introduction

French health politics are complicated by the plethora of actors involved in the fragmented, pluralist health care system. French health politics and decision-making are often criticized for being opaque; many of the stakeholders in the “system” often lament its lack of coherence and organization.\(^{106}\) The system’s opacity is caused by the fragmentation and pluralism in both the organization of its financing and its modes of delivery (both public and private). Moreover, reform politics in France lead to ambiguous compromises based on a myriad of interests, actors and institutions at the confluence of ideas from the public philosophy of republicanism, the traditions of *la médecine libérale*, neoliberal macro-economics, health economics, managerialism and new health paradigms. The result is often a policy mix that is more the result of muddling through than enacting a coherent plan.

Unlike other areas of social protection like retirement or unemployment, health politics is characterized by a large number of variables and actors, a diversity of professional and political subcultures and world views, cleavages within professions and political families, a segmented state riddled with turf wars over health and social matters, and even influential international players like the WHO, OECD and the EU who do not always speak internally with a coherent vision of health policy issues. The French health sector is thus fraught with ambiguity and complexity. In this context, policy layering or institutional conversion are two

\(^{106}\) The term, system, connotes a deliberately integrated organization, which is clearly lacking in the French case. The recent use of the phrase “governance” reflects an attempt on the part of the political and administrative elite to provide the appearance of a modicum of coherence and organization of the system (Hassenteufel and Palier 2005).
plausible avenues of reform as this allows multiple frames and paradigms to coexist at once. While there may be consensus about the existence of a problem or the need for reform, health policy actors rarely settle on a clear-cut dominant paradigm of health governance.\textsuperscript{107}

Most controversies and disputes in health policy discussions involve the intersection of health and economics or political economy, and therefore are often framed as questions regarding individual liberties and collective responsibilities. From its early days, policy battles regarding the French health system underscored the inherent tension between freedom and solidarity.\textsuperscript{108} Historical legislative outcomes often reflected this mediation between forces in defense of freedom and voluntary, contractual arrangements and those advocating greater mandatory social, and even national, solidarity. Although this underlying struggle surfaces during each major reform period, a compromise is usually made in the policy mix by striking a balance between competing, although not necessarily non-negotiable, principles.\textsuperscript{109}

After the end of the Trente glorieuses, the ideational struggle regarding both the health and social insurance systems gradually intensified, ultimately placing into question the basic fundamentals of the post-war policy arrangements—socializing risk through employment-based national health insurance (NHI) and (mostly mutual nonprofit) complementary insurers with health services provided by publicly funded hospitals, private clinics and private fee-for-service ambulatory care. The underlying logic of health care financing and delivery—the basic notions about how to pay for and provide health care—in

\textsuperscript{107} In interviews with doctors, health insurance and hospital administrators, Monneraud (2009) found a widespread awareness of continuously evolving normative frames about what is perceived to be a complex and chaotic French health system and the sentiment of the need to change it. A prevalent attitude among these actors was that it was impossible to identify a coherent, comprehensive vision of the system and that, although reforms appeared inevitable, they were often leading in opposing and conflicting directions.

\textsuperscript{108} As Dutton (2002b) citing Hatzfeld (1989) affirms, “the battle between liberty and obligation was the most evident struggle in the creation of the French and other European welfare states” (5).

\textsuperscript{109} As Dutton (2007) has shown, French doctors’ unions traded some financial autonomy to preserve clinical freedoms and professional autonomy.
France was challenged by new ideas and approaches in a changing France. Never fully realized, the post war model and its stated principles were in flux, carrying implications for the financing, access and provision of health care.\(^{110}\)

In general, changes signaled shifting towards tax-financing via a generalized social levy (la cotisation sociale générale or CSG), strengthening government control and oversight through a national health spending target (l'objectif national des dépenses de l'assurance maladie or ONDAM) and an annual social protection regime financing law (la loi sur le financement de la sécurité sociale or LFSS), means-testing guaranteed minimum of coverage through targeting, (la couverture maladie universelle or CMU), reducing patient freedoms and access through the gatekeeper physician (le médecin traitant) and higher out-of-pocket costs to patients (les restes à charges) and finally restructuring and streamlining of the hospital system.

While actors often lament the lack of organization and cohesion in the French health system, bold comprehensive reform has been difficult to achieve. Instead, governments of Left and Right have mostly taken piecemeal, incremental steps. The 1995-1996 Juppé reforms creating the law for the financing of social protection and the national targets for health insurance spending constituted a major attempt, however unsuccessful, to get control over the finances of the national system of social insurance and spending, with special emphasis on the ambulatory sector. The institution of the CMU and the CMU-C (complementary insurance) in 2000 and the CMU-C subsidy program in 2004 sought to guarantee universality of access to health care. Next, on the provider side, the 2004 Douste-Blazy Law instituted the treating physician (a soft-form of gate-keeping) and the coordinated treatment pathway in an effort to restructure the delivery of ambulatory care. Then, the gradual implementation of a new pricing

\(^{110}\) As Freeman (2000) explains, descriptions of health systems can only be snapshots, for they are dynamic, continually adapting and readapting to the wider political, economic and social systems of which they are a part.
and budgeting system and the 2009 Law on Hospitals, Patients, Health and Territories—possibly the boldest legislation of this period—aimed to reorganize hospitals and better coordinate the delivery of care. Over two decades, there has thus been a building crescendo towards a major adaptation of the French health system.

First, after introducing the basic characteristics of the French health system, this chapter explores the cognitive and normative processes involved in the diffusion and transfer of ideas regarding the governance of health care provision and financing. It emphasizes the role of the international policy community in the transfer of ideas and the processes of acculturation and translation into the local institutional structures and discursive systems of meaning. The growth of an international health policy community, the influence of international organizations, the rise of health economics and the transfer of US policy ideas have all contributed to a new cognitive and normative understanding and framing of health care issues. Finally, this chapter will end with a discussion of broad reform trends in the context of these ideational and discursive processes.

4.2 The French Health System: Origins and Evolution of a Hybrid Policy Paradigm

In the twentieth century, the French health system developed into a hybrid system that socialized most of its costs while maintaining a public/private mix of provision. Often erroneously assumed to be socialized medicine, the French system socializes risk but also has many outright private elements and market features, including a sizeable for-profit

\[111\] France has one of the few systems that combines characteristics of the public-integrated model (within public hospitals), the public-contract model (with the social security funds as public payers) and the private insurance/provider model (with a layer of private complementary insurers, both for-profit and not-for-profit along with private-practice doctors and hospitals) (Docteur and Oxley 2003). These arrangements make for a very complex relationship between the financing and delivery systems.
hospital sector, independent physicians in private practice ensuring most ambulatory care, fee-for-service payment and a long-standing use of cost sharing in the form of coinsurance and copayments borne by patients. While risk has been mostly socialized on the financing side, provision of care has been a complex mix of a national public health care system and a private contractual system. Only public hospitals are wholly owned, controlled and operated by the French state. This pluralist delivery system of public and private hospitals and clinics and private fee-for-service physicians has been strongly influenced by both the concepts of la médecine libérale and the notion of public service. In effect, it has been a system based on a compromise between two competing ideologies – liberal pluralism and egalitarian solidarity, embodying a unique mix of patient and doctor freedoms and the goal of equal access to high quality care.

As the #1 rated health system in 2000 by the World Health Organization, the French system has performed well, with excellent health outcomes, virtually no waiting times, a large supply and choice of providers, high patient satisfaction and quasi-universal coverage. These outcomes are linked to choices made about financing and delivery and the relationship between them. Public insurance mandated by the state has represented a form of national

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112 This system has shared many basic characteristics with arrangements in the United States. U.S. scholars on the French health care system often highlight the commonalities and usefulness of comparison (Dutton 2002a, 2007; Rodwin 1997; Rodwin 2003; Rodwin 2006; Rodwin and Sandier 1993). As in the US system, historically, insurance has been employment-based and derived from employer and employee payroll taxes. Also, many of the principles cherished by people in the US have been integral to the provision of care in France, namely total patient freedom of choice and physicians’ clinical and therapeutic freedoms within system dominated by office-based private practice. On the other hand, the main differences are the heavy reliance on for-profit private insurers and actuarial logic in the United States and the existence of an extensive publicly-funded hospital system in France.

113 In a recent attempt to develop useful topologies of healthcare systems, Wendt (2009) has advocated for combining indicators that would account for the interrelationship between spending, finance, access and provision of care. Through his comparison, Wendt has shown that “access to healthcare is related to levels of expenditure, the public-private mix of healthcare funding, and the density of service providers” (433). He strives to fill a gap in the literature that ignores how modes of governance are linked to financing arrangements, service
solidarity reflecting the national consensus that health care should be considered a public good and not a commodity. Equality and universality have been pursued through socialized financing, generalized access and a network of public hospitals and non-profit private hospitals fulfilling a public service mission.\textsuperscript{114} Liberties have been ensured through the unconstrained choices of both patients and doctors. Two particular aspects—equality of access and free circulation of patients—are often opposed as competing goals in reform debates (Palier 2004).

Following the creation of National Health Insurance (NHI) by the Liberation government in 1945, this hybrid system evolved over several decades and has been based largely on the principles of liberal private-practice medicine and Bismarckian social insurance (originally limited to certain categories of workers). In the late 1940s, health was deemed by the World Health Organization (WHO) to be “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 1946). Conceptions of health were changing; the prosperous \textit{trente glorieuses} allowed for the expansion and extension of health coverage (in theory to the entire population). Logically, new health demands along with the expansion of coverage rapidly occasioned mushrooming health costs. Already by the late 1950s, the political and administrative elite were seeking mechanisms for cost control. Enjoying a broad political legitimacy, de Gaulle imposed binding fee schedules by ministerial decree in 1960, asserting the state’s relative power and its ability to exact concessions from doctors.

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\textsuperscript{114}In French, these are called \textit{les établissements privés à but non lucratif participant au service public hospitalier} (PSPH) established by law in 1971.
By the 1960s and 70s, long before national health insurance was ever fully consolidated, policy discussions revealed the dilemma over competing goals and philosophies and the need to strike a balance between expansion of coverage and extension to the rest of the population and the recurring concern for cost control. Rodwin (1981) attributed spiraling costs to the pursuit of expansion of coverage combined with the *la médecine libérale* asserting that French notions of solidarity (understood as a belief in mutual aid and national cooperation) were inherently incompatible with the liberal-pluralism of both health insurance and modes of delivery. Rodwin predicted the eventual demise of this costly marriage due to the contradiction between unrestrained freedoms enjoyed by physicians while their incomes depended on public funds.

The publication of the *Crise de l'etat-providence* (Rosanvallon 1981) marks a major turning point from thinking only in terms of the legal expansion of social rights to questions about the effectiveness and economic efficiency of social spending. In the 1980s, the French governments decided to confront this “fiscal imperative” which was the central impetus for reform (Wilsford 1991, 1993). 116 Certainly the belief in the existence of a fiscal imperative prompted reform (or at the very least the construct itself was deployed to make the argument to reform). However, these early explanations (Rodwin 1981; Wilsford 1991) are structuralist in that they assume that financial pressures are an objective exogenous shock to the system, repeating the official orthodoxy about the reason for reforms rather than attributing causation to the the ideas and discourse themselves, the way the problem is constructed and the way solutions are constrained by this framing.

115 Although the vast majority of the population was covered by the main general regime, the multiplicity of health insurance funds and varying levels of benefits persisted well into the 2000s.

116 Furthermore, Wilsford argued that the fiscal imperative worked to curb physicians’ influence, power and privilege. However, in France, doctors’ fees had been held down long before the height of fiscal pressures and physicians’ incomes have lately been on the rise.
During this same period, France was governed by the economically liberal Giscard-d’Estaing government. In an ostensible attempt to bring costs under control, Prime Minister Raymond Barre negotiated with the liberal-tiling FMF union for a freeze on physicians’ fees and the creation of Sector 2 wherein doctors could opt out of the conventional fee schedule to practice *dépassements d’honoraires* or top-up billing. Based on assumptions about patient behavior and a belief in the virtues of market incentives, Sector 2 was created as an attempt to dampen demand and to affect the growth rate of health expenditures. Himself a liberal economist, Raymond Barre pursued the objective of higher out-of-pocket expenses as a means of demand-side control which opened the door to more general and widespread cost-shifting (Dutton 2007, 177). After President Mitterrand’s turn to budgetary rigor, the socialist government also pursued health spending control measures (Benamouzig 2005, 300). For many years, the 1984 Beregovoy hospital finance and budgeting reform constituted the only structural change to the system with clearly positive results in stemming the upward trend of expenditures. In contrast to Sector 2, the global budgeting system has been touted as one of the few successful measures having a measurable effect on cost control.

In health care financing, pluralism has been the rule rather than the exception in France, even after the establishment of a national system of social protection including health insurance. Multiple statutory health insurance schemes have persisted alongside the continually growing complementary private health insurance sector, and significant cost sharing directly by patients (Rodwin and Sandler 1993). Complementary insurance, provided by *mutuelles* (mutual aid societies managed by their memberships), non-profit provident institutions (created and managed by employees and employers) or for-profit private

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117 As mentioned above, cost-sharing is not new to the French system. However, the existence of sector 2 created a state-sanctioned mechanism whereby doctor’s could extract more from their patients and thus made cost-shifting more likely. 118 Wilsford (1996) attributes its enactment and success to the conjuncture of the 1983 U-turn and the policy of budget austerity pursued by the Mitterrand government.
insurance cover the coinsurance or copayments incurred for visits with health professionals, pharmaceuticals, hospital stays, dental and optical goods and services. At its inception in 1945, the insurance funds committed to reimburse 80% of doctors’ fees. In 1967, reimbursements levels for ambulatory care were reduced to 70% and have been continually eroded over time. The remaining amount (les restes à charge) must be covered in some way by the patient personally through an out-of-pocket payment or through an additional form of insurance. The complementary insurance market developed in the health insurance sector in order to fill the gaps created by the reductions in coverage by the national insurance funds. While this has prevented rationing based on ability to pay for those who subscribe to complementary coverage, it has also contributed to the inequalities and rationing of sorts for those who do not. While the public share of health care financing peaked at 80.2% in 1980, it steadily declined thereafter stabilizing at around 78% (75.5% for the national health insurance funds) (Commission des comptes de la sécurité sociale 2009). In essence, since the 1980s, successive governments have shifted the burden of controlling health spending onto patients by effectively privatizing parts of health insurance (Pierru 2003).

At €209 billion, total health expenditure was 11% of GDP in 2007. Well above the OECD average of 8.9%, France was second only to the United States whose expenditures reached 16% of GDP. However, spending levels as a portion of GDP seemed to have stabilized at 11% in 2005 (OECD 2009b, 198). The health sector constituted 10% of total employment providing 2.5 million jobs (Fénina, Le Garrec, and Duée 2009, 63). In 2008, 99.9 percent of the population had basic health insurance coverage of the sécurité sociale through the national health insurance (NHI) funds which were financed through both mandatory

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119 The majority of the population is covered by one of the three basic schemes: the Caisse Nationale de l’Assurance Maladie des Travailleurs Salariés (CNAMTS), the Mutualité Sociale Agricole (MSA), and the Régime social des indépendants (RSI). The CNAMTS covers employees in commerce and industry as well as most beneficiaries of the CMU (around 86 %
payroll taxes and the general social tax on all incomes (the CSG); these basic plans covered roughly 75.5% of all health expenditures. The second tier of private top-up (complementary) insurance, with its growing importance in French social protection, accounted for 13.7% of total health care financing. The state and base social security regime also contributed another 1.3% of total financing for complementary coverage of the poor. The remaining 9.4% was financed by households through out-of-pocket user charges (ibid., 20). Around 9 in 10 in the French population benefit from some form of complementary insurance. Most beneficiaries are members of mutuelles which constitute over half of the complementary insurer market. In 2008, 4.2 million people benefited from the CMU-C, the complementary insurance coverage provided to the low income population by the 2000 reform (ibid., 124). The creation of the CMU and the CMU-C was necessary in part because of the cost-shifting to patients that had occurred since the 1980s.

Wilsford (1996) emphasized the state’s autonomy in the health sector and the clear agenda pursued by the Social Affairs and Finance Ministries. Classified as both a state-directed policy network (Rochaix and Wilsford 2005, 102) and as state-directed pluralism, French health governance has incrementally accorded a stronger regulatory and provider role for the state. Through these ministries, the state has two chief responsibilities: the financial stability of the system and ensuring access (Minogiannis 2003, 204). At the national level, the state has overseen negotiation of providers’ fees and drug prices, set payroll and social contribution rates, controlled the planning, finance and operation of public hospitals and regulated the number of pharmacies and medical students.

of the population). The MSA covers farmers and agricultural employees (7.2%). The RSI covers the nonagricultural self-employed (5%). There has been an effort to align coverage levels and to absorb the remaining special regimes into the main funds. In the name of national solidarity, financial shortfalls from smaller funds with shrinking contributing populations are compensated by transfers (subsidies) from other funds. Those who are ineligible for employment-based coverage can benefit from the couverture maladie universelle, administered through the local fund that is part of the CNAMTS network.
While much of the delivery system is public, it is also pluralist and should not be confused with socialized medicine as in countries with a fully integrated national health system (NHS). Hospital care is divided between a combination of public hospitals and private hospitals and clinics. 66% of acute beds are found in publicly-owned hospitals where doctors long held the status of salaried civil servants; the other 34% are in either for-profit private hospitals or clinics (25%) or not-for-profit privately owned establishments (9%) (OECD 2009b, 192). Overseen by the central Health Ministry, the public hospital system, until recently financed through prospective global budgeting based on historic costs, has consisted of a wide range of sizes and levels of specialization, from large regional university medical centers devoted to education and research to small local hospitals. In the private sector, long financed by fee-for-service, hospitals and clinics have tended to specialize in less complicated procedures like outpatient surgeries and obstetrics.

With its strong tradition of *la médecine libérale*, ambulatory care is delivered primarily through private fee-for-service medicine. The roughly 208,000 physicians in France benefit from an almost unparalleled professional autonomy, based on their market monopoly and technical expertise and the principles of *la médecine libérale* affirmed in the 1927 Charter and reaffirmed in subsequent social insurance legislation.\(^\text{120}\) *La médecine libérale* is based in freedoms for both the patient and the physician. The original principles of liberal medicine include 1) patients’ and doctors’ freedom to choose each other, 2) doctor-patient confidentiality, 3) the physician’s therapeutic and clinical freedom and freedom of prescription and 4) direct payment to the physician along with the physician’s freedom to set fees.\(^\text{121}\)

\[^{120}\text{Four of the original principles are still found in the Code de la santé.}\]
\[^{121}\text{Direct personal payment to the doctor was originally conceived as a way to reflect individual responsibility of the patient. It was abandoned in the 1945 ordonnances creating national social insurance.}\]
Over several decades, France built up a large supply of physicians. In 2007, the number of practicing physicians per 1000 was 3.4 (above the OECD average of 3.1). On the other hand, there were significant geographical disparities with physicians (and many specialties) being highly concentrated in urban areas—what is often referred to as the medical demography problem. In 2007, physician density ranged from 122 per 100,000 population in rural areas to 458 per 100,000 in urban areas (ibid., 148). 122,000 physicians were in private-practice, while 86,000 were in salaried positions. Specialists slightly outnumbered general practitioners (1.7:1.6) (ibid., 65). Most physicians in France were party to the national conventions, negotiated by the representatives of the national insurance funds and the medical unions.

The foremost characteristic of the medical profession has been its ideological division and organizational fragmentation (Hassenteufel 1997; Wilsford 1991). Unions are divided geographically, ideologically and professionally. The difference in attitude toward sector 2, for example, reveals both a professional and ideological split between specialists and general practitioners. Opting for sector 2 declined among generalists and increased among specialists throughout the 2000s. While only 11% of GP’s were in Sector 2, 40% of specialists charged above standard fees in 2008 (Fénina, Le Garrec, and Duée 2009). These divisions carry over into the struggles for union representation. The oldest and most prominent union, the CSMF, has long had to deal with competing pressures as it was charged with representing diverse interests and specialties. These competing pressure have not only reflected material interests, but ideological and ideational differences as well. French private-practice physicians’ unions correspond to a distinct political (rather than professional) allegiance. The three main traditional unions have been situated on the political right—the CSMF is considered center-right, the FMF squarely right, the SML far right. MG-France, created in the 1980s, has represented the younger generation of general practitioners who are more inclined to be
center-left (Rochaix and Wilsford 2005). However, as of 2003, only 29% of physicians were members of unions (Sandier et al. 2004). Separate from the unions, the *Ordre des Médecins* acts as a professional association but has no political functions.

In short, the French health system has been characterized by an attachment to social solidarity, an important role for the centralized state, unlimited patient and doctors’ freedoms, particular groups’ rights and privileges and confrontational politics (Sorum 1998). The dichotomy between the liberal practice of medicine and the goals of solidarity have troubled decision-making from the outset and continue to frame policy reform questions. Nevertheless, quasi-universal coverage and access are ensured through a complex multi-layered system of mandated statutory social insurance, voluntary private supplementary insurance and out-of-pocket fees for patients, while care is delivered through a unique hybrid public/private mix of hospital and ambulatory care.

4.3 Ideas and Discourse in Circulation: International Health Policy Diffusion and Transfer

Ideas and discourses concerning health policy matters circulate in both national and international (or transnational) environments. The vehicles (both importer and exporters) of these ideas are individual persons (experts, economists, civil servants) and international organizations such as the World Health Organization (WHO) and the Organization of Economic Cooperation and Development (OECD). Although lacking decision-making functions, international actors weigh in both directly and indirectly in public policy making. In

122 “Elite discourses and policy deliberations cannot be separated from each other along formal organizational lines or levels of policy-making. This is because of the high degree of interaction and interdependency between national bureaucracy and their supranational and international counterparts” (Dostal 2004, 443).
their capacity of producer and diffuser of policy ideas, international organizations propagate the models, instruments and statistics along with the arguments, discourses and rhetoric that lend legitimacy to political decisions at the national level (Hassenteufel and Palier 2001, 29).

With the advent of comparative health policies studies performed and promoted by international organizations and the exchange of ideas leading to policy transfer and diffusion, an epistemic community in health policy has grown stronger in recent decades. The development of an epistemic community, the role of international organizations and the influence of policy transfer often emanating from the United States and in the field of health economics have all participated in the internationalization of the health policy sector and contributed to an ideational convergence around fundamental ways of approaching health issues.

Serré and Pierru (2001) posited the emergence of a new international orthodoxy regarding problems facing health systems and their potential solutions. In an increasingly shared economist view of health, efficiency\(^{123}\) trumped other potential concerns such as the effects of social and economic inequalities on health and unequal access to care. Especially in Europe, a cognitive and normative harmonization (Palier 2000) occurred around the use of market mechanisms and new public management techniques. International organizations played an instrumental role in the diffusion and transfer of shared ideas about necessary health care reforms (Palier 2004).

The approach of the OECD has been decidedly pro-market in its recommendations for member countries. Applying economic rationale to social questions, the OECD produced knowledge and statistical databases used for comparative purposes, tending to frame issues of health reform in terms of economic questions, to the detriment other cognitive and

\(^{123}\) While effectiveness concerns performance and outcomes regardless of costs, efficiency concerns value for money.
normative frames. In short, the OECD was prominent in agenda-setting, producing data to justify policy measures and providing policy frames to national actors. The economist outlook and economic objectives of OECD reports and studies tended to disguise their ideological and political nature and strip health discussions of their social, medical and human elements.\textsuperscript{124}

With regard to health, the neoliberal prescription advanced by OECD publications rested on the diagnosis of a widespread crisis in health care systems. Along with other organizations, the OECD was vital to framing the problem as one of efficiency to be remedied by managed competition and managed care (Serré and Pierru 2001, 111). This organizational discourse,\textsuperscript{125} with strong echoes in the French policy community and public discussions, was predicated on the elementary notion that the rate of growth of health spending should not exceed the rate of growth of a country’s GDP.\textsuperscript{126} The shared policy frame was propagated by government experts, think tanks, politicians, journalists and academics alike.\textsuperscript{127} While in fact a

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\textsuperscript{124} “Organizations create their own knowledge based on the strategically selected issues and aim to disseminate resulting expertise in communication with an organization’s policy environment” (Dostal 2004, 445). Dostal hints at the surreptitious nature of the seemingly non-ideological, objective data presented in OECD and World Bank reports. While these organizations are purported to merely observe objective reality, in fact, the objectification of these data and statistical indicators feeds into the political construction of both problems and solutions (Serré and Pierru 2001) and they often hold a monopoly in statistics collection and production (Hassenteufel and Palier 2001). Scientism and objectification make their assertions appear to be completely without bias. Furthermore, these rationalist technical observations confine the discussion to those matters that have been quantified in OECD databases. \\
\textsuperscript{125} For more on organizational discourse, see Dostal (2004) \\
\textsuperscript{126} Health policy discourse was long influenced by the postulation that a country’s health spending to GDP ratio should not exceed a certain (although undetermined) level based mostly on statistical comparisons and averages. As Serré and Pierru (2001, 113) infer, this approach has transformed averages into norms and supposed immutable economic laws. These simplistic quantifications and assumptions propagated in the policy community are an act of dissimulation that conceals their underlying political nature. \\
\textsuperscript{127} Spanning several decades, the majority of health policy discussions emphasized the fact that the rate of growth of health spending (overall or public) outstrips the rate of growth of GDP (Brunhes 2003; Colombo and Morgan 2006; Docteur and Oxley 2003; Kervasdoué and Rodwin 1984; OECD 2009a; Oxley and MacFarlan 1995; Rochaix and Wilsford 2005). A typical statement might be “health spending has progressed more rapidly than economic
debatable normative assumption, this cognitive short-cut was constructed by the organizational and “expert” discourse in such a way that it became a taken-for-granted, self-evident and uncontested assertion. Beginning in the 1980s, this organizational and international policy community discourse encouraged governments to concentrate essentially on the need for health spending controls as the guiding objective of reforms. Because spending controls alone would be mere rationing without the quest for more efficient allocation of health resources, seeking “better value for money” became the answer to holding down spending as a portion of GDP.

Additionally, mostly in the cognitive and normative background, there is a mutually reinforcing link between market approaches and biomedicine. In general, modern Western medicine has been dominated by the biomedical paradigm in health (Lewis 2000, 7), providing the deep structure foundational ideas underpinning the French approach to medicine as well. In the search for efficiency in health provision, health economics is the dominant paradigm behind health services research conceived as a remedy to the perceived cost crisis in the US and European health care systems. In effect, economism and scientism are two

activity” [translated from (Colombo and Morgan 2006, 19)] with the implied assumption that health services are not in themselves a productive activity.

Biomedical conceptions accord a dominant status to the medical profession and favor curative approaches placing emphasis on individuals –both the patient and the doctor, in contrast to social and cultural conceptions of health. Frankford (1994) asserted that health services research strengthens the biomedical bias and the dependence on scientism and advancing technology. Having evolved from a sort of cottage industry, biomedicine has also placed the hospital and the specialist at the center of the system (Kervasdoué and Rodwin 1984, 7).

The field of health economics starts from the premise of the imperfections of the health care market and is often concerned with ways of correcting these imperfections through public intervention or regulation in order to facilitate the better allocation of resources (Smith 2009). The three most often cited problems in health economics theory are 1) information asymmetry leading to failures such as supplier induced demand and no real competition between providers, 2) adverse selection leading to cream skimming patients and an incentive to offer low quality care, and 3) moral hazard leading to overconsumption by patients.
side of the same positivist coin. The vocabulary of economism limits ways of thinking and speaking about health issues, expressing them in terms of competition, efficiency and optimization. Furthermore, in a cognitive sense, the quest for efficiency feeds directly into the notion of evidence-based medicine, both further reinforced by new public management techniques applied to health. While cultivating a purposefully ambiguous attitude, the OECD has in effect been diffusing rhetoric in favor of managed competition and managed care.

With the emergence of public management techniques, private market logic can be integrated into state behavior in collectively financed systems, leaving the curative biomedical approach and economism intact.

A rather broad international consensus emerged around the belief that well-managed competition offered solutions to problems of both efficiency and equity. Managed competition was presented as a compromise middle ground aiming to reconcile the inefficiencies of total public sector provision and the failures of the unregulated health market. To address fiscal imperatives, managerial techniques sought efficiencies through

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130 Economism refers to the belief that the health care cost crisis is due to the advance of technology, population ageing, rising expectations and economic stagnation and can be resolved by a positivist economic approach to health services research. Scientism refers to a purely positivist perceptions of problems and solutions wherein “reality” consists only of phenomena that can be quantified and measured” (Frankford 1994, 774). In other words, if researchers simply set their minds and resources to studying, quantifying and documenting the science of health services and outcomes, they can determine the efficient allocation of resources.

131 While some OECD publications have professed solidarity and equity concerns, they are usually an afterthought (Oxley and MacFarlan 1995; OECD 2009a). Smith (2009) subtly warns that markets and competition can compromise solidarity objectives without careful management.

132 On the history and ideas in managed competition, see Enthoven (1993).

133 Donald Light raised the question of why there was “a growing chorus that competition would rein in the rising cost of medicine” in the face of overwhelming contradictions—the acknowledgement by fundamental health economics that health markets depart dramatically from the pure neoclassical model and that competition tends to spur growth (and not to contain it). He concluded that the belief in competition was for its political appeal. “Competition policy as an ideology or myth, provided an account of both why health care costs were rising and
better allocation of resources and introduced notions such as medical evaluation and evidence-based medicine, both tools of corporate management in health. While managerial practices have challenged the preeminence of the medical profession, they left intact the biomedical paradigm. “The penetration of a private businesslike management style into health care—which may be termed cultural privatization—is not confined to health insurance, but can be observed in many areas of health care” (Maarse 2006, 1001). Doctors, just as hospital administrators, learn to take up corporate management styles.

Trade in health policy ideas has often led to controversy. Alain Enthoven, considered the godfather of managed competition himself admonished that managed competition should not be conflated with free markets and deregulation. Managed competition does not create markets per se, but attempts to construct market-type mechanisms (Smith 2009). However, according to Enthoven, managed competition must be carefully implemented in its entirety as an integrated framework for it to work as intended. He stated clearly it is “not the latest buzzword that anybody should feel free to appropriate,” nor “a grab bag of ideas that sound good” (Enthoven 1993, 45). Marmor (1994) also warned against the rapid trade of ideas in health care such as market models and managed competition exported to Europe from the United States, because this often propagates many myths and misinterpretations.

Nevertheless, managed competition, along with managed care, did become a policy grab bag or sorts. Despite Enthoven’s caveat, managed competition, became a catchall health policy credo that could reconcile opposing objectives, i.e. efficiency and equity, quality and solidarity, in a similar fashion to the malleable use of the idea of the “market” in the European

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134 Managed competition, according to Enthoven (1993, 25), is “a purchasing strategy to obtain maximum value for money for employers and consumer” derived from microeconomic principles to ensure competition between integrated financing and delivery plans.

135 For example, managed care allows insurers to selectively contract with providers, in theory getting more competition, cost-efficiencies and quality improvement out of providers.
Union (Jabko 2006). The ambiguous and contradictory aspects of ideas contained in the doctrine of managed competition gave it a malleability and flexibility permitting it to assume different forms in different settings. Managed competition contains a fundamental paradox in the elemental claim that both governments and markets are inherently inefficient and, therefore, that strong regulation is necessary for competition to thrive successfully. Benefiting from the spread of the principles of managed competition, competition of any kind (not necessarily part of an integrated coherent systemic approach) was glorified and encouraged in the health policy community—whether between insurers, large purchasers or providers.

At the same time, alternative minority paradigms have also been part of the global health conversation and compete with the neoliberal/biomedical tandem, some based on primary care and others on the notion of public health. However, as Lewis (2000) explains, when public health ideas have been ostensibly embraced, they were merely co-opted by the underlying biomedical structure, failing to reorient health delivery systems toward a broader social conception of health. Coming from a more public health perspective, the WHO’s main stated objective is to promote health rights for all based on the principles of solidarity and equity. Yet, the oft-cited 2000 ranking by the WHO relied on cost-effectiveness and performance indicators signaling a shift in approach (Serré and Pierru 2001, 111) and leading some to conclude that even the WHO has succumbed to the pressure coming from other

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136 The WHO Alma Ata Report of 1978 challenged the hospital-centric biological model of health care by promoting primary health care “based on not only medical, but also social interventions governed by the communities and by the citizenry” (Navarro 2008, 152). The 1986 WHO International Conference on Health Promotion was held in anticipation of a growing new public health movement around the world; it produced the Ottawa Charter for Health Promotion, building upon earlier progress at the Alma Ata Conference and advocating the moral imperatives for equity in health.

137 Whereas the old public health paradigm was concerned about the population as a whole and such issues as the spread of disease and the safety of food and water, the new public health model addressed the “social structuring of health” (Lewis 2000, 155) according a large role for community, social structures and social cohesion as the rudiment of public health.
organizations to integrate economic preoccupations into its universalist “health-for-all”
advocacy (Pierru 2003).  

Neoliberal or market-based policy paradigms in health have promoted competition to
dilate and manage supply and demand and contain costs. In the neoliberal paradigm,
patients become consumers, clients or users. According to Navarro (2008), US world
dominance along with its neoliberal ideology stifled the development of alternative health
paradigms to the benefit of the dominant classes in both advanced and developing
economies. Neoliberalism (closely linked to what Frankford terms economism) in the health
sector can be associated with a decline in public expenditures as a percentage of total health
expenditures (THE), privatization of health care financing and provision, individualizing health
care financing through increased user charges, the decline of public health care
infrastructures and the development of commercial health insurance, the brain drain of health
care professionals from developing to developed countries, and the ascent of the
biotechnology industry (ibid.).

Even among market enthusiasts, at the crux of the debate is also the question of
whether health care is a burden on the economy or whether “health is wealth” (Unger 2004).  
In contrast to the organizational and public discourse of the 1980s and 1990s, health also
contributes to economic growth (European Communities 2005), and an alternative is to frame
health as an investment in society.  

From a different perspective, albeit still expressed in the

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138 For a thorough history of the evolution towards a more economic approach at the World
Health Organization, see Pierru (2003). Dostal (2004) would qualify the WHO’s shift as a part
of a strategy to wrest discursive control over its area of expertise away from the OECD.
139 Earlier in 2001, the WHO Commission of Macroeconomics and Health took a new stance
on health as a potentially key determinant of economic development and poverty reduction, in
an effort to examine health as not only the result of economic development but also the
inverse.
140 As “an indispensable factor of wealth creation” (Unger 2004), health is an input for the rest
of economy, creates jobs in a productive labor-intensive growth sector and enhances
well-being and quality of life for the population.
language of economism, good health favors earnings and employment. In opposition to the social burden argument, this reframing (reminiscent of Keynes) holds that good health correlates positively with growth and competitiveness and that the two are mutually reinforcing. In effect, until the 2000s on the international level, health was viewed merely as a by-product of and not an input to or investment in economic growth and prosperity.

Yet, the Unger report also suggested transforming health care into a patient-centered European market through a greater allocation of resources based on evidence and efficacy. The 21st century strategy aimed to guarantee a universal minimum of health coverage141 as a basic right combined with a greater role for the market, recognizing both collective and individual responsibilities. Regarding financing, it was foreseen that the private sector should take on a larger role, that future co-payments would be unavoidable, and that public insurance based on solidarity should be redefined (Unger 2004).142 Even in an attempt to put health within a new frame, a rationalist market-oriented mindset permeates these reflections on health spending as an investment. In essence, while espousing the belief in health as a basic human right, the EU report authors create ambiguity and speak the language of health as a productive factor input and a commodity, preparing for greater financial participation by individuals in systems with diminishing solidarity.

Nonetheless, these new approaches are still mainly reframing the economic argument with a view to showing that an investment in health as human capital serves the market economy. While this argument can be employed to counter the cost-control/fiscal imperative meme, the concern and the framing remains economist. Health as human capital

141 This is called the Guaranteed Healthcare Package (GHCP). Elsewhere others have advocated for a statutory basic benefits package.
142 At the same time, this attitude is based on the conventional wisdom about the impending demographic and fiscal crisis. The argument is as follows: public financing has limits, especially with a shrinking workforce. Therefore, publicly provided benefits packages must be redefined in order to reduce spending, leaving additional costs to be covered by the private sector (Unger 2004).
recasts cost-effective health care as an investment and specifies ill-health as an economic burden, not only because of health care costs but also foregone productivity and income due to ill-health. In the health as human capital frame, good health produces a virtuous cycle of labor productivity, long work life, greater savings and investment, lower health care costs in the latter years and shorter length of dependency in old-age.\textsuperscript{143}

In all of these instances, economism and market ideology permeate health care narratives and frame the discussion despite the tentative integration of ideas from other paradigms as well. Market mechanisms and competition become bywords to justify many types of health care reforms. As broad and ambiguous concepts, they do not represent the application of a coherent, consistent paradigm, but rather adaptive strategies (often following trends and fads) to frame and reframe policy agendas. A review of the discourse emanating from the international health policy community with reverberations in France points to an ideational and discursive convergence towards three general trends: decreased public financing and cost control through market mechanisms and partial privatization, a minimum of solidarity with a basic benefits package to be guaranteed by the state, and other additional layers of financing and provision left to private markets.\textsuperscript{144}

4.4 Ideas in Translation: A Gradual Acculturation to an Economic View of Health

Ideas—whether models or policy instruments—do not simply diffuse or transfer from one country to another or from international forums into national contexts. They translate into a

\textsuperscript{143} These were the first works on the impact of health on the economy advocating cost-effective investments in health promotion. Investment in preventive health can also be construed as the answer to the “demographic problem” of ageing.

\textsuperscript{144} On trends in Europe, Maarse (2006) drew similar conclusions. In health care financing, the public sector would remain primary but the fraction covered by the private sector is likely to grow. In provision, further privatization was also likely especially in countries with social insurance like France and Germany where existing private provision does not pose a threat to universal access.
local culture (Kjaer and Pedersen 2001) and undergo reinterpretation and reappropriation by
the importing country resulting in unique hybrid ideational and policy mixes (Hassenteufel and
Palier 2001). While broad principles are diffused, transferred and integrated, their translation
leads to diverse policy mixes in the name of the same principles. Market mechanisms,
liberalization, competition—all translate into different incarnations in different countries. Just
as with macroeconomics, health policy ideas have come to France through direct export and
import by individuals such as academics, researchers, and civil servants or through a more
indirect cognitive and normative accommodation and eventual acculturation.

The OECD’s influence in France is also exerted via its links to the European
Union—links that have been strengthened, leading to collaborative efforts under the auspices
of the OECD Health Committee and the European Commission’s Open Method of
Co-ordination (OMC) on Social Protection and Social Inclusion.\(^{145}\) Focused on the perennial
financing problem and the increasing pressure on public sector budgets, “member countries
have emphasized the need for achieving better value for money in health systems as one
means of offsetting some of the fiscal stress” (OECD 2009a, 3). The idea is that better
performance and functioning of health care systems—in a word, efficiency gains—are the
panacea to rising public sector costs.

Consequently, three main trends have been identified in comparative studies of
OECD health system reforms: universality of coverage, introduction of market-mechanisms
and the use of managed care techniques by both private and public regulators (Grignon 2009).

The vision for the European Health Care Market espoused by the report to the EU parliament

\(^{145}\) In 2008, bringing together policy-makers and experts from member countries as well as
OECD and EU officials, the two organizations jointly sponsored the conference entitled
harmonization (cognitive and normative) of policies through the emulation of other countries’
practices is encouraged through the Open Method of Coordination (OMC). As part of this
process, a joint report on social protection and social exclusion as well as member state
reports are published on a regular basis.
emphasized universality, evidence and effectiveness-based medicine and the need for cost
control (Unger 2004). Minogiannis (2003) found an ideological convergence around a more
efficient use of limited health care resources, more disciplined public financing and the
maintenance of social solidarity. Because of the macroeconomic model that was adopted by
the European Union, member states have had to confront similar problems and challenges to
their systems of social protection and health provision. Soft policy harmonization has occurred
more as a spillover effect from economic and monetary integration rather than any binding
decision made at the European level. While member states remain in charge of social
protection, this policy convergence can be seen as a form of cognitive and normative
integration whereby thinking is harmonized through sharing and exchange of ideas and
experience.

In a similar finding, studying trends towards privatization in eight European countries,
Maarse (2006) identified changes in policy preferences—namely a turn to neoliberal ideas and
new public management—and budgetary strain as the main factors in policy-driven
privatization of health care. Arguments in favor of cost-sharing to improve efficiency and
enhance individual responsibility and restricting the basket of publicly funded health services
are predicated on the neoliberal philosophy about the appropriate roles of the individual and
the state in health care. In effect, a mild form of libertarian-style neoliberalism as a
philosophical stance dovetailed with the need to rationalize health care provision in the hopes
of easing fiscal strains on public budgets.

France may be slow to change (at least in public perceptions), but it is changing
nonetheless under the watchful eye of the OECD. 146 As the French health system encourages
overconsumption and over-prescription because reimbursement rates are high, the OECD

146 “French governments have, though with some delay, incrementally implemented reforms
that reflect the logic of OECD policy recommendations” (Serré and Palier 2004, 104).
maintained, reforms should use incentives to modify the microeconomic behavior of both patients and providers and hence to improve resource allocation (OECD 2000, 2009c).

Suggestions, drawn from the microeconomic principles from managed care and managed competition, include a guaranteed minimum basket of goods and care, limits on access to specialists, new governance and price mechanisms in the hospital sector and regional agencies as purchasers (OECD 2000). Other OECD health policy recommendations for France have included changing the physician payment system away from fee-for-service, introducing evaluations, medical guidelines and budgetary constraints with sanctions, and strengthening competition between medical suppliers and insurers (Serré and Palier 2004, 105). In the mid to late 2000s, French health sector reforms began to move, however gingerly, in this direction with the introduction for example of the treating physician, a new form of physician payment (the CAPI), the T2A pricing system in the hospital sector, and the creation of regional health agencies.

These recommendations must be placed in the context of overarching “neoliberal” macroeconomic objectives to reduce the size of public expenditures in the economy and to ease constraints on the labor market. A common refrain heard in French public political discourse is that “heavy social charges are detrimental to innovation and business growth” (OECD 2009c, 13). Linkages are often drawn between taxation, social expenditures and improving the functioning of the labor market (OECD 2005; Leibfritz and O’Brien 2005).

The OECD has made repeated recommendations that France reduce its cost of labor. One of the policies pursued in France advocated by the OECD is the reduction of employers’ social contributions or payroll taxes (OCDE 2007; OECD 2009c), and especially low-wage work (Leibfritz and O’Brien 2005). Having acknowledged that the French government had

\[147\] Many of these suggestions have materialized in recent reforms discussed in chapters 5 and 6.
undertaken many of the structural reform recommendations made in the previous 2007 survey, the OECD encouraged France to continue along this path and also recommended the reduction of corporate and business taxes in the name of mitigating the negative effects of the fiscal system on the economy and making it more efficient (Leibfritz and O’Brien 2005, 38; OECD 2009c, 87). Eventually, analytical frames, arguments and economic policy paradigms found in reports circulated by international organizations make their way more or less into French health reform policies and politics (Serré and Pierru 2001, 122).

For all the appearance of immobility of institutions and resistance to “Anglosaxon” ways of thinking, the terrain in France has been more fertile than once expected for the adaptation of imported ideas, owing to evolutions in the field of health economics and within the high civil service. The development of health economics as an academic discipline in France in the late 1970s and 1980s eventually led to the politicization of economic ideas in the health sector and economic expertise began to supplant legal and medical expertise in health policy making (Serré 2002). Ideas being circulated in the health policy community received a welcome reception from some prominent groups in the field of health economics in France, which achieved autonomy from state institutions by the 1980s around the same time as the revival of neoliberal economics (Benamouzig 2005; Serré 2002). Together with the rise of health economics, the development of national health statistics and accounting allowed a new economic reasoning to be applied to health and crystallized the conception of health in terms of costs (Serré 1999, 2002). The growth of these professions coincided with the government’s pursuit of budget austerity giving currency to the expertise of the new health economists.

Many leading health economists received part of their education abroad and cultivated strong relationships with their US counterparts. In particular, Robert Launois adapted managed competition ideas and developed a project for France called the réseaux des soins coordonnés (RSC)—coordinated care networks. Launois invited Alain Enthoven to
France where he had contacts with neoliberal economists, think tanks and politicians. Inspired by his work, Launois and others including the US health policy expert, Victor Rodwin, advocated a system of prepaid coordinated care networks similar to HMOs in the US (Launois et al. 1985). Although French national health insurance would remain untouched, the main premise was that competition between provider networks was the solution to organization and financing problems, because it would promote supply-side efficiencies. This version of managed competition (like US HMOs) would have introduced an element of payer’s control over doctors who were resolutely opposed to it, essentially pitting ideas from neoliberal economics against the liberal practice of medicine.

Other ideas floated since the 1980s included the deregulation and privatization of the social insurance system. At the time that liberal economists like Robert Launois, Jean-Jacques Rosa or Michel Mougeot were proposing market mechanisms for the French health system, experts from the Institut national de la santé et de la recherché médicale (INSERM) mobilized in favor of medical evaluation, a French concept similar to evidence-based medicine. More left-leaning economists preferred a medical evaluation approach using economic instruments to help regulate doctors’ activities. While Launois’ project was abandoned after its failure to gain political traction in the 1980s, the seeds had been planted. The emphasis on market competition and efficiency as a means of regulation

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148 A decade later, Rodwin (1996) continued to promote managed care experiments à la USA and criticized the Juppé reform for its state-centrism.
149 An often overlooked and misunderstood irony is that, despite all of the market justifications for managed care arrangements, US HMO and PPOs are more controlled and “socialized” than systems under social health insurance like France or Germany.
150 Pierru (2007) identifies two opposing liberalisms in the health care debate—neoliberal economics and liberalism in medical practice. Effectively this opposition sets efficiency against efficaciousness. In neoliberal economics, the guiding principles is the efficient allocation of resources in which market actors seek utility maximization, whereas the liberal practice of medicine aims to maximize the health of the patient without regard to cost.
151 Claude Bebèar, president of AXA insurance, proposed contracting out national health insurance to private insurers in care networks with strict regulation by the state which would guarantee uniform premiums and forbid risk selection (Lhaik 1998).
would resurface in subsequent policy debates. Most importantly, economic reasoning began to acquire a cognitive autonomy and penetrated the health policy arena—professionally, cognitively and institutionally (Benamouzig 2005). Thereafter, actors, ideas and institutions assimilated this newfound economic conception of the French health system.

At around the same time, another set of ideas from managerialism was also exerting its influence over policy makers. In 1983, a Mitterrand appointee and Director of Hospitals, Jean de Kervasdoué, instituted a prospective financing system of global budgeting for hospital services based on the Diagnosis Related Groups (DRGs) used in the United States. De Kervasdoué has been an important actor in the French health policy community since the 1970s. In 1980, he co-edited with Victor Rodwin and others the proceedings of a conference on the need for health care rationing. Having studied in the US himself at Cornell University, Kervasdoué imported the ideas he had acquired following the work of Robert Fetter and John Thompson at Yale University. A supporter of Fetter’s case mix approach to financing, de Kervasdoué also launched the *Programme de Médicalisation des Systèmes Informatique* (PMSI) which laid the groundwork over two decades for the French version of the DRG system—the *Groupes homogènes de maladies* (GHM), and later the *tarification à l’activité* (T2A), case-based pricing for hospitals.

The original managed competition debate is only one of many examples of the cognitive and normative influence and specific policy ideas flowing from the US to France. Rodwin (1997) explored the lessons to be learned in the French health context from the US managed care experience—to contain costs, improve performance and coordinate services. The US HMO movement was the leader in health micromanagement through such techniques as the DRG hospital case mix and evaluative measure of physician procedures and performance. In the 1990s, many new principles and initiatives were adopted in France including the notion of *la maîtrise médicalisée des dépenses*—the medical control of...
costs—always juxtaposed with *la maitrise comptable des dépenses*—the budgetary control of costs. A soft form of managed care particular to France, the medical control of costs, much like the concept of medical evaluation was meant to reconcile economic, social and medical imperatives (Serré 1999, 64). It was thought to be a way to optimize rather than limit spending based on medical criteria.

Another example in the 2000s, Denise Silber (2007), an American health policy consultant and researcher living in France, examined the reform of the US Veteran’s Administration as a successful case study germane to French reform policy discussions. In the note published by the Institut Montaigne, the VA study was showcased as an example of a surprisingly effective reform of a public health system rooted in evidence-based medicine and better management and coordination of care. Those aspects cited with relevance to concurrent French reform debates include:

- public health objectives
- evaluation of medical procedures
- computerization of medical files
- coordination of hospital and ambulatory care
- accreditation procedures
- creation of integrated health clinics
- regionalized integrated health networks
- contractualization with health care professionals.

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152 The Institut Montaigne is a French think-tank founded by Claude Bébear, the former CEO of AXA, a large multinational insurance company based in France.

153 The basic strategy of the VA reform was to create regionalized integrated networks to coordinate between hospitals within a region and to shift part of care to the ambulatory sector. Ambulatory care for the veterans is practiced in multi-floored health centers much like those proposed in France complete with medical and radiology labs (Silber 2007, 47). Much of the success has been attributed to the computerization of medical records and the use of bar coding. Silber suggested that the French, who had made several abortive attempts to institute a personal medical file in France in the 2000s, send a mission to the Veteran’s Administration in the US. In September 2009, Ken Kizer, the architect of the VA reform was invited by Silber to address the First Convention on Health Analysis and Management in France attended by many in the French health policy making elite.
Essentially, the VA reform introduced both integrated health networks managed at the regional level and community-based clinics designed to provide one-stop ambulatory care. The 2009 HPST law encouraged the development of similar types of integrated group health care establishments in France to be overseen by the new regional health agencies.

From this discussion and these examples emerge cognitive and normative parallels, an ideational convergence around efficiency concerns and potential policy solutions from managed competition, managed care and evidence-based medicine—all part of international and transnational ideational and discursive exchanges. While there is often strong resistance to the open embrace of foreign ideas or to the wholesale adoption of managed competition or managed care as solutions applicable to France, there is ample evidence of ideational exchange, diffusion and translation. There are signs of a gradual acculturation to new ideas rooted in an economic view of health with both paradigmatic and policy ideas being translated into the local system of discursive meaning and adapted to existing institutions.

4.5 Health Policy Reform Discourse: The Influence of Neoliberalism, Managed Competition and Managed Care

In the French health sector, incremental evolution is the normal condition (Rochaix and Wilsford 2005), punctuated by moments of perceived crisis and bolder structural change.\textsuperscript{154} In times of major structural change, health care reform is placed higher on the political agenda.\textsuperscript{155} The state bureaucracy makes policy by default in normal times while a more partisan and publicly visible decision-making process kicks in when health policy issues strike harder at deep core ideas (Minogiannis 2003, 203). Since the Juppé government began

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{154} Change in punctuated evolution is mostly incremental and intermittently more substantial.
\item \textsuperscript{155} For a brief historical account of the major legislative achievements and reforms prior to 1980s see Kervasdoué, Rodwin and Stephan (1984).
\end{itemize}
\end{footnotesize}
exploring reform options in the mid-1990s, change has been more explicitly placed on the policy agenda. Since that time, the need for more comprehensive structural reform has been more vigorously debated among experts and more openly in the public dialogue. The social construction of the need to reform helps political leaders to avoid protest movements. “If the population perceives reform as ‘unavoidable,’ due to the activation of shared symbols and discursive frames, then attempts to mobilize against it may be regarded as futile—even illegitimate” (Béland and Marier 2006). During the 1990s and 2000s, the health care reform debate revolved around the perennial financial crisis of the base regime of the general fund (the famous trou de la sécu), the demographic pressures of ageing and the effects of the non-wage costs of labor on competiveness as justification for the need to control costs and regulate care provision.

For over three decades, France has been grappling with the perception of crisis due to spiraling health care costs (Boyer 2002; Jemiai 2004; Rosanvallon 1981, 1995; Singerman 2000; Wilsford 1991, 1993). The rhetoric of crisis, coupled with the pressures to meet the Maastricht criteria, dominated debates in the 1990s, a time when politicians, civil servants, health economists and health professionals began to publicly criticize the French health system and to speak openly about crisis setting the stage for change (Pierru 2003). Many reforms were motivated by the desire to align the health system with macro-economic policy; budgetary orthodoxy and policy options were dictated by the objectives of European integration (Palier 2004). The need for reform was constructed mostly through crisis rhetoric using benchmark notions like the “trou de la sécu” (the budget deficit) and the looming “papy-boom” (the grandpa boom) – evoking the ageing population and an impending

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156 According to Frankford (1994), this perception of crisis derives from the inextricable links between scientism and economism and beliefs about the health care economy.  
157 As discussed in chapter 2, French health politics have been characterized mostly by path dependency (Wilsford 1994, 1996) and consequently by suboptimal arrangements (ibid.) that were difficult to change.
demographic crisis. Health reform laws were often enacted in response to what were perceived to be crisis situations (Tabuteau 2006b, 2009). However, crises can either be acute events like the 2003 heat wave or ongoing problems like chronic budget deficits. Thus, the health policy process has tended to be layered and fragmented, a slow steady evolution interrupted by major episodes of structural reform occurring every four or five years.

Normative and cognitive elements often evolve over time in a way that eventually leads to institutional change. "While the formal aspects of institutional change may occur abruptly, the informal aspects, notably the cultural-cognitive and normative ones, are more gradual and tend to come first" (Campbell 2004, 57). In France, many of the ideational and discursive processes affecting policy in the 1990s and 2000s can be traced back to the earlier beginnings of a neoliberal ideational shift from the 1970s and 1980s and a gradual acculturation to new ideas in health care management. As a major conceptual change, the use of market measures to influence patient behavior set a precedent for openly using cost-sharing to not only make patients participate in the cost of care but also to curb demand (as higher fees in sector 2 would hopefully deter some patients). The neoliberal worldview more easily tolerates a duality in the delivery system, what the French call la médecine à deux vitesses, in which some have access to better care by virtue of their ability and willingness to pay more. While Sector 2 has done little to curtail demand or to bend the cost curve in ambulatory care, it has raised serious questions about equality of access to care.

Nevertheless, aside from the global budgeting in the hospital sector, most policies up to the 1980s were demand-side measures. Conversely, the 1990s marked a shift toward much more state involvement in the governance and provision of health care—alternatively referred to as the regulatory health care state (Hassenteufel and Palier 2008) or state-led managed

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158 The spate of deaths caused by the 2003 heat wave in France prompted the 2004 Public Health Policy Law. The 2004 Douste-Blazy Law on Health Insurance Reform was a response to the perceived financial crisis.
care (Rodwin 2003; Rodwin and Le Pen 2004). In the early 1990s, the notion of a global budget for all of the health insurance funds was introduced and the 1996 Juppé reform tried to establish an enforceable mechanism for prospective budgeting in the recalcitrant ambulatory sector. Later, the Douste-Blazy reform brought the three major insurance funds into a national union to assert better control over national spending targets.

Didier Tabuteau (2006b) contributed to the development of the notion of public health and health security and fought for the establishment of new agencies to deal with these matters. In the late 1980s, Health Minister Claude Evin established the National Agency for the Development of Medical Evaluation in a move towards evidence-based medicine. In the 1990s, the benchmark notion of medical utility was introduced and later invoked often to remove pharmaceuticals from the list of drugs reimbursed by insurance funds. With the emergence of evidence-based medicine and managed care techniques, the debate over cost containment began to contrast cost-accounting controls like global national spending caps versus medical control of costs using medical evaluation and performance objectives (la maîtrise comptable v. la maîtrise médicalisée).

Quality of care—a new watchword in the health policy community—thus soon came to be a focal concern for the state in France. Through quality control and evaluation measures, a managerial approach was initiated in the early 1990s to improve efficiency and eventually even competition between hospitals (Hassenteufel and Palier 2008). The 1993 Teulade Law established national medical guidelines for the first time in France, official standard practice protocols called références médicales opposables (RMOs). Physicians and health funds agreed on clinical guidelines that were to be followed in everyday practice. While no extensive system of control was put in place, this was significant in that it was the first time negotiations concerned quality of care and not merely financial questions (Saltman, Busse, and Figueras 2004, 64). This was the first instance of medical principles introduced into regulation of the
ambulatory sector. Also, a flurry of new agencies to better oversee the health of the French population surfaced throughout the 1990s and 2000s.\(^{159}\)

Furthermore, changes took place with regard to the institutional structures of management and organization of care. Regionalization also began in the 1990s with the advent of regional hospital agencies and regional strategic health plans to manage hospital supply and capacity, the regional union of private practice physicians with a view to better coordination with office-based practice, and the grouping of local funds into regional health insurance fund unions (Sandier et al. 2004). The 2004 treating physician and coordinated treatment pathways were designed to eliminate waste and doctor shopping and to introduce the notion of coordinated care into a system still based on the solo-practice independent physician. The Plan 2007 adopted in 2003 was to phase in the T2A payment-by-case to both public and private hospital financing. This market-type mechanism was intended to take into account hospital and department performance and to make them more efficient, as was the 2009 HPST reform giving further oversight, management and coordination functions to newly expanded regional health agencies.

4.6 Conclusion

As part of an international and European ideational convergence, the neoliberal paradigm and economic view of health has become pervasive in France, putting in question

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\(^{159}\) These agencies include: in 1990, the National Agency for the Development of Medical Evaluation; in 1991, the High Committee on Public Health; in 1993, a new Drug Agency. In 1996, the National Agency for the Development of Evaluation became the National Accrediting and Evaluation Agency which was subsumed into the High Authority on Health in 2004 broadening the reach of the state into quality control of health products, establishments and practitioners. In 1998, the Drug Agency became the French Agency for the Safety of Health Products. In 2001, the Agency for Environmental Health Safety was instituted (similar to the US Environmental Protection Agency).
some of the basic principles of employment-based social insurance and a loosely-associated public/private delivery system. Ideational and discursive challenges to the existing health policy paradigm derive from both within and without. Neoliberal views, albeit a minority, are not foreign to France, but the process of acculturation to new ideas has occurred through many international policy influences—the development of an international health policy community, the discursive practices of international organizations and the transfer of policy ideas emanating from the US health policy community with strong links to French health policy experts. Combined with the emergence of health economics as an autonomous field in France, these ideational and discursive processes have contributed to a cognitive and normative shift and the adoption of a widespread economic view and framing of health care.

As part of the construction of this view of health, efficiency and economic frames become commonplace and part of the conventional wisdom, the obvious example being the frame of health as a share of GDP. This economic view also goes hand in hand with scientific, rational curative biomedical approaches that have given rise to notions such as evidence-based medicine. In particular, managed competition and managed care ideas were propagated as a solution to fiscal crises and quality objectives. The doctrine of managed competition contained many ambiguous and even contradictory ideas that were conceived as the remedy for both inefficiencies and inequities.

In many ways, these developments reflect how managed competition has become a grab-bag from which policy entrepreneurs could pluck policy ideas and translate them into a unique environment, giving them a local flavor. Translating them into the local setting, policy makers conduct a *bricolage* to forge policies consistent with the underlying value frames in society, be they solidarist and universalist or freedom-claiming and individualist. In France, policy frames have always oscillated between these two poles.
Neoliberalism and the market-based paradigm, managed competition and managed care have all become part of the health care conversation in France and have influenced policy making in the 1990s and 2000s. Economism and market ideology have permeated many health care narratives and frames justifying major reforms affecting the governance of health care finance and delivery. Often passed with the neoliberal crisis rhetoric as a backdrop, reforms are seeking better value for money in order to ease fiscal strains on the publicly-financed system while still meeting the goals of solidarity and equity of access.
CHAPTER 5 - The Paradigm for Finance and Access in the French Health System: Contested Forms of Solidarity and Responsibility

5.1 Introduction

Health care in France—financed mainly through statutory health insurance, mutual aid, private insurance, and cost-sharing with patients—long combined social insurance, public funding and private elements. These hybrid features reflected the multiple cognitive and normative frameworks underpinning the system. The two-tiered health insurance system providing cover to the French population through basic mandatory public insurance and private supplementary insurance developed over the 20th century in fits and starts, culminating in a law ensuring health coverage for the poor as well as a subsidy system to allow vulnerable populations to purchase supplementary coverage.

During the 1990s and 2000s, the main regime evolved from an entirely social insurance-based system funded by contributions from employees and employers to a hybrid one including more general income taxation. The integration of smaller funds into the main general fund, the substitution of a general social levy for workers’ payroll taxes, the creation of the couverture maladie universelle (CMU) and the increasing intervention of the state in health spending all pointed toward universalism (Majnoni d'Intignano 2005, 39). These policy changes—increased state-financing and involvement along with a shift to rights based on residence—put in question the principle of social insurance on which the system was founded (Barbier and Théret 2004, 67). This was all part of a general trend in the direction of universalism based on a redefined form of national solidarity in health protection.

Since the post-war institution of sécurité sociale, one of the greatest tensions has been between market mechanisms as a way to regulate demand and the republican principles of equality of access. Demand-side measures conceived to make the patient accountable for
health decisions were integral to the initial set-up in 1945 when the national insurance funds were to cover only 80% of costs, with the rest being the responsibility of the patient. However, they did not achieve the desired results because over time private complementary insurers stepped in to cover the balance of patients’ costs. Repeated attempts to use demand-side tools to curb consumption failed to contain spending. However, they eventually produced the unintended effect of posing a threat to access to care due to inequalities in complementary coverage and increased out-of-pocket expenses to patients.\footnote{This has also been exacerbated by the expansion of sector 2 and the uncontrolled practice of billing above the standard fees discussed in chapter 6.} The debate around the creation and implementation of the couverture maladie universelle (CMU) drew attention to these issues and the gap between formal rights and the reality of fully universal health care.

This chapter traces the process of change in the logic and practice of financing of health insurance and examines the applied policy ideas and discourse underlying policy reforms affecting finance, coverage and access.\footnote{Most political discussions and works published on the French health system tend to focus on these issues and not the interaction between finance and its overall organization. Thus, health care politics have been characterized firstly by questions about expansion and universalization of coverage and about how to pay and how much to spend. “Political debate has focused more on the structure of the entire social security system than on the social organization of medicine, the objectives of the health system or alternative means of achieving them” (Kervasdoué, Rodwin, and Stephan 1984, 138). Only recently has the discussion also turned to the organization and governance of the provision of care and exploration of new modes of delivery. See chapter 6.} After a brief presentation of the history of social insurance and the changing notions of solidarity in France, this chapter will show how a justificatory discourse—namely, arguments about health spending, the fiscal imperative and the social cost of labor were used to legitimize reforms of health care financing. Stretching notions of solidarity and the crisis narrative have allowed both a push for effective universal coverage, state-control over finances and the disengagement of the public insurance fund. At the same time, they have undergirded a discursive battle over the potential privatization the insurance system. Under the influence of ideas from supply-side economics and managed
competition propagated by the financial and welfare elite as well as other others such as the Medef employers’ union, private insurers and prominent think tanks, coverage in the public insurance regime became more universal, but reforms also placed more responsibility on the individual posing a threat to equal access to care.

5.2 French Social Insurance and the Layering of New Forms of Solidarity: A Case of Concept Stretching of a Deep Core Idea

In France, solidarity as a concept is broad and malleable enough to be a desirable social goal for a wide swathe of the political landscape. Although seemingly a simple notion, solidarity both as an abstract principle and in its practical applications, is complex, organic, ambiguous and multiple (Daniel and Tuchszirer 1999; Maarse and Paulus 2003; Saltman, Busse, and Figueras 2004). With its varied cognitive and political meanings, “this principle is invoked by almost all actors involved in social protection but serves to justify radically different political projects” (Daniel and Tuchszirer 1999, 8). In effect, solidarity is the basis for several different forms of social protection—public assistance, social insurance and publicly-funded services.\textsuperscript{162} Moreover, there are also many different models of solidarity, such as employment-based solidarity based on occupational categories or national solidarity based on shared national identity or residency. Solidarity can be between social classes, generations, the healthy and the sick or the actively working population and those who do not work.

When the basic notion of solidarity as applied to health is invoked in France, one is likely to hear “from each according to his means and to each according to his needs.” Social insurance logic differs fundamentally from actuarial logic in that the insured are not expected

\textsuperscript{162} See Daniel and Tuchszirer (1999) for the different historical usages of solidarity as a justification for policy measures.
to contribute based on individual risk profiles. There is a fundamental recognition of a redistributive effect—from the well to the sick, from the top to the bottom, from the young to the old. Nevertheless, every effort from its inception to make French national health insurance a fully unified system failed because either the liberal practice of medicine or occupationally-based pluralism in health insurance cover trumped purely national solidarity objectives. Steps in this direction were taken as part of a long, incremental process.

During the seminal decade of the 1920s, the first health insurance disputes centered on conflicts between compulsory insurance and the principles of *la médecine libérale* and did much to construct the dichotomy between solidarity and doctors’ interests. Only through compromise, the 1930 social insurance law was passed and implemented by incorporating

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163 As it relates to health insurance, solidarity has three dimensions: risk solidarity, income solidarity and the scope of solidarity (Maarse and Paulus 2003). In contrast to private actuarial insurance, risk solidarity does not associate health risks with contribution rates (premiums paid). Thus the amount of health cover cannot be dependent on the amount of contributions made. With the insurance principle applied to risk solidarity, it is generally accepted that the large majority will pay for a minority who will be the unfortunate ones to suffer the risks for which all are insured (Cash 2004, 19). Also, as contribution amounts vary with income, the better off contribute more to the system. In theory, the ability to pay principle applies with the aim of redistribution based on the principle of equality. From each according to his means (income solidarity), to each according to his needs (risk solidarity) usually form the basis for solidarity in social health insurance. Yet professionally-based social insurance does not guarantee universalism as would solidarity based on social citizenship rights. Universalism based on both the principles of equality and solidarity seeks also to provide “to each according to his needs” but without any requirement for access other than citizenship or legal residency.

164 In 1967, a major reform of *sécurité sociale* separated the regime into branches based on risk categories, thus creating the sickness branch in an attempt to give more control to the central authorities. In the mid-1990s, Alain Juppé explored the idea of a single unified *assurance maladie universelle* (AMU), a universal health insurance based on legal residency, which was abandoned in favor of the *couverture maladie universelle*, the CMU, a separate means-tested program for the poor. In 2004, the creation of the *Union Nationale des Caisses d’Assurance Maladie* (UNCAM) placed all three major insurance funds under one umbrella organization with a politically appointed director granted expanded decision-making authority.

165 Smith (2004, 30) referred to this law as the Magna Carta of the French welfare state. Valat (2006) posited the significance of the 1930 law in planting the seeds for the modernization of French society. He underscored the symbolic and qualitative aspect of the recognition of the medical needs of the working class, the first experiment with employer/worker co-management and the possible creation of a “social insurance generation” in the French union movement.
doctors' freedoms into the legal statutes. Yet, as the embryo of statutory insurance system, this legislation was corporatist and fragmented and only applied to the least fortunate by requiring compulsory protection for workers whose earnings were below a certain level. No one was advocating yet for national public insurance for the middle and upper classes that often enjoyed voluntary, mutual arrangements with better coverage.

At the Liberation, a new sense of national solidarity emerged following the Depression, the social tumult of the 1930s and especially World War II. With a patronat, a medical corps and a mutual movement largely discredited for their complicity in the Vichy regime, war-ravaged France was presented a historic opportunity for change (Valat 2005). The father of French social security, Pierre Laroque’s goal was to create a comprehensive social protection system. In the immediate post-war period, emulating parts of the Beveridge plan in the UK, Laroque launched an experiment in national social democracy by founding a system that was to be universal and united.

With Beveridgean universalist aspirations, the liberation government under Laroque’s leadership passed the 1945 ordinances on sécurité sociale establishing national health insurance for salaried workers to be administered by the social partners. The preambule to the 1946 Constitution stated that the nation guarantees health protection to all (as did the 1958 Constitution of the Fifth Republic). Laroque’s plan encountered corporatist resistance from particularistic interests—many in the middle class such as the self-employed and professional

166 As Dutton (2007, 34) pointed out, “solidaristes represented an alternative to class warfare; they advocated commonsense compromises between socialism and unbridled capitalism.” Much in the spirit of Bismarck, they sought to accord the most precarious workers a minimum of security to maintain social peace and cohesion (Stone 1985).

167 Unlike the Beveridgean scenario, however, French social security was not to be uniform as its goal was security and income maintenance, and not redistribution. On the influence of the 1942 Beveridge report, “Social Insurance and Allied Services” on the initial texts, laws and decrees in 1945 and 1946 in France, see Kerschen (1995) or Borgetto (2005).

168 The October 19, 1945 ordinance on health insurance, maternity, disability, old-age and death created national health insurance for industrial and commercial workers.
classes—who fought to block their integration into this system, because they already enjoyed insurance coverage with more favorable terms (Dutton 2002b; Baldwin 1990). Finally, after the left-dominated government came to an end in 1947, a compromise was reached granting numerous special regimes the right to continue alongside the general regime for salaried workers. The mutualist culture that had come to be dominant in the middle classes left its mark on the post-war social security arrangements.

Hence, while still retaining a universalist Beveridgean element expressed in the 1945/46 texts and decrees, French sécurité sociale developed over time having inherited the voluntarist culture of the local mutualist benefit movement. Both national and professional solidarity recognize some form of social interdependence and collective responsibility (Béland and Hansen 2000), but the trade-based pluralist system of social insurance based on professional solidarity grew in stages from local to national funds. By the 1960s, the self-employed and salaried middle class, initially opposed to national health insurance, embraced broader social protection and solidarity and the collective sharing of health risks on a national basis, but this arrangement still allowed inequities in coverage and premium levels to persist (Kervasdoué, Rodwin, and Stephan 1984). In contradiction with the dichotomy setting compulsory social insurance against the liberal practice of medicine, the expansion of coverage was a boon to private practice physicians with a burgeoning socially-insured patient base. While this opposition was often used as a discursive tool in political rhetoric, the

169 Special regimes were permitted for these categories: civil servants of the state, magistrates, local government employees, electric and gas employees, the military, sailors, notaries, miners, rail and transport workers, the banking sector, chambers of commerce, theater actors, tobacco merchants and clerics (Hesse 1999, 18-19).
170 The farmers’ regime, the Mutualité sociale agricole was created in 1961. The regime for the self-employed (in French, often referred to as indépendents or artisans) was founded in 1966—the Caisse Nationale d’Assurance Maladie des Professions Indépendantes (CANAM).
171 The expansion of the medical sector—public and private—was enabled by the socialization of expenses as well as capital investment by the state (Jobert 1981).
compromise between doctors and insurance funds demonstrated that the two were not wholly incompatible. Yet this social depiction—the social belief in the clash between collective financing and physicians’ interests—often had an impact in health policy discussions and negotiations.\(^{172}\)

Societies organize around different conceptions of risk. Social insurance is predicated on a paradigm of collectivizing social risk, implying that individuals run similar risks, and that risks, which are largely uncertain and arbitrary, can befall anyone.\(^{173}\) In France, *sécurité sociale* harks back to the interwar and World War II conditions and the growing belief in the need to collectively protect the population from social risks.\(^{174}\) However, at the origin, social benefits were considered to be rights earned through employment and contributions. Rooted in the *solidariste* notions of both social and individual responsibility as well as mutual obligation, eligibility in social insurance was based on individual contributions. By mandating coverage, it obliged able-bodied working persons to be provident in the face of an uncertain future.\(^{175}\) While social insurance rejects actuarial principles, it nevertheless recognizes an element of individual responsibility.

Aside from the formal aspects of social insurance institutions and the Bismarckian goals of income or status maintenance, social protection often serves other objectives

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\(^{172}\) Paradoxically, the relationship between the social partners and the medical professionals in this context came to be known as the inflationary coalition with little to no incentive to hold down health care spending. Bismarckian systems, unlike national health services, place a high premium on choice and freedom (Hassenteufel and Palier 2008).

\(^{173}\) Rosanvallon (1995) described a model in crisis—an insurance paradigm that was losing relevance in the face of actuarial technology that could take into account individual proclivities and behavior.

\(^{174}\) The animating aim of social insurance is to spread the risk of costly life contingencies that are recognized as a collective, rather than private, responsibility. The bounds of social insurance thus delimit the scope of shared risk—the degree to which potent threats to income are spread across citizens of varying circumstances (‘risk-socialization’) or left to individuals or families to cope with on their own (‘risk-privatization’) (Hacker, 2005, p. 50).

\(^{175}\) The first social insurance experiments were also concerned with forcing poor workers to insure themselves against risks such as sickness or old age.
including nation-building, social cohesion,\textsuperscript{176} fighting poverty and exclusion, social peace, correcting inequalities, redistribution (both vertical and horizontal), and risk management. In a purely social insurance model, access to benefits would be linked only with one’s effort and would be viewed as deferred salary.\textsuperscript{177} However, in most social health insurance countries including France, even social contributions, often traditionally conceived of as deferred compensation (especially for retirement) came to serve national solidarity purposes, such as in the case of health where the notion of rights as earned benefits is more tenuous, and the concept of risk solidarity more pertinent. In social health insurance, in particular, while having worked and contributed confers access to benefits, the level of benefits is not related to amounts paid by the beneficiary.

Despite its Bismarckian formal arrangements, health insurance in France is considered the principal social democratic success (Smith 2004), the area of social protection where solidarity and universalism are the most meaningful and redistribution the most accepted.\textsuperscript{178} Health insurance became the domain considered by French people to best embody solidarity between them (LH2-AG2R Prévoyance - Le Figaro Entreprises et Emploi 2006). In health, the objectives of Beveridge were clearly more important in the minds of people than the formal methods of Bismarck. Whether occupational or national, solidarity is a robust cognitive and normative rampart against the introduction of risk selection that would occur without public involvement. Moreover, social health insurance has come to be a way of life and not merely a set of financial arrangements; social health institutions have become

\textsuperscript{176} The compulsory nature of social insurance both removes adverse selection (preventing that only those who are most likely to use insurance will get it) and creates social cohesion (by making all have a stake in the same program) (Bouget 1998).
\textsuperscript{177} Once central to the French welfare state, benefits as deferred salary have been transformed into a burden on labor and a threat to competitiveness (Palier 2007b).
\textsuperscript{178} In reality, solidarity, and consequently redistribution in health care, is mostly intergenerational. Nevertheless, the better off are more likely to use ambulatory services and specialist care and have greater longevity and therefore consume more of the resources of the French health system (Peneff 2005).
sociological and political structures that embody societal values (Saltman, Busse, and Figueras 2004). In France, national health insurance became a fundamental pillar of the social compact (Tabuteau 2007) and a crucial element of national cohesion.\textsuperscript{179} The French sense of national belonging was often expressed through the population’s attachment to its system of social protection (especially what they call the \textit{Sécu}, in reference to the health insurance fund) reflecting the social and national cohesion functions of the welfare state.

In the social policy lexicon in France, solidarity eventually became divorced from its original links to social insurance. Keywords in the cultural and ideological repertoire can be infused with new meaning in order to justify policy change. A culturally resonant “keyword” in the republican model, solidarity was resurrected through its reframing and through value amplification in order to legitimize new forms of social benefits (Béland 2009a).\textsuperscript{180} In the context of the debate on new social risks like social exclusion and \textit{précarité}, the idea of solidarity made a comeback as a keyword but assumed a different meaning from its Third Republic origins. In this way, “the old idea of solidarity represented a powerful political weapon in the symbolic struggle over the institutional and ideological redefinition of the French welfare state” (ibid., 452). In the new discourse on social exclusion and \textit{précarité} and the search for social inclusion and cohesion within the national territory, solidarity implied collective responsibility for individuals rather than a mutual obligation among persons of the same social status and profession.

Risk solidarity having become more important than income solidarity in health, and professional solidarity having become a national affair, the space from professional to national solidarity was not all that wide. An oddity of the French social protection landscape, social


\textsuperscript{180} Through value amplification in the public discourse, social exclusion as a major preoccupation in France became a benchmark idea that soon crossed borders and became a part of the vocabulary of the international social policy community as well.
insurance protections among workers were sometimes opposed to national solidarity in state-financed, means-tested schemes like the revenue minimum d’insertion (a French workfare-style program without major sanctions) or the couverture maladie universelle. This conceptual separation coincided with the diffusion of a pervasive solidarity discourse which has had a significant place in health reform politics (Béland and Hansen 2000; Béland 2009a; Tabuteau 2007). However, the new national solidarity principles giving rise to minimalist means-tested social protections were accused of contributing to the dualization of social protections, with the state becoming responsible for the poor who run the risk of lesser coverage than the working population.

In the health sector, while efforts have been made to ensure equal treatment to all and to avoid a dual system of health care, many reforms—even those done in the name of solidarity—have caused difficulties in access to care. Policy makers continue to struggle to make the reality match the rhetoric (or at least to give the appearance thereof). While solidarity remains a strong robust value in the ideological and cultural repertoire, it is mobilized to various ends and appropriated by all actors to lend credence to their proposals. It new incarnations have tended to stretch and reshape its contours. As a traditional malleable, and highly evocative, keyword, it can be filled without almost any policy content.

5.3 The Crisis Narrative: “Exploding” Health Costs, the Omnipresent trou and the Social Cost of Labor Justify the Retreat of Public Health Insurance

Crisis rhetoric was often used to construct the imperative to change the French health system. The ideas that were used to explain the apparent failures of the existing system

181 The notion of undue charges was used by unions in the 1980s to argue for the separation of national and professional solidarity and to demand that the state assume responsibility for non-employment based social protections (Barbier and Théret 2004, 37).
derived mostly from the neoliberal critique of the welfare state which deemed public spending
to be too high to remain competitive in global markets and achieve European monetary
integration. Paradoxically, the justificatory discourse advanced publicly to legitimate reform
emphasized the need to change in order to save the existing system of solidarity. The crisis
narrative held that, without reform, the cherished principle of solidarity would not withstand the
financial strains caused by an ageing population and rising health expenditures. Given the
perceived fiscal imperative, cost containment became the principal aim of public authorities
and health policy tended to be reduced to the economic concerns of the public health
insurance regime (Serré 2002, 68). The economic paradigm supplanted medical and social
paradigms as the main cognitive and normative framework underpinning health policy, by both
defining problems and providing solutions. Most health system reforms were undertaken in the
name of rescuing the system from financial collapse, to preserve social solidarity and even to
prevent the encroachment of the private sector and widening inequalities.

At 3601 USD PPP, total health expenditure per capita in 2007 was among the highest
in the OECD. However, the annual average growth rate from 1997 to 2007 was 2.5% while the
OECD average was 4.1%. Of a total of 30 OECD countries, France ranked 26th in terms of
annual average growth rate in per capita health expenditure during that same period (OECD
2009b, 161). The trend was clearly a dampening of growth of both total and public health
expenditure per capita in France, unlike other OECD countries. During the 1990s, the share of
public spending on health care steadily declined. By 2008, total public spending was at a low
of 76.8% (the basic public insurance regimes at 75.5%), while the complementary insurers’
share of total health spending grew from 12.2% in 1995 to 13.7% in 2008. Household
expenditures fluctuated between 8.4 and 9.6 % over the same period (Ministère du travail et
al. 2009, 12). Yet these figures revealed little about the content and breakdown of spending
and masked the fact that the private share (whether insurance or out-of-pocket) could be
substantial for certain types of care, i.e. dental and optical, and for consultations with many specialists who charge above standard fees.\textsuperscript{182}

Over the entire reform period, the prevailing discourse held that costs must be controlled given that the health care market has an inherent tendency to be inflationary. Going as far back as the 1970s, the economic argument was made—that the rate of growth of the social budget should not be allowed to exceed the rate of growth of GDP (Rodwin 1981). As discussed in chapter 4, this argument came to be unchallenged international conventional wisdom. Yet, the initial assertion consists of fallacious reasoning at best, and at worst, a totally arbitrary assumption.\textsuperscript{183} There is no economically logical reason why health spending cannot grow as a portion of GDP; yet for many decades much of the policy community did not question this basic assertion. However, if an ageing or more demanding population needs or desires more health care, for example, then health might very well take up more of a country’s resources, all the while making efficiency gains and producing better outcomes. Hence, many of these casually constructed assumptions do not hold up to logical scrutiny. Often, aggregate statistics about spending per capita are deployed primarily for framing and rhetorical purposes based on unsubstantiated assumptions without any real discussion about the utility or desirability of health spending.

\textsuperscript{182} Health expenditures accounted for 14.9% of all household consumption in France, compared to an OECD average of 12.9% and the US at 19.8%. Inpatient care expenditures in France are among the highest as compared to other OECD countries, signaling a strong reliance on the publicly funded hospital system, although the share of total medical goods and services consumed by hospital care shrunk from 48.6% in 1995 to 44.1% in 2008. Ambulatory care remained stationary at around 27.5% of total medical consumption. Increases in spending on pharmaceuticals, transportation of patients and other medical goods explain this disparity (Fénina, Le Garrec, and Duée 2009, 79). Spending on drugs has also been among the highest in the world (OECD 2009b).

\textsuperscript{183} On the other hand, many health economists eventually argued that health is a superior good—the more developed an economy, the more health care is consumed. In 2004, the High Committee for the Future of Health Insurance finally acknowledged that health spending was bound to increase at a higher rate than GDP, but that the trend would not continue forever upward (Chadelat 2005, 69).
The conventional wisdom as also claimed that the main cause of health spending growth is demographic and that an ageing population would lead to an explosion of health expenditures. Yet health economics and policy experts have found these predictions to be overstated and that demographics and ageing accounted for much less than popular beliefs and public discourse would proclaim (Dormont 2006; Grignon 2003; Huber 2009).\textsuperscript{184} Firstly, medical consumption in the last years of life diminishes as the age of death increases (Cash 2004, 19). As health improves and life-span increases (by several months every year in France), the proportion of persons in the last year of life diminishes and has a downward effect on spending (Grignon 2003).\textsuperscript{185} Based on close analyses of demographic data and medical consumption, it was expected that demographics (a growing and ageing population) would not cause the spending to explode to catastrophic levels (Cash 2004, 68). Other factors like technical progress, new pathologies and the expectations of patients and their families play an even larger role in the upward trend in health care spending. Changes in medical practices such as prescription of drugs have been found to better explain expenditure growth (Dormont and Huber 2006). Nevertheless, despite the empirical evidence, a very simplistic narrative regarding future health spending has been propagated to gain adhesion to reform programs.

As part of the narrative, the fiscal imperative—excessive spending combined with budgetary constraints—has been critical to the construction of the belief in policy failure. Together, these two crystallized and amplified the value of fiscal rectitude and the need to control costs and make structural changes to the system. Assumptions about the fiscal

\textsuperscript{184} A pervasive alarmism in the rhetoric, warning of an explosion of health spending, can be directed to various ends. For some, it is the justification to ask the elderly to sacrifice coverage by basic health insurance. For others such as private insurers, it is used to urge the adoption of health savings accounts. Finally, for others, the explosion is seen as an inevitable evolution that cannot and should not be countered by arbitrary spending controls (Dormont 2006).

\textsuperscript{185} Health care needs may be reduced if the population is ageing and becoming healthier. Furthermore, with increased long-term investments in the health of the population, the burden of ill-health on the economy can be lowered.
imperative are a taken-for-granted aspect of the crisis discourse. The notion of crisis in the national health insurance funds due to deficits (dramatized as the “trou abyssal”) provided the opportunity to reformulate a basic policy frame—raising awareness about the cost of health care and the need to regulate spending (Damamme and Jobert 2001). Many government officials, fund administrators and employers’ groups brandished this deficit as justification for reforms which include lowering reimbursement levels, enforcing cost containment measures, expanding cost-sharing and rooting out abuse, fraud and waste.

The *trou de la sécu*, as the deficit is known, is used often as the focusing event (Kingdon 1995, 96), concentrating attention on the problem in the public forum and legitimizing public action to remedy it. Even though French social security deficits are predictable, they are usually interpreted as a crisis and their dramatization often has led to changes in reimbursement rules or professional practice (Tabuteau 2009).\(^\text{186}\) Virtually every year, official reports about the expectations for the annual deficit focus attention on the necessity of reform. These very public announcements usually prompt an alarmist echo in the media which have played a large role in the social construction of the myth\(^\text{187}\) of the “*trou de la sécu*” (Duval 2002, 2007). The publication and overwhelming press coverage of reports on the financial status of the social security regime show how influential statistics and economism have become in framing problems, setting reform agendas and circumscribing potential solutions. The politicization and dramatization of reports in the media—even raising the threat of bankruptcy—has served as a common discursive resource used to prepare interests groups and the public for austerity measures.

\(^{186}\) The “*trou de la sécu*” became an obsession after the 1983 turn in macroeconomic policy and was exacerbated by the 1993 recession and the Maastricht treaty (Barbier and Théret 2004, 36).

\(^{187}\) By myth is meant that the *trou* takes on a life of its own, a mythical quality, that gives it an independent existence in the social and political sphere, regardless of the veracity or falsity of its factual existence (Duval 2007).
In this narrative, the “trou” is repeatedly presented as a threat to the viability of the public system, caused by excessive spending due to abuse and overuse. It also became the symbol of a discourse of culpability on the part of the users of the system. In essence, the public was led to believe that the deficits were due to excess demand and not from a lack of financing. Although made to appear merely technical, the “trou de la sécu” was used as a symbolic political weapon in health care debates by evoking dysfunction—a social reality constructed by public authorities, influential actors and the media and used as a discursive tool to identify a social problem and to delegitimize the existing policy mix.\(^{188}\)

In the context of the widespread perception of the welfare state crisis, one of the main arguments (which turned out not to hold true) was that low wage countries with no social provisions posed the threat of social dumping and would undermine the competitiveness of advanced economies with mature welfare states (Castles 2004). In the crisis environment following the 1970s, these arguments became part of both the discursive background and foreground. By the 1990s, employers’ groups and the right-wing embarked on a campaign demanding the lowering of social contributions aiming to reduce not only direct salaries, but also indirect salaries, only paying strictly for productive work and leaving social protection to the state or the individual.\(^{189}\) In employment-based systems of national health insurance, contributions as a portion of the cost of labor became a salient issue in post-Keynesian economic thinking. The basic neoliberal argument was that the fiscal burden remained too

\(^{188}\) That the trou is a social construction and not necessarily an objective reality is well-illustrated by Barbier and Théret (2004). According to the authors, a change in accounting techniques—using expected revenues for a given year (since payments often arrive late) rather than those already collected by the end of that year—virtually eliminated the deficits in the late 1990s and revealed retrospectively how overstated the “trous” had been in the early 1990s using this method of accounting—the same deficits that served to justify Juppé’s social protection reforms.

\(^{189}\) Employers wanted to separate from the cost of labor all that concerned maintenance of the work force, to distance themselves from involvement in social protection (Berthiot, Chavigné, and Filoche 2004).
high, affecting the non-wage cost of labor and dampening competitiveness in a global market, which in turn caused capital flight and reduced the purchasing power of labor.

Decisions were thus based on this plausible theoretical logic, but not on empirical corroboration of these claims. Despite a lack of evidence that high social contributions necessarily constituted a competitive handicap, payroll tax financing was delegitimized through an official discourse arguing that the French welfare state must reduce its cost of labor in order to remain competitive in the European and international economy (Gueldry 2001, 101; Boyer 2002, 22; Bras 2004; Duval 2007). This came to be a broadly held view that began to affect how the French perceived their health care system.\footnote{In a January 25, 2007 survey of five European countries (Germany, France, Italy, the UK and Sweden), French respondents (38%) were more likely than others (from 17-25%) to consider the health sector to be a burden for society rather than a contribution to economic growth of the country (Institut CSA 2007). In another opinion poll, while still a minority view, 32% viewed health as a cost—a burden to the economy and competitiveness, a position more prevalent on the Right (39%) than on the Left (24%) (Institut français d'opinion public pour La Fondation Impact Santé 2007).} The French employer class had historically demonstrated its opposition to collective social protection (Duval 2007) and employers had been making this same argument since early 20\textsuperscript{th} century debates, evoking the potential for social insurance to induce an inflationary spiral that would be detrimental to wages and to competition (Dutton 2007, 43). The notion that the French welfare state in general was causing a loss of competitiveness raised questions about the public financing of health care and fed into a vision of health as a weight on, and not a productive factor, in the economy. In a post-Keynesian globalized discursive environment, employers were better able to trot out old policy notions in a more favorable climate where their ideas had become the conventional wisdom.

In a Bismarckian paradigm, health insurance contributions were previously conceived as part of a worker's rightfully earned compensation. In the neoliberal supply-side discourse that became part of mainstream thinking, contributions were no longer considered a legitimate
aspect of non-wage compensation but were delegitimized as simply a burdensome cost of labor. Shifting the way that contributions were perceived helped to also discredit the social insurance model and provide opportunities to turn to other financing mechanisms (Palier 2007b). Throughout the 1990s and 2000s, given the conventional wisdom regarding the burden of the “charges sociales”\(^{191}\) on the French economy, government experts were called upon to explore alternative forms of financing in order to diminish the pressure on wages and employment while still raising revenues from employers (Soubie et al. 1994; Chadelat 1997; Malinvaud 1998; Conseil économique et social 2007; Le Sénat 2007). However, France’s overall labor costs were not particularly high and fell well within the European average. OECD comparisons include many countries with dissimilar economies. Comparisons of France with other similar countries in Europe such as Germany and the Nordic countries place France at the lower end. The cost of labor in France is identical to the cost of labor in Denmark, suggesting that social contributions are treated in the labor market as part of compensation (Concialdi 2003). The cost of labor is thus not higher because of social contributions. Gross wages tend to be lower where contributions are higher, but total labor costs are similar in social insurance countries and in high taxation countries. Furthermore, competitiveness is a function of many factors and not mainly the cost of labor.

Nevertheless, the focus moved to non-wage costs of low-wage unskilled labor (Barbier and Théret 2004, 34) which was encouraged and applauded by the OECD (Leibfritz and O’Brien 2005). Along with the shift to tax-based financing, employers’ were granted exemptions from social contributions on low wage earners as part of an employment policy to encourage low wage hiring beginning with the Balladur government in 1993 and pursued by successive governments on both Left and Right. Although the state was to compensate for the

\(^{191}\) Demonstrating the influence of monetarism and a concerted campaign by the main employers’ union to frame the debate on financing of social protection, payroll taxes were often referred to as “charges,” a term with clearly negative connotations.
loss of revenues as a result of employers’ exoneration, these “job-friendly” policies were shown to have exacerbated the social security and public health insurance fund deficits.

In part because of this, there was an ongoing political quarrel about the authenticity of the deficit and also whether or not it was due to excessive spending or the lack of revenues (and implicitly who or what was to blame). Citing the uncompensated sums by the state, delays in payment and employers’ exemptions, headlines read “La CGT : le ‘trou’ de la Sécu n’existe pas” (La Nouvelle République du Centre Ouest 2005). Suspicions circulated that the state deliberately exacerbated deficits of the social insurance funds in order to surrender social protection to private insurers. Over a 20 year period, employers’ social security contributions on minimum wage employment declined from 33% to 4.38% of gross salary (Ministère du travail et al. 2009, 10). Employers participated less and less in the financing of French social protection, notably in what came to be perceived as universal—namely health and family—benefits. In 2006, the Cour des comptes began to question the effectiveness of these policies. In 2008, exemptions from social contributions amounted to €30.7 billion (the amount of the deficit) of which the state compensated for 92% through earmarked funding in effect providing a tax-based subsidy to employers for low-wage work (Agences centrales des organismes de Sécurité sociale 2009). Increasingly, this was being criticized as a poverty trap, as employers were given an incentive to keep wages under the ceiling to benefit from exemptions.

There was also speculation that this deficit was deliberately “organized” by the public authorities with the complicity of the media. Referred to in France as the “la politique des

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192 In the early years, Force ouvrière (FO) argued that the deficit was not real, but that it was the result of decisions made by the state and these were part of the undue burden placed on workers—the employers’ exoneration, the compensation for shortfalls in other funds, coverage for the handicapped (Soubie et al. 1994).
caisses vides” similar to “starving the beast” in US parlance,193 the idea was to run public
deficits in order to discredit and reform a system.194 In a vicious cycle, a policy to run deficits (a
political choice) was buttressed by an alarmist discourse making problems appear to be mere
technical issues, and the solutions constrained by implicit assumptions about the causes of
the deficit. By planting the seeds of insecurity, policy-makers would then be able to enact
broader change, presented as inevitable. In France, the notions of charges sociales and the
trou de la sécu combined together as discursive tools to justify tax exemptions for employers
and to contain public health spending, with the risk of eroding the cherished solidarity in the
national public insurance system.

In the late 2000s, a majority of French people were convinced that the deficit was the
foremost threat to the health care system (Institut français d’opinion public for
GlaxoSmithKline 2008) and a serious problem urgently in need of a solution (TNS Sofres and
Générale de santé 2009; Institut français d’opinion public for GlaxoSmithKline 2008). The
general consensus was that health spending was too high because the system was not
well-managed, with fewer and fewer agreeing that “you cannot place a price on health” down 9
percentage points between 2000 (72%) and 2006 (63%) and an equal decline in those able to
justify spending growth (75% in 2000 down to 66% in 2006) (Boisselot 2006). With a repeated
persuasive alarmist discourse, a growing public sentiment emerged recognizing legitimate
reasons to limit health spending. Despite the efforts of some scholars to question the
orthodoxy espoused by the business and government elite about the payroll tax burden on

193 See Bartlett (2007). In the age of neoliberalism, small government advocates preferred to
defund government programs to stem what they perceived as an insatiable demand for social
spending.

194 In the US, some experts on Social Security and Medicare debates observed a similar set of
rhetorical tactics in the framing of crisis on the part of their detractors. In False Alarm: Why the
Greatest Threat to Social Security and Medicare Is the Campaign to “Save” Them, Joseph
White (2001) wrote about how the political rhetoric and the myth about “the entitlement crisis”
framed debates about “saving” Social Security and Medicare and obscured the public
understanding of social insurance.
labor and pushback from labor unions and far-Left parties, the discourse was beginning to affect the French public’s attitude toward the costs of the health system. The discourse and the media’s uncritical repetition of the orthodoxy were bound to eventually influence public perceptions. The terms used in the debate itself defined the scope of potential policy responses to the perceived financial crises. A set of beliefs constructed around a commitment to monetarist objectives and budget austerity and the ideational and discursive processes involved to justify these choices narrowed health policy options.

5.4 Structural Reforms in Finance and Access: The Promise and Limits to National Solidarity and Health as an Effective Universal Right

During the post-war period, French health insurance was financed mainly by compulsory employee and employer payroll taxes divided into three main national social insurance funds—for salaried industrial and commercial workers, for agricultural employees and for the self-employed. All of these regimes followed the Bismarkian principle of rights based on employment. Until changes in the 1990s, these corporatist organizations were financed by contributions linked to wages and administered by employees and employer’s unions. The creation in 1991 of a new mode of financing, a 1.1% contribution sociale généralisée (CSG), played a major part in the structural changes to health insurance governance; the CSG departs dramatically from the original corporatist income security model of social protection. In a break with the occupational basis of social insurance, the CSG was

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195 Social insurance can be viewed as a form of taxation even though it is attached to employment. Social contributions are like pseudo-taxes in that they allow governments to raise revenue although without being held accountable for spending (Freeman 2000, 3). In France, payroll taxation with a wage ceiling tended to be a regressive form of financing (Kervasdoué, Rodwin, and Stephan 1984, 138).
legitimized on the grounds of new conceptions of national solidarity in the era of high
unemployment and social exclusion.

Over the 1990s, the CSG was increased several times as part of a move away from
employment-based financing and gradually earmarked mostly for the health insurance funds.
The government increased the CSG to 2.4% in 1993 and to 3.4% in 1997. The 1998 Law
on Social Security Financing raised the CSG to a total of 7.5% on wage and capital income
and 6.4% on replacement income. Employees’ payroll taxes to the health funds were reduced
and a large portion of the CSG was to be allocated specifically to the health fund. This quiet
incremental process substituted a general social levy (a kind of hybrid social
collection) on all income as one of the primary sources of financing for health
care, so that the share of health care funding directly related to wages dipped below 60%
(Saltman, Busse, and Figueras 2004). By 2006, 45% of financing of the basic health insurance
regime derived from taxation—either the CSG or excise taxes earmarked for health care
(Direction de la recherche, Ministère du Travail, Ministère de la Santé, Ministère du Budget,
and Hennion 2008, 4). As the first direct tax on households, the CSG made health care
financing more universal and more progressive. It was a more equitable form of financing as it
shifted some of the financial burden to those with higher incomes (Minogiannis 2003).
Moreover, with this subtle transformation to increased taxation, the image of the social insuree
was replaced with that of the tax payer (Rosanvallon 1995, 80). Legitimacy was thus stripped

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196 When the center-right government of Alain Juppé raised the CSG, it did not reduce
employees’ contributions as did his socialist successor, Lionel Jospin. While Juppé placed
more burden on lower incomes, Jospin spread the some of the cost to the better-off.
197 All unions except for the CFDT opposed its introduction because the shift away from social
contributions weakened unions’ legitimacy as administrators of the social insurance funds
(Béland 2009a; Rosanvallon 1995).
away from unions and given to the tax-payer citizen, the parliament and the nation to oversee the governance of French national health insurance.\textsuperscript{198}

The Juppé government accelerated this shift to taxation and took the logic further, wresting control away from the social partners. Prompted and legitimized by the exploding budget deficits in 1993 and 1994, the Juppé reforms constituted a stark break with the past, putting into question the role of social democracy in French social protection and clearly giving the state new fields of action with the annual parliamentary vote over financing social security (LFSS) and the national health insurance spending targets (ONDAM). The Juppé reform made clear that recourse to the CSG was conceived to be employment-friendly, to reinforce social equity and to expand the revenue base all at the same time (Réforme de la protection sociale 1995). The Juppé government made the lowering of deficits and social costs to employers its main objectives (Courtaigne 1995). A direct link can be drawn between the excessive health spending discourse, the monetarist objective of deficit reduction and these new financing and containment policies adopted in the Juppé reforms.

The Plan for the Reform of French Social Protection announced by Alain Juppé on November 15, 1995, laid out a broad framework for future reforms with the goal of “saving [the] system of social protection because it [was the] best weapon to fight against exclusion and to reduce the social fracture” (\textit{Le Monde} 1995c).\textsuperscript{199} Under pressures to meet European

\textsuperscript{198} Moreover, a functionalist effect of weakening trade unions and their influence opened up opportunities for further incrementalism and new institutional reforms by removing the defenders of the status quo (Bonoli and Palier 1998, 327-328).
\textsuperscript{199} Two groups of leftist intellectuals played a very prominent role in the the Juppé reform debate. The center-left group, on the initiative of the editors of \textit{l’Esprit} and Pierre Rosanvallon who had worked extensively on the problems of précarité and social exclusion, expressed their support for the proposed health care reforms. In the name of an expanded sense of national solidarity and social justice, this group of preeminent experts, political scientists, sociologists and advocates for the poor and socially excluded defended the establishment of universal health insurance and the proposed reforms of the financing and governance of the health care system (\textit{Le Monde} 1995d). Alternatively, another group associated with the far-left and communists, including Pierre Bourdieu, Luc Boltanski and Jacques Derrida, declared their
objectives and facing burgeoning budget deficits, austerity was presented as inevitable and served as the justification for the most far-reaching structural reform of French social protection ever undertaken (Bouget 1998; Singerman 2000). Unlike previous reforms, these structural changes made possible further transformation including more state control, privatization and regionalization, although no express political or governmental claim was made regarding the kind of new model this structural adaptation should bring (Tabuteau 2009). The most significant innovation of the Juppé reform with regard to health was the constitutional revision that required parliament to pass yearly financing laws for publicly-funded social protections and to set national health spending targets with financial sanctions on physicians. While the abandoned pension reforms that caused the most public fury were the most associated with the Juppé plan, the ordinances of 1996 establishing these new state functions in health care passed without much ado, yet they did more to alter the logic of French social protection. The novel character of the ONDAM and the LFSS cannot be overstated. The medical profession recognized the fundamental normative implications of the state’s involvement in setting budgetary targets for the ambulatory sector and potentially regulating the supply of physicians’ services, and as a result, the government paid an electoral price for having pursued these reforms without the assent of a critical constituency.

While the ONDAM was originally conceived to have a binding quality through sanctions imposed on doctors who overshot targets (much like an earlier reform in Germany), it was challenged by physicians’ unions. The sanctions were struck down in 1998 by the Constitutional Council which deemed them to be unfair and unequal treatment to hold physicians collectively responsible for cost overruns. For many (including physicians) the ONDAM constraint (a cap on spending) had nothing to do with health, but merely with the pursuit of budgetary rigor (Le Pen 2006, 9).

The Juppé reform was supported by a new coalition including many health policy experts and civil servants—both academic and governmental, the largest grouping of mutual insurers,
The deficits of the early 1990s—that may or may not have been overstated—in the context of the necessity to respect the EMU convergence criteria gave the Juppé government justifications for making structural changes to the governance of the social security funds. As Raoul Briet affirmed of the unprecedented financial crisis, “in the fall of 1995, France was at risk with regard, in particular, to the public deficit criteria, since we must have been at around 4.5% of GNP” when the target was 3% (2005, 58). This was viewed as a matter of utmost national strategic and political interest—to meet the conditions for EMU and the social security funds became the symbol of an entirely new economic and social orientation that was embodied in the Juppé reforms. As a “guichet ouvert”—an open-ended payment source, the health insurance funds, administered by the social partners ran at odds with the goals of the government. The only way to change this was to replace the existing “inflationary coalition” with other actors receptive to the ideas of social policy experts—health economists and civil servants who had put forth an alternative policy frame—the supply-side control of costs. Given the embrace of universalism and general taxation financing of health, parliament would become the legitimate institution to oversee health spending. Parliamentary democracy would replace social democracy in health care governance (see chapter 6).

Universalism and general taxation go together logically on the premise that all available resources should be employed to protect everyone. The shortcomings of social protection based solely on employment were revealed by the economic crises during the 1970s, when new poverty and social exclusion became a part of the public social discourse. Universal goals were articulated in 1974 and a law passed to harmonize and extend social protection to all in health and maternity insurance, old-age and family entitlements. In the CFDT and the generalist physicians’ union, MG-France (the only physicians union in favor of the reform). The RPR suffered electoral defeat in 1997 when many doctors abandoned their traditional right-wing preference and went as far as trying to influence their own patients, explicitly discouraging them from voting RPR. For more on the politics of the Juppé reform, see Esprit (1996) and Mongin (1997).
principle, this was realized in the voluntary 1978 personal insurance law extending coverage either by membership in the obligatory regime or personal insurance (Jacquot 2000).

Coverage would be provided through personal contributions or in the form of state assistance for those of insufficient means. Theoretically, the entire population was legally eligible for basic health insurance; yet two decades later, problems of actual coverage persisted, highlighting the need to make changes to reach the stated universalist goals.

In 1960, only 31% of the French population had complementary health insurance coverage. Increases in cost shifting to patients since the 1980s stimulated the growth of this second tier of insurance, since this coverage became a necessary condition for effective access to care. By 2000, approximately 85% of the population enjoyed some form of complementary coverage with varying levels of reimbursement (Chadelat 2005, 71). Of the 15% remaining uncovered, many could not afford copayments and thus were unable to exercise their right to care (Brocas 2001, 227). This disparity in complementary coverage became one of the principal sources of inequality in the French health system. Extension of coverage became imperative because of increased cost-shifting to patients since the 1980s.

Effective universal coverage became a public concern and was placed on the policy agenda again in the 1990s. The original Juppé plan had proposed the idea of a national health insurance regime based on residency with uniform contribution rates and benefits. With sustained high unemployment, social exclusion and précarité became salient political issues—with people falling through the cracks of the employment-based social insurance system. Several government reports underscored the growing numbers of French people forgoing health care for financial reasons and, most notably, for lack of complementary health protection (Bocognano and Dumesnil 1999; Haut Comité de la santé publique 1998).

203 The Juppé government intended to propose the AMU legislation to parliament. This process was halted by the dissolution of the legislature in 1997 by President Chirac which brought the socialists to power (Frotiée 2004).
According to the High Committee on Public Health, the phenomenon of *précarisation* (understood as a fragile social situation due to the absence of some form of work, family or other social security) had become widespread, affecting 20-25% of the total population living in France—12-15 million people. *Précarisation*, with its clear effects on health, was viewed as disruptive of French society, both deepening inequalities and threatening national cohesion. Therefore, the committee recommended the urgent adoption of universal health insurance based on a simple residence criterion (Haut Comité de la santé publique 1998). A new discursive coalition—social policy experts, non-governmental charity organizations,204 unions and mutual insurers—coalesced around the notion of social exclusion and mobilized to forge a new policy direction to include the most vulnerable populations in the existing health insurance and delivery system. The argument was often made that health was linked to the ability to obtain employment. Health was construed as a necessary component of social inclusion.

Lack of complementary coverage was found to be one of the main obstacles to health care and was often the cause of the choice to forgo or delay treatment. Also, it was determined that the unemployed, those on state assistance and those without complementary coverage ran a substantially higher risk of ill health (Bocognano, Dumesnil, and Frérot 1999). The situation of the poorest had deteriorated due to earlier reforms that tended to privatize coverage, such as the increase in physicians allowed to set higher fees and the increase in user charges for hospital and ambulatory care and drugs (Barbier and Théret 2004, 70). The quest for universal coverage called for action. All of these findings accompanied by the new

204 Humanitarian organizations and mutual insurers played a very significant role in the negotiations and the final legislation of the CMU project. *Médecins Sans Frontières* and *Médecins du Monde* were instrumental in making sure that the complementary CMU could be offered through the existing public funds and that they would be guaranteed by the state. They engaged in a media campaign against handing the CMU population over to the competitive insurance market (Frotiée 2004, 80). Given the choice, most CMU beneficiaries opted to have their complementary insurance administered by the public insurance fund rather than a mutual insurer or a private insurance company.
preoccupation and discourse on précarité led to a new approach to solidarity with regard to the health of the most vulnerable.

By declaring a right to the same benefits in kind for all, health care was to become a right based on residency in the national territory (Bouget 1998, 162). While the Juppé plan’s notion of the assurance maladie universelle (AMU) intended to extend the right to basic health insurance to all legal residents, it did not deal with the vexing problem of financial obstacles to care and the need for complementary insurance (Sénéquier 1999, 4). Because the main problem was access for the most fragile populations, the Jospin government’s reform discussions turned sharply to the need to concentrate efforts on them. While Prime Minister Juppé’s AMU project was to move towards a uniform, base insurance regime with a defined uniform benefit package for all residents in France, Prime Minister Jospin’s CMU recognized the need to address the inequities caused by disparities in complementary coverage in order to resolve the problem of effective access to care. The Jospin government, and notably the Social Affairs Minister, Martine Aubry, made the CMU primarily about providing access for the poor and excluded (Frotiéé 2004). In effect, with the adoption of the CMU and especially free access to the complementary CMU, health was clearly acknowledged as a right not linked to employment. However, while this universalism acknowledged the legal right to health insurance coverage, it did not strive to create a fully integrated universal system of care. The idea was to make an already existing right an effective one (Boulard 1999) by extending complementary insurance (which had become a necessary condition for access to all types of care).  

205 For more on the way the CMU, which is neither social assistance nor social insurance, altered conceptions of social risk and personalized the right to health, see Chauchard and Marié (2001).

206 This can be thought of as private social insurance whereby mandates or incentives are used rather than government control (Maarse 2006).
The *couverture maladie universelle* (CMU) went into effect on January 1, 2000 as part of the Action to Prevent and Combat Exclusion. It guaranteed primary coverage for all legal residents and second-tier complementary coverage (CMU-C) for low-income families and individuals as part of a movement from health (care) viewed as a social risk to health (care) as a basic human right. Just as the RMI and the CSG before it, the CMU marked a stark break with the logic of the past by establishing national rules of coverage based on residency and a system for the provision of complementary insurance to the poorest in France (4.8 million in 2006). The CMU granted recipients an exemption from advance payment (the insurer acts as a third-party payer). In terms of institutional change, the CMU layers atop the occupational system a new form of access to the general health insurance regime through a new national criterion of three months of stable, legal residence. It was conceived as a way of bringing beneficiaries into the existing system by removing the financial barriers to complementary coverage.

As discussed earlier, policy can often be the result of incoherent paradigms. Sometimes, applied policy ideas do not achieve the normative objectives of the broad policy paradigm, and different sets of ideas from conflicting paradigms can be institutionalized by the same policy measures. Ostensibly, the CMU aimed to achieve the goal of universalism based on national solidarity and the republican ideal of equality, yet universal coverage was in part a misnomer, given that it required means-testing as the basis of eligibility. Those just above the income ceiling for eligibility often did not get even basic coverage.\(^2\) Furthermore, studies

\(^2\) *Medecins du Monde* (2006) found that 22% (a number that more than doubled from 2001) of those received in their health clinics had no legal right to benefit from health coverage of any kind. Of those who had legal rights to coverage, 82% did not have it, often due to the need for a residential address, financial difficulties, lack of knowledge about their legal rights or the complexity of the administrative process. Often victim of the ceiling effect, 70% of those benefiting from the basic CMU complained of financial obstacles. Even 30% of patients benefiting from the CMU-C cited financial difficulties as the main obstacle to care, i.e. they could not pay up front or they could not afford complementary insurance.
repeatedly revealed a refusal on the part of many practitioners to treat CMU patients (Desprès and Naiditch 2006; Médecins du Monde 2006). 208

Although it was based on the principle of equity with a view to realizing the goal of effective equality of access, it resulted paradoxically in discrimination against its recipients. By granting CMU recipients specific rights which legally set them apart from others, a certain stigma became attached to them. Some health professionals decried the culture d’assistance (a notion similar to dependency or entitlement in the United States) and discriminated against these patients. Also, Sector 2 doctors were forbidden from overbilling for those with CMU, engendering a disincentive for them to accept such patients. In these ways, the CMU restricted choice of health care provider for the poor.

Still, the CMU was revolutionary in many of its aspects. It adopted the system of third-party payment to all of its beneficiaries challenging one of the core principles of la médecine libérale. It effectively introduced the notion of “panier de soins,” a defined benefit package for complementary coverage by setting benefit amounts for some dental and optical services (an effort in cost containment) (Jacquot 2000). The basic CMU was financed by the state and the social security regime, while the complementary CMU was financed through a contribution by the state and a tax on the revenues of complementary insurers’ health insurance contracts—both mutuelles and private insurance companies—effectively passing the costs along to those who already benefited from this type of coverage and introducing a new national compulsory solidarity arrangement based on the equity principle. It also blurred the line between statutory, public insurance and voluntary, private insurance and established

208 The Médecins du Monde survey (2006) revealed that 10% of doctors either directly or indirectly refused care to CMU recipients. The situation was much worse for foreigners who received the Aide médicale d’état (AME) and who were refused by 40% of doctors. Another study conducted in the Val-de-Marne in 2005 on the request of the CMU Fund found a refusal rate of 41% among specialists and 39% among dentists in particular. Generalists, on the other hand, refused CMU patients at a rate of 4.1% in Sector 1 and 16.7% in Sector 2 (Desprès and Naiditch 2006).
competition between them, since the beneficiary was free to choose between the local public insurance fund, a non-profit mutual aid insurer or even a private for-profit company as the provider of his complementary insurance. Fears arose that this arrangement would be the Trojan horse to introduce widespread competition between insurers and to open the door for the private insurance sector to conquer a larger share of the health insurance market. While this represents a change in principle, in the end, the vast majority of CMU recipients opted to enroll with the public insurance regime for their complementary coverage.

By the mid-2000s, 91-92% enjoyed complementary coverage—5-7% through the CMU-C. With 8-9% (among what are called the near or middle poor) still lacking complementary coverage, the absence of which still being cited as the main factor in foregoing care (Frérot, Doussin, and Le Fur 2003; Allonier, Dourgnon, and Rochereau 2006), a voucher system (aide à la complémentaire santé – ACS) was instituted in 2005 to provide partial reimbursement of the price of a complementary health insurance contract.\(^{209}\) With the ACS, those residents in France whose income was up to 15% above the eligibility ceiling for the CMU-C could receive a tax-credit subsidy to purchase complementary insurance. However, lack of coverage, as well as the variations in the quality of complementary insurance remained a problem.\(^{210}\) For reasons of cost, the CMU-C ceiling was kept low from the outset leaving a large number without the necessary coverage for real universal access. In effect, the budget orthodoxy pursued by successive governments constrained choices and placed limits on national solidarity even in the pursuit of universalism.

\(^{209}\) This program enjoyed limited success in its first years with only 400,000 enrollees out of an expected 2 million originally targeted. Grignon and Kambia-Chopin (2009) found that those below a €700 per month income were unlikely to purchase complementary health insurance even with a substantial subsidy.

\(^{210}\) Of those receiving the subsidy, many were still opting for low level coverage because they could still not afford the cost of good coverage (Franc and Perronnin 2007). Some 2.5% had low-quality plans failing to cover over-billing, dental prostheses or prescription glasses (Grignon and Kambia-Chopin 2009).
5.5 Threats to the Social Risk Paradigm, Threats to Equity: The Changing Mix of Individual and Collective Responsibility

Despite the constant march toward universalism, there was a concomitant emergence of a neoliberal logic of individual responsibility. Economic and moral arguments were employed to justify increased financial participation of the patient—cost sharing in the policy jargon. Based on assumptions about moral hazard, cost sharing increases were pursued ostensibly as measures intended to make patients aware of the costs of care and hence to dampen demand for care. However, they mostly had the simple effect of reducing public spending on health care and transferring cost and risk back to the individual, with implications for equality of access and questionable usefulness for the efficiency of health resources allocation (Bras 2004). Nevertheless, the trend was to increase the use of coinsurance, copayments and deductibles, especially pursued by right-wing governments during the 2000s.\(^\text{211}\) While the notion of solidarity in the face of social risk was not completely abandoned, a set of ideas and discourse about individual responsibility underpinning cost-sharing measures helped to circumscribe it.

Cost sharing has been an integral feature of the system set up in France from its early foundations. In 1945, for example, the base regime initially intended to reimburse 80% of physician costs. Cost sharing was linked to the direct payment of physicians by their patients, conceived as a way for the patient to share responsibility for his health and to strengthen the doctor/patient relationship. As such, cost sharing and the notion of personal responsibility has

\(^{211}\) While many scholars argue that health policy is mostly made by the technocratic policy elite (Genieys and Hassenteufel 2001) and differs little between Left and Right governments, politics still matters regarding who will pay and how much redistributive solidarity there will be. The left preferred to put more of the financial burden on the better off with use of the CSG, while cost-sharing which is more regressive and places more burden on the sick has been pursued almost exclusively by the Right.
long been an aspect of *la médecine libérale*. However, in time, cost sharing measures were also often utilized for purely budgetary reasons and to raise revenues. Under tight budgetary pressure in 1983, the Mitterrand government introduced a cost-sharing reform into the public hospital system—a copayment called the *forfait hospitalier* (originally 20F per day), couched under the notion of a room and board fee for a hospital stay.

In France, the *tickets modérateurs* (a form of coinsurance) and copayments like the *forfait hospitalier* were supposed to make patients more accountable for their health care expenses based on the notion of moral hazard. The *ticket modérateur* is also raised when certain drugs are deemed to be of insufficient medical utility as part of the growing trend of lowering public reimbursement rates. Another way of shifting costs to the patient is to remove drugs or procedures from coverage by the base insurance regime. In effect, what the base regime will cover constitutes the “*panier de biens et de services*” or basic benefits package, a concept from managed care that has become part of the discussion about what should be included at a minimum by the collectively financed regime.

In spite of the official claim of the dubious medical value of some these drugs, doctors could continue to prescribe them and complementary insurers would still cover them. Because of the development of complementary insurance, these user charges do not have an effect on overall demand for care. However, they have been found to have an effect on access to care.  

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212 The term *ticket modérateur* dates back to a German practice studied in the 1920s in which the patient would give the doctor a ticket representing his coinsurance prepayment to the fund to be redeemed by the doctor. In the first 1930 social insurance law, the insuree incurred a 15-20% coinsurance. In the 1945 ordinances, the first exemptions from this coinsurance were established for long-term illness and expensive care at a time when few insurees had additional insurance. Gradually, a secondary complementary insurance market developed to cover the coinsurance payments which increased over time. In 2010, coinsurance was, for example, 30% for physicians’ fees, 20% for hospital services, and 35% and 65% for different categories of medicine. The fixed-rate *forfait hospitalier* has also steadily increased from roughly 3€ in 1983 to 18€ in 2010. In 2004, a new non-reimbursable form of fixed copayment was introduced: 1€ for each medical act or consultation performed outside of hospitalization. Finally, in 2008, more unreimbursable copayments up to a yearly €50 deductible were added to the system.
for the poor. Studies show that those without complementary coverage or those who cannot pay up-front are more likely to cancel or delay care (Palier 2004). Thus, cost sharing is known to affect usage on the basis of the ability to pay and not on the basis of need.

In theory, then, cost sharing is used to both finance the health system and to influence patient behavior given assumptions about the moral hazard that user charges are purported to mitigate. Yet, experts have concluded that user charges can have severe consequences for low income and chronically ill patients who are unable to pay, while there is little evidence that it has the anticipated effect on moral hazard. Gladwell (2005) placed in doubt the taken-for-granted existence and effects of moral hazard which even the most prominent of health economists like the Princeton professor, Uwe Reinhardt, considered to be overblown. “Increases in co-payments substantial enough to have significant effects on demand are likely to have undesirable effects on access and may have additional social costs” (Docteur and Oxley 2003, 27). In keeping with its somewhat ambiguous attitude toward cost sharing, OECD health economists have not viewed it as a way of influencing demand without some effects on access, yet at times the OECD has praised the transfer of costs towards households (Serré and Pierru 2001 119). Effectively privatizing some risk, cost sharing nonetheless became an inequitable default policy used increasingly during the 2000s—mostly through tinkering with reimbursement rates and déremboursement (removal from the list of reimbursable goods or services).

While the economic orthodoxy of the 1980s was that the social wage (the non-wage cost of labor) encumbered economic growth, outright retrenchment (effectively blatant rationing) in basic publicly-funded health care entitlements was not politically viable. Copayments conceived to temper demand—cost-sharing through user charges like copayments, however, allowed cost-shifting to take some of the burden off of public finances in a more subtle fashion, although people became increasingly aware that coverage had
diminished. While user charges actually decreased in the aggregate, this can be explained by the increasing number of people who were covered at 100% and thus exempt from cost-sharing for any expenses related to a chronic or serious illness (Tabuteau 2009). Yet, for the average patient, potential out-of-pocket expenses increased and many costs were shifted to complementary insurers and to their enrollees through higher premiums.

A discourse of responsibility of the central actors permeated most reform debates. Patient responsibility was increasingly invoked by the government but largely questioned by the experts (Bras 2004; Dormont 2009). The financial crisis of the health insurance funds in 2002 and 2003 was utilized to bring back demand-side measures in the name of personal responsibility of patients. As part of the UMP’s pursuit of the policy of “responsabilisation,” the €1 non-reimbursable copayment was established in 2004, the 18 euro copayment for procedures over €91 created in 2006 and the various “franchises” introduced by the Social Security Financing Law in 2008 were ostensibly meant to hold individuals accountable for health care costs (Tabuteau 2009, 37). Initially, President Sarkozy invoked personal responsibility as the justification for the deductibles introduced in 2008, provoking controversy and mobilizing fervent public opposition including a petition campaign and hunger strikes.

Opinion polls showed that the French population was aware of the creeping policy of restricting reimbursements and expected a further deterioration of coverage, namely for drugs and sector 2 physicians. While not a majority view, a growing number of people accepted that the individual should be made to pay more (TNS Sofres 2008).

The 2004 Health Insurance Reform Law was founded on the need to hold all actors responsible including complementary insurers whose new national organization was integrated into decision-making about reimbursement levels and were expected to engage in “responsible contracts” in order to benefit from special tax status. These responsible contracts were to respect the efforts of the general health regime to control cost by not reimbursing certain copayments such as the extra fees for non-compliance to the new gatekeeper system (Chadelat 2005, 72).

The franchises were 50 centimes on drugs and auxiliary services and €2 on transportation with a daily ceiling of €4 and a €50 annual ceiling. This type of deductible constituted solidarity only between those who were sick as the healthy do not participate if they did not use health services (Tabuteau 2006a, 224).
Later, when he spoke of their earmarking for the fight against Alzheimers and cancer, the public found them more acceptable and opposition eventually waned. Ironically, this meant that only those using the system were being asked to pay for these preventive programs.

Implied in the idea of a non-reimbursable copayment (up to a fixed deductible amount) was the patient’s culpability for needing health care. There was concern that this type of mechanism might erode the commitment of the healthy to the system, as they might never benefit and would eventually be seduced by the idea of cheaper private insurance. The dominant sentiment among the people was that the financing reforms pursued by the government were designed to make patients (rather than doctors) accountable, leading to a system that would exclude more and more people (Viavoice, CISS, and L’Expansion 2008). Essentially, this constituted a threat to equity. While the dissuasive effect of a 50 centimes or €2 copay was highly questionable, many French people (50%) viewed it as a source of inequality while others (46%) believed that it would avoid unuseful care (Direction de la recherche, Ministère du Travail, Ministère de la Santé, Ministère du Budget, David et al. 2008) in resonance with the government’s justificatory discourse on responsibility. At the same time, the government committed to a concerted effort against fraud and abuse, creating a National Committee to Combat Fraud. While individual responsibility, fraud and abuse have been used to frame this aspect of the public debate, this obscures the fact that the vast majority of expenses are incurred by the small population of the most chronically and seriously ill, often during the last months of life. Even so, a discourse of accountability has been used to effectively make shifting a portion of risk and financial burden to the individual patient seem inevitable.

However, reforms that were undertaken by the right-wing governments provoked the ire of many critics. There was a growing sense that proponents of neoliberal economic ideas were waging an assault on the French system and threatening equality and solidarity. In 2001,
the Medef employers’ union, under the leadership of its vice-president Denis Kessler, an insurance executive, proposed an overhaul of the French health insurance system. Opposed to British-style nationalization and American-style private insurance, Kessler came out in favor of a system of managed competition between both insurers and providers, much like the Launois project from the 1980s (Taupin 2001). According to Kessler, managed competition would guarantee universality, reinforce solidarity, re-establish equality would lead to an efficacious organization of well-defined, well-regulated managed care. The think tank, Institut Montaigne, founded by AXA insurance magnate, Claude Bébéar, published similar proposals in 2002 and 2004, advocating a clearly defined universal benefit package, the couverture santé solidaire, potentially managed by competing insurers (Institut Montaigne 2002; Institut Montaigne 2004).

Then, in 2003, the Chadelat government report called for a complete reorganization of insurance with three layers: 1) a basic tier financed by the obligatory public fund that would partially reimburse goods and services in a benefit package, 2) a second tier that would be voluntary, but regulated, and would cover the co-payments of the first tier and 3) a third voluntary tier that would be unregulated and would cover services outside the benefit package (Commission des comptes de la Sécurité sociale 2003). Many criticized this plan as another demand-side approach putting much of the responsibility on the patient, but it also leaned toward a system of co-management between the obligatory and voluntary insurers. Together, the basic regime and the complementary insurers would define the basket of care, the benefits to be covered. Unions were mostly opposed, aside from the CFDT, which favored the

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216 In the Medef proposal, all residents would be covered by health insurance, financed through the CSG, for a basic benefit package defined by a government agency. The government would define the benefit package and levy the necessary resources through the CSG. The benefits would be managed by care providers who would receive a lump sum for each patient in their networks. The provider organizations could be public, private or mutualist. Risk selection would be prohibited and the French would make the choice of provider organization (Kessler 2002).
comanagement and universalist aspirations of the reform, and which would avoid a separation into major risks for the base regime and minor (more profitable) risks for the voluntary insurers (CFDT 2003). For others, however, this would mark the beginning of the privatization of the Sécu (Gallois and Guélaud 2003). This was clearly a proposal to ease the public burden and to accord a larger role to the second tier insurers. Most of these proposals provoked strong hostility and reaction as a threat to solidarity and the first step towards the unraveling the system.

Leftist scholars, activists and experts warned that many of the enacted reforms and other proposals constituted a surreptitious neoliberal plan invented by the Medef employers’ union and successive right-wing governments to delegitimize and eventually destroy and privatize French national health insurance (Berthiot, Chavigné, and Filoche 2004; Caudron et al. 2003; Caudron et al. 2005; Attac 2004). During this period, other ideas floated to the public were seen as a threat to equality of access. In 2006, for example, a major insurer, AGF, launched a project (that was eventually abandoned) whereby, for the modest sum of €12,000 per year, a patient could buy exclusive concierge access to the best specialists in France (Frémeaux 2006). Another insurer, MMA, proposed the idea of a contract with its clients who would be reimbursed for not using the policy, with the obvious danger that the sick might forego care for financial benefit. Finally, in the 2007 election, Edouard Fillias, a candidate for president from a small minority party, Alternative Libérale, ran on a platform of ending the monopoly in health insurance and claimed the legality of opting out of the Sécu (Agence France Presse 2006). While none of these proposals gained much traction and most were abandoned, the individual responsibility discourse and partial privatization already underway

217 The Fédération française des sociétés d’assurance—the private insurance lobby—made repeated pleas to the government to be given exclusive rights to certain health risks, such as dental and optical care (Tisserond 2004; Le Point 2008).
pointed toward a potential acculturation to more market-based provision of health insurance coverage.

5.6 Conclusion

These changes adopted in French health care financing and access accorded the state a larger role in their governance. At the same time, the state pursued a policy of retreat away from public financing, leaving a larger share to the private sector. From 1995 to 2008, the share of the Sécu in health spending declined from 77.1% to 75.5% (Fénina, Le Garrec, and Duée 2009, 130). In terms of health risks, national solidarity was most robust when it came to the sickest and for a basic minimum of care. On the other hand, the dangers of the erosion of solidarity were frequently discussed as the individual was called upon to bear more of the costs for ambulatory care. There seemed to be a thrust toward the tightening of rules for national solidarity around a basic perimeter and the loosening of rules around additional coverage and costs left to the marketplace.

The value of health as a basic human right coexisted with notions of individual responsibility in health. Two frames exerted their influence on French health protection reforms, on the one hand redefining solidarity, and on the other hand, partially individualizing health risks. While ostensibly contradictory, the two have converged on a middle ground in a complex public/private mix. The CMU policy passed in the name of social inclusion, universalism and republican values served to redefine the old cultural and ideological repertoire. Much like the organizational discourse discussed in chapter 4, the discourse in France reflected a growing acceptance of the upward trend in total health spending, while tighter control was exerted over the public insurance system, implying an acceptance of an increased privatization of risk. These reforms carried implications for an evolving sense of
solidarity. Public opinion gradually moved in favor of reforms as long as universality was seen to be preserved on some level. The population became more amenable to the need and the ability to reduce spending without threatening universal access. The French remained highly attached to their health system, its universality and the quality of the public service it provided as a strong component of French national identity. Nevertheless, they also appeared resigned to the inevitability that the entire system was bound to evolve into a less egalitarian, liberal-type system in the end affording them less protection (Sliman 2009).

The deep core idea of solidarity remained strong in the French cultural and ideological landscape. However, social actors adopted a discursive strategy of an evolving interpretation of solidarity in changing economic and social conditions. National solidarity being a malleable concept, policy was made through its adaptation, making it compatible with other beliefs about macro-economic imperatives. Much of the rationale and thinking about health policy reforms were framed by the theoretical premises about the macro-economy, micro-economic behaviors and demography however unsubstantiated by empirical evidence.

In the puzzling over the perceived (or manufactured) crisis of the French welfare state, the economic view has come to dominate. Through strategic learning, actors come together around a consensus on which to base policy decisions. Policy entrepreneurs provide explanations for the perceived failure based on ideology. The supply-side economist views fuel the crisis narrative. In the case of the French insurance system, a concerted effort has been made by employers, insurers and the right-wing discourse to discredit the system as it is. On the other hand, the far left-wing adherents to the “solidaristic catechism” (Smith 2004) decry any suggestion of change as a neoliberal Anglo-American invasion. While framed within this dichotomy, the reality of policy making lies between these extremes and is made in the tension between them. While the system is neither completely bankrupt nor is it on the road to privatization, a shift to more individual, and less, collective responsibility is discernable.
CHAPTER 6 - A Health Care System in Flux: The Managed Care Revolution Seeking to Reconcile Efficiency and Equity

6.1 Introduction

The French health delivery system has been characterized by a blend of both Bismarckian and Beveridgean elements. In the ambulatory sector, the logic of socialized financing and the free solo practice of medicine prevailed for nearly a century. In the hospital sector, social insurance, combined with state funding, control and provision based on a public service ethos developed in the post-war period. On the one hand, total freedom for both doctors and patients long characterized private practice medicine under the banner of *la médecine libérale* primarily funded through collective financing. On the other hand, the public hospital system was conceived to guarantee equal access for all to quality hospital care.

“Identities are the historically constructed ideas that individuals or organizations have about who they are vis-à-vis others” (Campbell 2002, 24). Constructed identities such as that of *la médecine libérale* or the public hospital physician shape how political actors perceive their interests and the policy positions they take. Historically, corporatist identities among the insured, but also among physicians, constituted the largest hindrance to a universal, unified system. The strong historical identity among many doctors and their political representatives was exploited to oppose the initial push towards social insurance in the 1930s and was often tapped in order to block ambitious initiatives. The perception of an inherent opposition between doctors’ freedoms and public service long framed policy struggles. “The idea of organizing health care around the concept of a public service provoke[d] strong resistance, in France, from health professionals who fear[ed] imminent restrictions of clinical freedom and anticipate[d] deleterious effects on the quality of care” (Kervasdoué, Rodwin, and Stephan
1984, 163). Paradoxically, both traditions—la médecine libérale and public service—eventually faced challenges from pure economic concerns combined with a broad ideational convergence around managed competition and managed care in the international health policy community.

Both the international diffusion of health policy models and internal ideational factors explain the adoption of an efficiency paradigm in France (Hassenteufel 2001). This search for efficiency would rely upon both economic and medical criteria. Through methods such as budgetary constraints, competition, managerial approaches and medical evaluation, there was a strengthening of the role of the state with a simultaneous embrace of market mechanisms and techniques used in private enterprise. Just as in the rest of Europe, French health experts were not only trying to contain costs but also to enhance value for money by garnering better data of what works by relying on evidence-based medicine (Evans 2005).

After several decades of demand-side measures and costs controls, French policy-makers turned their attention to the supply-side, adopting many imported ideas from managed care and managed competition. Structural reforms were undertaken to optimize the system and to change the behavior of actors through new micro-economic management (Conseil économique et social 2007). While much of the discussion underscored the need to change the way care was organized, economic frames dominated the diagnosis of problems as well as proposed solutions. Irrespective of the veracity of claims about health spending or the causes of deficits, the belief in the fiscal imperative constrained and shaped the approach to reform of the system of health care provision. While right-wing governments during the 2000s did continue to use demand-side fixes for health spending shortfalls, they also began to take bold steps toward altering the entire governance and organization of health care in the name of better care at a lower cost.
Thus, reforms were concerned with both efficiency and equity. To meet both efficiency and equity objectives, the state needed to strengthen its position to weigh in on the organization and provision of health care. Reflecting a wider convergence trend throughout Europe of the regulatory health care state (Hassenteufel and Palier 2008) and organized competition (Hassenteufel 2001), the French health care system was moving towards a unique French version of state-led managed care (Rodwin and Le Pen 2004). New ways of organizing the delivery of ambulatory care became a central part of the reform agenda.

The first structural reforms began in the early 1990s as health care specialists shifted towards an analysis of the regulation of supply. Reform discussions revolved around policy ideas that affected physicians’ professional autonomy, their total freedom of clinical practice, their freedom to set fees and the fee-for-service payment system as well as patient freedoms and the need to better organize and coordinate care. Threats to equity had grown on the supply-side, namely the explosion of doctors practicing over-billing, geographic inequalities due to the disparity in physician density, and the continuation of private consultations in public hospitals. The original principles of la médecine libérale that had justified the development of these inequities would need to be put in question in order to remedy them.

On the hospital side, a revolution was taking place as well. With efficiency as the main driver, the financing, governance and organization of the hospital system were to be completely overhauled. Through the introduction of public management techniques, the French model of the public service mission was also being redefined. This chapter will show how policy ideas and discourse surrounding reforms in both the ambulatory and hospital sectors reflect evolving contested paradigms.
6.2 The Professional Culture of *la médecine libérale*: Intransigence or Adaptability

The principles of *la médecine libérale* emerged out of the political struggles over compulsory health insurance in the early 20th century. Originally, the very identity of *la médecine libérale* was forged in opposition to mandatory health insurance (Hassenteufel 1997, 94). The physicians’ fight against mandated coverage spawned a major professional organization defending their interests, the *Confédération syndicale des médecins français* (CSMF), and the 1928 Medical Charter enumerating the principles of free practice of medicine in France, namely the patient’s free choice of doctor, doctor-patient confidentiality, the right to fee-for-service direct payment by the patient and therapeutic and prescriptive freedom (Dutton 2007; Wilsford 1991). In 1928, the first law on compulsory insurance for the lowest income salaried workers was thus vigorously opposed by the CSMF over the issue of the medical profession’s freedom to set fees.

Physicians’ accession to compulsory national social insurance hinged on their demand that patients make direct payment to them. Direct payment was conceived to maintain the patient’s sense of personal responsibility and was often invoked by doctors’ unions in defense of *la médecine libérale* (Dutton 2007, 124). Third-party payment was anathema to notions of private-practice in France, and direct payment (part of *l’entente directe*) was viewed as the main guarantor of physician’s freedoms. In keeping with the principle of fee-for-service direct payment, a system of reimbursement was adopted requiring up front payment on the part of the patient to the physician. The patient was subsequently

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218 Third party payment was as offensive to French doctors as national health insurance was to US physicians. In 1951, when French doctors toured the US on a mission to study the US system, they were outraged by the willingness of the US doctors to accept third-party payment which they considered to be the most egregious threat to the doctor/patient relationship (Dutton 2007, 134-35). While for US physicians the bogeyman was always public health insurance, it was third-party payment for the French medical profession. In both countries, similar arguments are made about government encroachment and the threat of socialized medicine.
reimbursed by the insurance fund a percentage of the charge set by the contractual fee schedule agreement.

Professional autonomy was also a central concern in the early days. When mutual aid societies and doctors' unions battled in the 1930s over the monopoly private-practice doctors exercised in fee-for-service provision of care, effectively enjoying professional sovereignty over the whole medical field, physicians threatened to walk away from the health insurance law and prevailed. The achievement of the legal protection of private-practice fee-for-service medicine along with the passage of compulsory health insurance in 1930 was a triumph for the centrist group which "accepted the principle of compulsion as long as physicians maintained broad control over medical decision making and doctor-patient relations" (ibid., 63). By signing on to this new social insurance system, the CSMF won strong guarantees of physicians' monopoly and autonomy and strengthened the hand of solo private-practice doctors, leaving a legacy for generations to come.  

The most striking characteristic of the French medical profession has been its fragmentation within and between unions (Wilsford 1991; Hassenteufel 1997). These first divisions over compulsory health insurance highlight the very ideological nature of union representation and the ideational battles that occurred between different groups of doctors. There have always been rivaling factions within the medical corps—some favoring more collective arrangements, some against government interference and centrists who were willing to compromise. At every major reform episode, new unions spun off from existing

In retrospect, the ability to compromise shattered the notion that socialized financing fundamentally contradicted physicians' professional autonomy and their monopoly. Yet this stark opposition served to frame the debates and the way many physicians and their unions conceptualized and represented their interests.

Paul Cibrie, founder of the CSMF and author of the Medical Charter, was a centrist who also was wary of employer-controlled health care and traded insurance compulsion for complete professional autonomy and the recognition of the medical profession as the sole legitimate authority with regard to health matters.
unions and formed around the adoption or the rejection of the identity of la médecine libérale. Disputes were often related to the principle of directe entente—the agreement between the doctor and patient over fees.

Consequently, the issue of fee-setting was never entirely resolved and has been a contentious issue since the 1945 ordinances establishing the national health insurance fund stripped doctors of their ability to set their own fees. Since agreements were only signed at the department level between local funds and physicians’ unions, problems of non-compliant physicians and varying levels of reimbursement persisted until 1960 when President De Gaulle imposed a new system of binding fee schedules by decree. While the negotiations were still held at the departmental level, physicians would enjoy the right to adopt the convention individually, dealing a blow to medical unions (Godt 1985). Patients of doctors who did not abide by the schedule suffered extremely low reimbursement rates (Wilsford 1993). This was seemingly a critical moment for restriction of doctors’ power and asserting state control over the system (Immergut 1992). The state was able and willing to circumvent doctor’s unions which destroyed their political unity in the process.

However, this also prompted the strategic adaptation of pragmatic union representatives and their conception of la médecine libérale. Thereafter, the CSMF under the leadership of Jacques Monier became a willing partner in accords, having adopted a strategy of defending physicians’ interest on the inside of the system. Coming out of the 1967 Jeanneney reforms, which intended to strengthen the central government’s control over the

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221 Finally, by 1960, a large majority of the profession had accepted integration of medical unions into the national health insurance system symbolized by the election to the CSMF of Jacques Monier, a physician from a rural union and a strong supporter of contracting with the health funds (Hassenteufel 1997, 115).
social protection regime, the first national convention in 1971 finally eliminated the prospect of individual signatures with health funds when the CSMF agreed to price-setting at the national level. In exchange for signing the national convention, physicians were offered subsidies for their own health insurance within the system. By 1980, nearly 98% of physicians were party to the national conventions (Godt 1985). In effect, the medical profession benefited from the continued expansion of the sécurité sociale and was guaranteed this captive market. Yet there was still no ideological consensus about the interests of the profession or the best way to defend private-practice medicine.

On more than one occasion, splits within medical unions occurred over differences regarding the willingness to cooperate with the state on payment issues. The centrists in the CSMF did not find a fundamental contradiction between compulsory health insurance and doctors' interests. By 1960, the majority of the profession had accepted the logic of social insurance (Hassenteufel 1997 115), but conservative hardliners, mostly the affluent, privileged physicians from the larger urban areas broke off from the CSMF over the issue of binding fee schedules. These “strong partisans of la médecine libérale opted out of the NHI [National Health Insurance] system and formed a rival trade union—the Fédération des Médecins de France (FMF)” (Rodwin 1981, 23). Thereafter, the question of the right to free fee-setting and over-billing (dépassement d'honoraires) was an issue at every major reform. From the outset, a small group of exceptional physicians enjoyed a special status and the right to higher fees (le

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222 The Jeanneney reforms much like later reforms followed several government and employers’ union reports that brandished the deficit as a threat to the survival of the system (Godt 1985; Duval 2007).
223 There had been a growing concern about the potential effects of price competition that might result from the expanding supply of physicians (Samson 2009).
224 This recurring ideological division affecting French health reform politics dates back to the earlier parts of the twentieth century when generalists in rural areas were often more inclined than urban specialists to work with the funds to expand their clientele (Godt 1985). While there was always a segment of the medical corps that opposed the integration of doctors into a contractual system with health insurance funds, there were always many (mostly rural) others who favored these agreements.
droit de dépassements d’honoraires). In order to reach agreements, physicians with special training or exceptional skills and experience were granted an exception to the binding fee schedules and were allowed to exceed the standard fees in both the 1960 fee schedule and the first national agreement in 1971.

Later, in the same spirit, a second sector was created allowing some doctors to exceed the Sector 1 fee schedule based on the neoliberal philosophy that the market competition in Sector 2 would drive down fees (Godt 1985). In 1980, the national convention was signed by the more conservative FMF union which obtained these greater billing freedoms (droits de dépassements) in Sector 2 in exchange for its accord. Through a strategy of division of the medical profession, Prime Minister Raymond Barre relied on the acquiescence of the smaller FMF union by creating the Sector 2 in an open embrace of pro-market measures.\textsuperscript{225} The idea was that by allowing certain doctors to charge higher fees, demand would decline and costs would be contained through laws of the market. Although sector 2 was created ostensibly to stifle demand through price competition and also promote better quality of care, not only did it not reduce doctors’ activities or improve quality, but it led to much higher prices (Poullier and Sandier 2000). Originally opposed to freedom of fee setting and the establishment of a second sector, the CSMF quickly changed course soon after in 1981, electing a new president in favor of Sector 2, turning away from its centrist position, and promoting a more conservative program in defense of la médecine libérale. In turn, this sequence of events produced a new rift in the CSMF leading to the defection of a group of disaffected generalists still opposed to Sector 2 who later formed MG-France.\textsuperscript{226} Following the change in leadership in the CSMF and its embrace of Sector 2, MG-France grew in part out of

\textsuperscript{225} Benamouzig (2005) affirmed that this was more the result of a classic power struggle than of an explicit adoption of neoliberal market ideas. The adoption of Sector 2, nevertheless, had a lasting effect on the medical corps and the ability of specialists to set their own fees.\textsuperscript{226} For more on the inception of MG-France and an inside account of how it became a union recognized by the state to represent doctors, see Tabuteau (2006a).
opposition to Sector 2 which was seen to favor specialists but also from a strong sentiment among many general practitioners that they should have their own specialized training and should cease to be degraded both professionally and financially.

Normatively, sector 2 marked a reverse in philosophy. This was a blatant breach in the compromise between equality and liberty arrived at in the short period of unchallenged national conventions. In effect, the creation of Sector 2—composed mostly of specialists—opened the floodgates to cost-shifting back to patients and exposed the political and ideological divisions in the medical corps (Dutton 2007). Although Sector 2 did not have any demonstrable success in reaching its stated objectives of dampening demand, it exacerbated the split between general practitioners and specialists and was thenceforth a major bone of contention between them.

In 1980, some 19.5% opted out of Sector 1 to charge higher fees in sector 2. By 1989, the numbers had jumped to nearly one third of all physicians (Tabuteau 2006a, 174). By 2004, 40% of specialists were in Sector 2.227 “Doctors’ liberty of fees had once again collided head-on with the republic’s goal of equality” (Dutton 2007, 191). The problems of access to care caused by evolutions in Sector 2 combined with budget concerns highlighted further the need to tackle the difficult task of regulating the ambulatory sector. While some physicians’ groups were more amenable to adapting the practice of medicine, others were intransigent in their defense of traditional principles. In either case, physicians and their unions remained a formidable force in health care politics who managed to stave off pressures on their economic power and who have often turned their fragmentation to their advantage.

Albeit counterintuitive, high physician density and fee-for-service payment with price controls have been found to provide perverse incentives for increased activity and excess.

227 In some specialties such as surgery, the numbers in sector 2 were as high as 82% in 2004 (Aballea et al. 2007, 13).
usage of the system in France. When physician density increases and the number of consultations declines, physicians increase the volume of care provided in each consultation (Delattre and Dormont 2003). They compensate by doing more with fewer patients. By the 1980s, health policy experts were aware of the phenomenon of supply-induced demand (Godt 1985; Delattre and Dormont 2003; Dormont and Huber 2006). The fee-for-service system in the ambulatory sector encourages high volume and supply-induced demand. Moreover, without price competition, a greater supply of physicians increases the volume of services in a fee-for-service system. With non-discriminating payers—a public insurer who pays blindly without any controls and supplementary insurers doing the same—fixed prices lead to excess usage as doctors increase their volume to maintain or increase their incomes.

Though doctors seemed to have experienced a loss of relative power, ever since the Juppé government made a blatant move to control them, the threat of electoral consequences has given them more clout, causing successive governments to give in to their demands and to put off confronting the reform of Sector 2. Belying the claims and complaints made by medical professionals, their incomes have increased at a higher rate than the average in France, especially for those in specialties and those working in hospitals (Kervasdoué 2006b). While fees have been held down, incomes have clearly not suffered as much as might be expected given the discourse propagated by doctors’ unions, although there are troubling

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228 See also Jean Peneff’s *La France malade des ses médecins* (2005) for a searing sociological demonstration and critique of supply-induced demand. In contrast to the thesis of a decline or erosion of doctors’ power, Peneff depicts a medical corps whose social and political clout persists, which is able to turn reform to its advantage and still carries a significant weight in public and political discourse.

229 With effectively a monopsony payer facing a professional monopoly, “fee-setting in this context leads to a classic bilateral monopoly situation that, in economic theory, is ‘indeterminate.’ The resulting fees are largely determined by ability to bluff, skill in bargaining, and, above all, power, all of which fall outside the economist’s preoccupations” (Rodwin 1981, 29). In other words, when doctors are politically emboldened, they often extract higher fees.
disparities between specialists and GPs. Nonetheless, in 2004 on average GPs earned 2.6 times the average French wage (Fujisawa and Lafortune 2008). From 2000-2007, incomes for physicians in private-practice increased at an average annual rate of 1.8% (controlling for inflation). Furthermore, in 2007, those in Sector 1 saw a 12% increase in income. A fee hike from €21 to €22 per visit contributed to a 3% annual increase in GPs’ incomes that year. Contrary to popular discourse, physicians have been rewarded economically, enjoying large relative income gains as a profession since the 1980s (Kervasdoué 2005). In consequence, the trade-off of guarantees of therapeutic freedom for price controls did not automatically lead to a loss of economic power. Still enjoying relative therapeutic freedom, physicians have adapted their behavior to enhance their economic power.

A number of physicians unions participate in health politics in France. Although only some are legally recognized to represent doctors in contractual negotiations, the union landscape ranges from the most free-market FMF, SML and Alliance (the main defenders of free fee setting) to the traditional center-right CSMF, the center-left MG-France and the alternative left SMG. While FMF and SML spun off from the core CSMF to better defend la médecine libérale, MG-France and later Espace-Généraliste developed out of a sentiment that general medicine was being neglected by the other unions whose defense of la médecine libérale tended to favor the interests of specialists. In 2006, representative unions included CSMF, MG-France and SML for generalists and the CSMF, FMF, SML and Alliance for specialists. These ideological differences underscore that doctors’ representations of themselves and their interests are not based on pure material self-interest, but on their belief systems, social representations and assumptions about what is in the interest of their profession.

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230 On average specialists in France earn 1.7 times as much as general practitioners; radiologists, anesthetists and surgeons can have earnings up to 3 times that of a GP (Fujisawa and Lafortune 2008).
While the fragmentation of unions has been considered a source of weakness by some (Immergut 1992; Wilsford 1991), it can also give doctors the upper hand in framing and defining policy in ambulatory care. The imposition of a national contractual system requiring negotiation with physicians’ unions has had the unforeseen consequence of reinforcing their ability to thwart reform. This competition among unions allows doctors to regularly punish those who are willing to compromise with public authorities (Bras 2008). Both the CSMF and MG-France have paid dearly in union elections for working closely with public authorities on reforms. Moreover, in the public forum, rather than appearing to defend their incomes, doctors often position themselves as the protectors of the system ensuring freedom, solidarity and quality care for all in the face of a government bent on cutting back in the name of deficit reduction. The balance of power has benefited physicians more than institutional analyses have often claimed, as evidenced by their ability to improve their economic status and to increase their incomes as well as to influence public opinion.

6.3 Reforming the Governance of Ambulatory Care: Clashing Liberalisms in the French Version of State-led Managed Care

Reform of ambulatory care by the state was, thus, stymied by the interrelated immobility of interests (Rochaix and Wilsford 2005) and the inadequacy of the dominant medical ideology of la médecine libérale (Kervasdoué 2006b). Despite a strong state and the organizational division of the French medical profession (Wilsford 1991), the liberal tradition and the principles enshrined in the 1927 charter have posed major obstacles to reform of the ambulatory sector. “This liberal ethos [has become] French health care’s ideational and political background” (Vail 1999, 317). While the official reform narrative acknowledged the
responsibility of doctors and the need to hold them accountable, stiff resistance from the representatives of private-practice physicians often renders change difficult.

The ethos of *la médecine libérale* clashes with the neoliberal supply-side ideas behind the push for reform (Godt 1989a). Consequently, two competing discursive coalitions have come to dominate the health care debate—the neoliberal coalition and the liberal medicine coalition (Pierru 2007). While both are attached to freedoms, the perception of their interests, their goals and their policy prescriptions diverge. Neoliberalism on the macroeconomic scale seeking to shrink public health spending, which embraces managed competition and managed care solutions, is largely incompatible with traditional notions of *la médecine libérale*. Yet, there has been a growing consensus that financial sustainability of the social security system is incompatible with unfettered patient and physicians’ freedoms (Hassenteufel and Palier 2005; Palier 2004; Rodwin 2006). For example, free fee-setting, fee-for-service, direct payment and the prerogative to settle and practice anywhere in France without consideration for the needs of the population are increasingly viewed as impediments to the efficiency and efficacy of a rationally organized health system (Samson 2009; Suarez 2008). There has been a building ideational and discursive momentum questioning the precepts on which *la médecine libérale* was founded.

Because of French physicians’ strong aversion to pure financial controls, the benchmark notion of *maîtrise médicalisée* (medical regulation) of costs became popular at the health insurance funds in the early 1990s on the initiative of Gilles Johanet, Director of the CNAMTS (Genieys and Hassenteufel 2001; Serré 1999). The *maîtrise médicalisée* was intended to represent the middle ground between the neoliberal economists in the Finance Ministry concerned only with controlling spending and the free-wheeling spend-thrift physicians with no concern for costs. Since doctors were not interested in controlling costs, a discourse was developed regarding medical utility and quality objectives. Instead of limiting
spending, *la maîtrise médicalemente* aimed to optimize spending based on medical criteria. In order to gain the assent of doctors attached to the principles of *la médecine libérale*, cost-savings needed to be sought through medically-driven policies and the development of a public health culture.\(^{231}\) Civil servants were trying to develop a public health discourse to counter the individualism among doctors and to unify the medical profession.

In 1993, RMO clinical guidelines (*références médicales opposables*) and care protocols were introduced, along with a new coding system for medicine, services and pathologies in order to know what was being reimbursed by the insurance funds, with a view to curtailing costs through medical, as opposed to pure budgetary, regulation. “Derived usually from more general, evidence-based practice guidelines, RMOs are prohibitions of patient management practices deemed inappropriate (in particular, in relation to ordering tests and prescribing medications), including failure to carry out recommended tests” (Sorum 1998, 662). Hence, these nationally recognized professional guidelines introduced the principle of external controls, however weak the sanctions.\(^{232}\) The principles of total professional autonomy and therapeutic freedom were conceptually breached by the use of these newly established practice guidelines (Hassenteufel 1999). The days of pure self-regulation by the medical profession were numbered.

Despite physicians’ objections, however, many of the experts still maintained that both budgetary and medical regulation were necessary and complementary (Mongin 1997; Tabuteau 2006a). Asserting the prospect of regulating health spending is an implicit challenge to doctors’ freedoms. Both pure budgetary controls as part of a program to shrink public spending and medical control of costs to make physicians more cost effective through greater

\(^{231}\) For an interview with Gilles Johanet on the Juppé reform and the medical and budgetary control of costs, see Mongin (1997).

\(^{232}\) Whereas the CSMF and SML viewed the acceptance of RMOs as a way of avoiding pure financial controls, MG-France opposed them because they fell mostly on general practitioners and not specialists.
regulation run counter to the original principles of *la médecine libérale*, but physicians are more open in theory to the idea of medical controls rather than pure financial controls which they often denounce as rationing and a threat to quality of care.

However, the distinction is not that clear and often what is passed off as *maîtrise médicalisée* is really an arbitrary way of getting doctors to agree to budget tightening and spending reductions, i.e. getting them to reduce sick releases in exchange for better pay. Cost containment measures can be couched under ostensible medical criteria, such as when drugs are removed from the reimbursable list for insufficient medical service rendered. This is an example of a discursive use of a benchmark notion in health policy discussions that can be deployed in order to justify policy measures. When Prime Minister Juppé announced his original plan for global budgeting for private expenditures holding physicians collectively responsible for overruns, he argued that this would be based on medical criteria (*Le Monde* 1995c), but doctors’ unions denounced the measure as pure accounting control of costs.

Another aspect of medical management of costs has involved the question of patient's freedom of access to more than one physician for the same condition and direct access to specialists without passing through a primary care physician. Although anecdotal stories are often told for rhetorical purposes of patients going to multiple physicians for the same pathology, engaging in doctor shopping until they are satisfied, studies have shown that this problem is much less significant than government and media narratives often portray (Bras 2006; Tabuteau 2006a). Nevertheless, the first experiments in coordination of care and a gatekeeper arrangement with new modes of payment began with a proposal by MG-France called the *contrat de santé*, an agreement whereby doctors would adopt certain prevention

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233 In 1996, the Juppé plan introduced a *carnet de santé*, a portable personal health record, intended to tackle the problem of “*nomadisme médical*.” Conceived as a tool of the medical control of costs to make patients more medically responsible and to not go directly to specialists, the final version lost its obligatory nature.
and management practices in exchange for an annual lump-sum capitation payment per patient. Because this innovative arrangement allowed for third-party payment for patients who agreed to sign a contract, it was opposed by the CSMF and other unions on the grounds that it was a breach of the direct payment principle. Many have placed in question both the fee-for-service and direct payment as constitutive of the liberal medical profession with a third-party monopsony payer. This professional monopoly combined with a demand-side that is funded by the public purse contradict the very foundation of competitive market transactions (Kervasdoué 2005). Philosophically and conceptually, the claims to freedoms in *la médecine libérale* are on shaky ground; and yet they have held much sway with both the public and the profession.

With objectives other than physician freedoms, MG-France opted for tactical cooperation with the state on the Juppé reform (Rochaix and Wilsford 2005) in order to press for a gatekeeper and primary care role for general practitioners. The *médecin référent*, which was part of the initial Juppé proposals, recognized the importance of generalists in the system and questioned the autonomy of medicine much to the chagrin of specialists (Damamme and Jobert 2001). The other more conservative unions (CSMF, SML, FMF), boycotted the optional *médecin référent*, and mobilized together in opposition to the entire reform, blasting it for its reliance on pure budgetary caps which they said would lead to the rationing of care (Hassenteufel 1997, 341). Eventually the financial sanctions were abandoned because the medical lobby fought hard and had it deemed unconstitutional. Nevertheless, the growing influence of the generalists’ unions altered the dynamics of the profession, diminishing the dominance, but strengthening the resolve, of specialists’ unions.

The 2004 Douste-Blazy reform was highly criticized for mostly returning to demand-side cost-shifting to patients while giving lip service to making the providers more
responsible. As Claude Frémont, a very publicly outspoken fund director, declared with irony, the government was holding patients accountable by making them pay more and doctors by hiking their fees. In the ambulatory sector, the main innovation of the Douste-Blazy reform was the institution of the mandatory treating physician which in the official discourse was intended to restrict access to care and to curb *le nomadisme* medical or doctor shopping (even though reports show that the rhetoric about *le nomadisme* has been highly overblown). In conformity with OECD suggestions, this reform aimed to use microeconomic incentives to affect the behavior of both doctors and patients through the use of a gatekeeper physician as well as financial penalties for bypassing the treating physician. For the first time, with the obligatory referral system, the notion of restricting patient access to physicians was accepted, however only by giving specialists the right to overbill when patients consulted with them outside the coordinated treatment plan. Because specialists were granted this concession by the friendly UMP government, the CSMF negotiated and signed on to this reform, while MG-France and other generalist representatives ferociously opposed this form of gatekeeping, as there would be no compensation for the treating physician. Despite the initial resistance by many physicians, the treating physician has entered in the cultural norms. However, it is no longer expected to have cost-saving benefits and is mostly touted for its coordination of care aspects, improving quality and efficiency of care.

Furthermore, in time, quality assurance and quality control were also being developed by new government regulatory agencies to have more oversight over physicians’ activities.

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234 After the electoral backlash suffered from the Juppé reforms, the UMP did not want to suffer the same retaliation as had the RPR in 1997 (Sorum 1998) and thus adopted a protest avoidance strategy (Béland and Marier 2006) with the doctors, appeasing them first with fee hikes and then catering to their base constituency by making concessions to specialists and their unions in the 2004 reform.

235 On the other hand, acculturation to the treating physician was not as difficult as expected as most French people were accustomed to the cultural notion of the family doctor.
Also other examples of medical regulation of costs included incentives for the use of generics and stricter control over long-term illnesses (ALDs) (Conseil économique et social 2007). Developing medical evaluation and control of spending came into sharper focus in order to render the health care system more efficient and to improve quality of care. Some measures met with greater success in the late 2000s when doctors were reported to have made savings for the CNAM by limiting the prescription of antibiotics and other drugs as set out by their contracts and also by the development of the use of generics. However, an assessment by the High Council for the Future of Health Insurance (HCAAM) concluded that while many good initiatives had been taken in the direction of establishing best practices with a view to quality improvement, the results were limited after nearly 20 years of these timid managed care measures (Dupuis 2009b). Nevertheless, concepts from managed care were gradually taking on greater importance in the French approach to the governance of ambulatory care.

6.4 Adaptive French Medical Culture: New Fee-setting Arrangements, New Modes of Remuneration and New Attitudes towards Doctors’ Freedoms

A major dilemma raised by Sector 2 was its effect on equal access to care and the supply of physicians available to the population in all parts of the country; some regions were eventually bereft of any Sector 1 physicians to choose from in certain specialties. Although Sector 2 was partially frozen in 1990, it still became problematic as too many physicians were escaping from Sector 1. Because specialists were more likely to be in sector 2, there was a more pressing need for good complementary coverage to cover their higher bills. In certain places like Paris, it became difficult to find doctors in Sector 1, making it all the more indispensable to have good complementary coverage to ensure access and the patient’s free choice of physician without financial penalties acting as a deterrent to seeking care. During the 1990s, Sector 2 began to pose a major dilemma for the principle of equality of access, causing
certain populations to opt for the emergency room in the absence of access to primary care in the ambulatory sector (Tabuteau 2006a, 175). Fears surfaced of a divide into private practice care for the well-off and overextended hospital care for the less fortunate. Moreover, increasing pressures for fee-setting freedoms represented a major threat to the system of contractual agreements between doctors and the public health insurance fund.236

In 2007, the issue of overbilling arose when a special mission of the Inspection générale des affaires sociales studied the question of dépassements d’honoraires which amounted to €2 billion out of a total of €18 billion in doctors’ fees in 2004. In real terms, the total amount of physician’s fees charged above the standard fees allowable by the national convention doubled over a fifteen year period from 1990-2005. While disparities endured between specialties and regions, on average the rate of overbilling practiced by specialists increased from 29% in 1995 to 47% in 2004 (Aballea et al. 2007).237 The explosion in overbilling during this period was viewed as a step backward, erosion of national solidarity, and contrary to the foundational principles of national health insurance. The government meekly responded by requiring physicians whose fees were in excess of €70 to make it clear in writing to the patient before hand.

Finally, the conflict between doctors’ billing freedoms and the goal of equality of access crystallized in the optional sector reform debate. Due to the relationship between the

236 For Didier Tabuteau (2003) and other civil servants, members of the welfare elite who sought to preserve solidarity and reinforce equality of access, a legally binding fee was key to the system. Allowing fee freedoms to explode would reduce significantly the place of the national health insurance funds and would open the door to the mutual and private insurers to take the preponderant place in the system. As he warned, the public fund could be transformed into a regime providing only a basic minimum with a safety-net for the worst off, while the insured would have to go on the market with disparities in benefits and prices. 237 In some specialties, these dépassements constituted a larger and larger part of the income of these specialists creating a greater income divide with generalists and specialists in Sector 1. For the insured, these practices often constituted an obstacle to care and threatened solidarity. For other physicians, these practices made the system inequitable and favored the generation that began after the 1990 freeze. For the state and main health insurance funds, the system was inflationist, geographically unequal and inefficacious (Aballea et al. 2007).
growth in specialties, sector 2 and the complementary insurance market, a new sector was created in 2009 that acknowledged this reality. Over-billing would now be clearly defined and contracts negotiated with complementary insurers to cover excess fees. President Sarkozy himself declared “over-billing in private clinics prompts some of our fellow citizens to forgo health care and this is not acceptable” (Dupuis 2009a). With a view to creating an option that would be more appealing than sector 2, the Minister of Health, Roselyne Bachelot worked with the mutual insurers, and namely Jean-Pierre Davant, the President of the Mutualité française, to reign in doctors’ fees (Karel 2009). The Mutualité, representing the majority of complementary insurers, was thus willing to engage in a new contractual experiment in order to address this problem.

In principle, the optional sector was conceived to get control of spiraling fees, especially in highly technical areas where many were in Sector 2. Incorporating medical guidelines and evaluation techniques in this measure, physicians (initially limited to surgeons, anesthetists, and obstetricians) in the optional sector would agree to follow certain practices and to greater transparency with regard to the quality of their work. They would also respect the fee of the Sécurité sociale for 30% of their activities. In exchange, for the other 70%, they could practice limited excess billing (up to 50% of the agreed fee) which would be better covered by complementary insurers. The patients’ advocacy group, Collectif Interassociatif sur la Santé (CISS), denounced the optional sector as a step towards the end of a system of health care solidarity, because it was an institutional transfer of responsibility from the obligatory regime to the voluntary complementary insurers that many still did not have (Collectif Interassociatif sur la santé 2009). Nevertheless, many placed hope in this project as

238 While the complementary insurers were not bound to this, their national union (Union nationale des organismes d’assurance maladie complémentaire, UNOCAM) would encourage its members to do so.
a means of phasing out sector 2 and stemming the potential further explosion of specialists’ costs.

At the same time, two other precepts of *la médecine libérale* were also in question—freedom of *installation* (a recent new focal point) and fee-for-service payment. Given the physicians’ freedom to settle and practice wherever they chose, wide geographical disparities became an important public health concern in the 2000s. This ability to set up practice anywhere was deemed incompatible with a quest for optimal allocation of resources across the French territory (Suarez 2008, 49). The first actions taken were voluntary measures such as providing financial incentives to encourage doctors to build group practices in medically deprived areas (Bourgueil and Berland 2006). The French public was beginning to agree that doctors must relinquish some freedoms and was willing to make a break with the principles of free practice for a better functioning system.239 While the CSMF and SML continued to argue for voluntary arrangements and financial incentives, the health funds and government proposed a “contribution” (an excise tax) on physicians in high-density zones who refused to participate in the *contrat santé solidarité*—a public service mission—viewed as an obligation to provide care in the underserved zones (Dupuis and Gattuso 2009). Public authorities are clearly trying to redefine the role of private-practice physicians confronting them with a novel discourse of their public service obligation.

Finally, fee-for-service has been one of the main defining features of private practice medicine in France. Depending on the type of practice and their ideology, not all physicians are equally attached to this practice as an exclusive payment method. Hence, general practitioners, who perform fewer technical procedures (which are more lucrative) and whose fees have been kept much lower than those of specialists, tend to be more willing to explore

239 When polled, large majorities over 70% favored forcing doctors to practice in underserved regions (dramatized in French as “*les déserts médicaux*”) (Le Généraliste 2009; Institut français d’opinion public for GlaxoSmithKline 2008).
alternative payment methods—salary, capitation or pay-for-performance (P4P). In addition, public authorities having become acutely aware of medical students being turned off to general practice medicine, experimentation of mixed payment systems and alternatives to the traditional fee-for-service solo office practice became a visible political issue in the later 2000s to attract students to general medicine.

A new voluntary arrangement came out of negotiations in 2009, the Contrat d'amélioration des pratiques individuelles (CAPI), the contract for the improvement of individual practices. The CAPI combines a new capitation payment with medical guidelines, disease management practices and efficiency goals in generic drug prescription. A form of pay for performance, a referring physician can earn an extra €5000-6000 yearly by complying with all of the contract’s objectives. Apparently, an evolution of some doctor’s identities and their expectations was underway. While doctors’ union opposed the CAPI on the grounds that it compromised a doctors’ independence and prescriptive freedoms, in the first 6 months, 12,600 general practitioners (30% of those eligible) signed on (Saint Roman 2009; Egora 2009). The CAPI did not emerge out of a change in political institutions or a change in the relative balance of power between doctors and the state, but from a shift in thinking in the health policy community and a change in doctors’ identification with their profession. These new attitudes toward fee-setting, compensation methods and other freedoms indicate a reassessment of la médecine libérale as the sole means of regulating the ambulatory sectors.

6.5 Changing Structures of Governance: Wresting Control from the Social Partners in Order to Introduce Managed Care and Managed Competition in Both Ambulatory and Hospital Care

Structural changes to the relationship between insurers and providers were necessary to facilitate decision making in the health care system. The state has been pursuing the
gradual reduction of the role of the social partners in the administration of health matters.

National health insurance passed through several phases since its inception from worker control, to *paritarisme*, to government control. At the liberation, the administration by the beneficiaries (the workers’ organizations) was based on the principles of social democracy, with 75% worker and 25% employer representation. The 1967 Jeanneney Reforms designed to give greater authority to the central national organizations was intended to gain control over the finances of the entire social security system (and specifically over the health insurance funds). The balance of power between workers and employers changed in a victory for the *patronat* as the administrative councils would thereafter give equal representation to workers and employers (*paritarisme*) and the employee’s share of contributions was increased. In a blow to social democracy, the 1996 Juppé reform eliminated the popular election of representatives in the health insurance funds (that had been reinstituted for a short period by the socialists). Subsequently, the *patronat* challenged the state’s incursion into social protection in its November 1999 reform program dubbed the *refondation sociale*. Later it practiced the *siège vide*, a period during which the *Mouvement des Entreprises Françaises* (the Medef), controlled by its liberal laissez-faire wing, refused to participate in the administration of the CNAM, the national health care fund. The state needed to remove veto points—both the employers and employees—in order to enact desired changes.

In the early 1990s, two reports were commissioned bringing together groups of experts to examine the “deep crisis” in health care (Soubie 1993; Soubie et al. 1994) from which many reforms were drawn over the following two decades (Bras and Tabuteau 2009). While a commitment to a basic public insurance system was confirmed; a new policy frame emerged

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240 Serré (2002, 77) finds an implicit acceptance of principal/agent theories (introduced in France by health economists, Michel Mougeot and Lise Rochaix) in the 1994 Soubie White Paper, showing the influence of neoclassical economics over administrative and government experts in France.
around the need to regulate the health care supply. Hence, the structures and rules of governance needed to be changed in order to better organize and coordinate the entire system of financing and provision, for the long-term goal was no longer simply to limit spending.

The Sante 2010 Report (Soubie 1993) laid out a comprehensive vision of reform for a new health care governance based on seven pillars: 1) the creation of a universal health insurance regime financed by taxation, 2) the definition of the benefit package by a specialized national body based on cost effectiveness, 3) health spending objectives to be voted by parliament, 4) an institution defining public health policy relying on a national health insurance body to budget spending for the regions; 5) regional health services agencies charged with governing the system, 6) a regional financing mechanism, and 7) contractual relations and competition between providers who could choose between capitation payment, fee-for-service, or coordinated care networks (Bras and Tabuteau 2009, 85). The vision presented here has influenced many subsequent reforms, whether they were adopted (or attempted) as suggested or some variation thereof developed over time.

In order to achieve this vision, the way the system was financed and governed would first have to be altered. Parliamentary control was first reinforced through the constitutional reform requiring an annual budget vote and the setting of health spending targets, effectively abandoning social democracy in the administration of these funds and taking control away from unions.241 Paritarisme—governance by the social partners alone—was clearly repudiated as a way of governing health care financing. At the same time, a change in the statutory composition of the managing boards accorded more influence to the state (Bonoli and Palier 1998). The need to remove the social partners relates directly to the ability to make

241 The left-wing unions opposed the Juppé reforms. Force ouvrière denounced these changes as a co-optation of their institutions by the state; the CGT warned of state control over spending leading to rationing of care (Le Monde 1995b).
subsequent changes in the governance and organization. In so doing, the state was empowered to the detriment of the social partners.

While the Juppé reform’s global budgeting for ambulatory care was met with staunch opposition and the national spending targets were not respected, their very creation placed deficits in the health insurance funds high on the public agenda. Furthermore, changes in the governance of the health insurance system began to have far-reaching consequences for the management of health care. Inspired by the Soubie Report Sante 2010 (Nouchi 1995), regional bodies created under the Juppé plan (and later expanded) were charged with hospital planning, budgeting and fostering better coordination between insurers, hospitals and private-practice physicians. The regional unions bringing together the main health insurance funds (URCAMs) were to oversee and coordinate budgets and manage risk at the regional level. Linking the state and the insurance funds at the regional level, the Regional hospital agencies (ARHs) were responsible for planning and distributing funds to hospitals within the limits set by parliamentary vote each year, effectively according more influence to the state (Franc and Polton 2006). The Juppé reform kicked off a process of regionalization that was consolidated with later reforms with a view to creating a single regional structure.²⁴²

Later, the 2003 report of the HCAAM emphasized the need to designate a “pilot” for the entire system (Fragonard 2004). With the advent of the National Union of Health Insurance Funds (Union National des Caisses d’Assurance Maladie, UNCAM) in the 2004 Douste-Blazy reform, the three main funds were grouped into one body to represent the insured. Most importantly, the Director of the CNAMTS, the main insurance fund, became the Director of the UNCAM and was given more powers. With the new director-general, a political appointee of

²⁴² Regionalization helps to strengthen the hand of planners and purchasers against providers. Also as buyers, third-party payers can become more discriminating (Freeman 2000, 50). Regionalization also helps to shift blame away from central government authorities for difficult decisions in a system with such recalcitrant interest groups and conflictual relations (Evans 2005, 290).
the government, the state created the institutional pathway to gain greater control over the governance of both the insurance and the delivery system at the national level. This director-general would alone have the authority to negotiate and sign agreements with medical professionals and to nominate the directors of local and regional funds. He was squarely in the pilot’s seat. The state thus shifted some other responsibilities to the insurance funds including defining what should be covered and setting copayment and co-insurance rates.

6.6 The Changing Hospital Sector: Public Service or Private Enterprise?

Little has been written of the less visible politics of the French hospital system. While the politics of ambulatory medicine were fraught with conflict, hospital policy went largely uncontested during the long period of expansion. Most major decisions were made by an empowered executive that decided by decree. In 1958, the Debré Hospital Reform Law merged medical schools with regional hospitals, creating the University Hospital Centers (CHU) and granting those in university hospitals full-time salaried positions with civil servant status combining clinical service, teaching and research (Godt 1989a; Hassenteufel 1997). As a concession extracted by prestigious hospital physicians, the Debré Law set the precedent of allowing private consultations and receiving private patients in public hospitals, which continued thereafter to be an incentive to attract and retain the best practitioners in the public

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243 This new governance reduced the relative role of the social partners and was tacitly accepted by both the employees’ and employers’ unions according to Jean-Marie Spaeth (2008), a CFDT representative and former president of the CNAM.
The 1970 Boulin Law was passed to control costs and to create *the carte sanitaire* to manage the spatial distribution of the hospital supply of beds and investment in equipment.

Managerial techniques introduced into the hospital system made their way to France via international policy transfer. Reforms aimed at cost containment in the hospital sector were long the principal focus of reforms, because the state had exclusive and unambiguous domain over hospital policy (Freeman and Moran 2000, 47). For decades, the only major structural change to the health care system to have clearly met its stated goal—the stabilization of hospital expenditure— was the prospective budgeting reform by Prime Minister Beregovoy and then Director of Hospitals, Jean de Kervasdoué. Before global budgeting was instituted in 1984, hospital expenditures in France under a per diem system were growing at an annual rate of 15.1 % per year. However gradually, managerialism was replacing the public service concept with that of the public enterprise (Godt 1989a, 205). Kervasdoué, an adept of Robert Fetter's work on Diagnosis Related Groups in the United States, also instituted the *Programme de Médicalisation des Systèmes d'Information* (PMSI) in 1985 as part of a nearly two-decade long endeavor to implement new management styles in hospitals based on knowledge of the patient case mix and measuring clinical activities involved in treatment.

Eventually global budgeting was viewed as a system favoring the worst performing and least dynamic hospitals and penalizing those that made efficiency and quality improvements. With

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244 While socialist President Mitterrand attempted to eliminate this practice, Prime Minister Jacques Chirac restored private practice in public hospitals in a gesture to win back support from conservative physicians who had defected from the right in the 1981 presidential elections.

245 As part of a widespread international diffusion of DRGs, the Yale University Health Services Management Group, under the leadership of Fetter, worked jointly with the French developers of the PMSI program in France which was designed to track hospital medical activity using a patient classification DRG-type system, in France called GHM (Homogeneous Patient Groups, or *Groupes Homogènes de Malades*) (Gilardi, Fuglister, and Luyet 2009; Michelot and Rodrigues 2008).
the team of young policy entrepreneurs open to foreign ideas, the system evolved gradually away from global budgeting based on historic costs to a casemix-based financing system.

Because of the potential reaction by the hospital personnel, Michelot and Rodrigues (2008) described how the PMSI was presented as a mere epidemiological tool. Later they were told that it was necessary for both internal micro-management and external macro-level decisions, but that it was not going to be a pricing tool. This was essentially a technocratic strategy of policy making by stealth dissimulating the ultimate intentions of this program. The Juppé ordinances openly adopted casemix as a pricing tool to modify budgets within and between regions. And finally, the Plan Hôpital 2007 (enacted in 2003) began giving hospitals more autonomy to make them better managed and it made provisions for a gradual phasing in of a new financing system in the French hospitals termed the tarification à l’activité (T2A)—activity based pricing. As part of the pursuit of better value for money, the Hôpital 2007 along with the more far reaching HPST reform in 2009 were conceived to make the system more efficient and to relieve fiscal pressures (OECD 2009a). These two reforms reflected the shift to the efficiency paradigm in hospital care.

The public service mission of hospitals was defined by law in 1971 as the obligation to provide care to all on a permanent basis. Many of the non-profit hospitals have been managed by mutuelles or other organizations as part of the system of hospitals participating in the public service mission. Other for-profit institutions are highly concentrated in simple surgical procedures and obstetrics, leaving major interventions to the capital intensive hospitals. This distinction has effectively allowed non-profit hospitals to cherry-pick profitable procedures and treatments, because they are not obligated to fulfill any of the public service missions, causing

246 The OECD working paper and country surveys from 2000 recommended that French hospitals create incentives to provide quality at optimal costs along the lines of a DRG system and also that the regional agencies be expanded and given more autonomy and tools of economic management (Imai, Jacobzone, and Lenain 2000; OECD 2000).
recurring conflicts between the public and private hospital sectors. Private hospitals have often claimed that they were more efficient than the public sector, but they do not bear the burden of teaching, research and high-cost illness that are endemic to the public service hospital sector (Rodwin 1981). The public and private hospitals were for a long time under two different finance regimes. While public and non-profits hospitals used global budgeting since the 1980s, for-profit hospitals continued to use negotiated fee-for-service and per-diem pricing.

In order to standardize prices and to foster competition between the public and private sector, the tarification à l’activité (T2A) was begun in 2004 and was to be fully in place by 2012. As the first real micro-economic management of allocation of resources on a large scale, the T2A is a market mechanism, a prospective payment system touted as a means of promoting competition between hospitals. The T2A is a form of payments-per-case in which fees are set prospectively according to the patient’s diagnosis, the provider receiving a lump sum for the treatment based on standardized treatment costs (Docteur and Oxley 2003, 32). The danger of such a patient classification system is the cream-skimming of profitable patients by hospitals which runs counter to the public service mission. Moreover, experts have warned that without a delicate balance of a complex set of accompanying regulations, the T2A can have perverse effects weakening spending control and distorting financing so as to not meet health care demands (Or and Renaud 2009). Rather than reducing costs through competition and efficiency gains, a prospective payment system can lead to increased activity thus inciting demand, to the inflation of diagnoses (upcoding) and costs and to shifting costs to

247 Or and Renaud (2009) submitted that the principle of paying a fixed price based on average costs—the basic premise the DRG system—was increasingly contested as it is found that it neither increases the efficiency of the hospital market nor each individual establishment.
Without a doubt, the T2A represented a major change for the public hospital system.

A tool of managed competition, casemix in France was promoted as the only alternative. So, while Michelot and Rodrigues (2008) asserted that the T2A reform was rather consensual and well-accepted, the adoption of this policy is a clear example of an initial change by stealth (the use for financing was part of the original plan), a gradual acculturation to managerial thinking and finally a sense of *fait accompli* on the part of a hospital corps seemingly afforded no other viable policy option. The international trend of DRG-style hospital financing reforms, however different in each national variation, is a prime example of policy idea transfer based on a taken-for-granted quality as if it is the only solution to the problem, an unquestioned precept of a consensual theoretical belief system. In effect, policy makers make such choices because “everybody is doing it” and not due to any evidence that the policy will meet the stated objectives or that there are no better feasible alternatives.

In a bold effort to reorganize and modernize the entire health care system, the 2009 HPST Law aimed to define more clearly the role and organization of primary care physicians and to reform the governance and management of health care providers and institutions. While it was a deconcentration of power rather than decentralization, the Regional Health Agencies (ARS) were intended to bring together all of the major health care actors—insurers and providers, social services, hospital and office-based practice to develop a more holistic approach to managing patient care. The ARS were charged with coordinating health policies for hospital, ambulatory care, public health and prevention for an entire region, and in so doing, they would integrate some personnel from the health insurance funds to manage public health and hospital planning.

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248 Jean de Kervasdoué (2006a) himself warned that it would be inflationary without a system of controls.
The HPST law was presented by the government as a reform to make the system more efficient to make productivity gains in order to meet the 5-10% shortfall in the budget. Proponents explained that using private sector practices in the public system was the same search for efficiency although without privatization. While opponents denounced it as a threat to public service, others believed that efficiency improvement would lead to better care at better costs, not less care.\footnote{The efficiency discourse on the HPST overlaps entirely with that of the EU and OECD.} The dominance of economic thinking was of utmost concern for hospital personnel who feared that the system was being given over to profitability and not health.

In the new hospital governance, control was taken away from local officials. In the new management structure, executive decision making authority resided in one person. A controversial aspect of the reform was the authority vested in the Hospital Director, not a medical person but an economic manager, who was to essentially be given the powers of a CEO and become \textit{``un vrai patron à l'hôpital.''} Furthermore, the new public service mission was also broadened to include any establishment regardless of its legal status. By altering the notion of \textit{service public hospitalier} (hospital public service), the legislation opened the way for profit-making entities to participate in public service with an expanded definition of the services to be provided. Essentially, the Director of the Regional Health Agency was to organize all aspects of public service health care provision, now very broadly defined to include the for-profit sector as well.

Many express fears that outright privatization of the hospital system might be on the horizon (Maarse 2006).\footnote{Maarse posits that political resistance to hospital privatization might be less pronounced in countries accustomed to a tradition of private hospital care such as in France and Germany than in those with a public health service. Policy makers do not see a conflict between privatization and universal access as long as there is contracting between public authorities, insurance funds and for-profit private providers.} With the T2A, the risk of eventual total privatization looms. Public
hospitals being forced to take the least profitable patients will appear that they are underperforming, lose funds and eventually be condemned to closure (Mills and Caudron 2006; Stamane 2003). The public was skeptical and supported hospital personnel in their mobilization against the reform. Several prominent hospital physicians opposed reform and feared that the Sarkozy government was turning health care from a public service into a “lucrative business.” The 2009 hospital reform reflected a blatant embrace of the efficiency paradigm for hospitals which were to behave like businesses—balancing budgets and better managing resources.

6.7 Conclusion

Despite its autonomous state and its dirigiste history, like most other advanced countries, France has had a strong freedom component in health care access and provision. While long dominant in the French health system, the paradigm of la médecine libérale now competes alongside other paradigms both old and new—of public health, public service, general medicine and primary care. Moreover, with the shift to supply-side regulation and new forms of governance, ideas from managed care and managed competition have made their way into French health policy making as part of a quest for efficiency.

Cumulative incremental reforms were building into larger structural changes and also producing a change in expectations and mentality. Experiments in the early 1990s to propagate good practice guidelines developed into a full-fledged agency, the High Authority on Health. Experiments with individual contracts with physicians, an optional gatekeeper program and alternative payment systems later led to a widespread acceptance of the

251 The hospital reform was one of the least popular of those proposed by the Sarkozy/Fillon government (Le Figaro Magazine 2008).
mandatory gatekeeper system and agreement on payment for performance. Regional financing bodies for the hospital system later became all-encompassing regional agencies meant to integrate all relevant actors into a managed health care system, with a view to developing contractual relations in coordinated care health networks.

Reforms have been taxed with being both the nationalization and the privatization of the health care system. Opponents of change argue at the extremes because of a convergence toward the middle. The state has been involved in a double action gradually asserting control through governance reforms and new regulatory bodies while at the same time introducing market mechanisms within the public system and potentially opening the way for the market to play a larger role in the provision of hospital care. In effect, there is a movement away from the acceptance of the dogmatic defense of *la médecine libérale* and the corporatist defense of privilege in the public hospitals. Occupying the theoretical middle ground, the ideas and discourse of managed care and managed competition undergirded these changes in the French health delivery system.
7.1 Introduction

In these few lines, Dr. Lehmann’s interpretation of events evokes the specter of what a “neoliberal” consumerist health care design might bring. Lehmann lays out the neoliberal narrative as it applies to the health system in France. He draws linkages between the discourse propagated to the public and recent trends, claiming that these measures have fundamentally altered the French health landscape. Policy ideas are being contested and debated about how to pay for and deliver health care, often with the neoliberal critique in the ideational background.

The neoliberal narrative and the widespread discourse around globalization and European imperatives have contributed to attitudes about the need for changes in social protection and health care. At the very least, there has been an attempt to build a consensus around the existence of a problem and its potential remedies. Therefore, although a paradigm shift may not be perceptible, the spread of ideas inside and across borders, within the policy
community and in the public sphere in general has posed a challenge to the system and to existing health care arrangements. At a time when international observers were upholding France as the model health care system, a spirited national discussion revealed a country in search of new solutions and a general malaise about future access to health care.

Regardless of any countervailing neoliberal public discourse, successive opinion polls demonstrated the French people’s attachment to l’assurance maladie (the national health insurance scheme) as a legitimate and desirable form of solidarity. However, the complex hybrid nature of the French health care system and the ambiguous and malleable underlying solidarity tradition are easily exploited to the advantage of policy reformers who seek to pursue institutional reforms. At the end of the day, French health reform politics often consist largely of compromises by strange bedfellows cobbled together at the confluence of old and new notions of solidarity and la médecine libérale and new approaches from neoliberal economics and the managed-care movement.

7.2 A Changing Health Policy Paradigm: The Marriage of Moderate Neoliberalism and National Solidarity

Neither the French welfare state nor the French health care state is frozen. While mostly incremental yet also transformative, change has occurred through punctuated evolution. Health care policy making has been characterized by an incremental evolution and processes of strategic learning and adaptation on the part of actors who identify (or manufacture) policy failures. First, with changes to governance, financing and rights, the system has become more Beveridgean, although the question remains unresolved as to how much the system will appeal to private insurance in the future. Second, while challenging la médecine libérale is difficult, the ideational and discursive terrain is being prepared for new
forms of practice and evolving identities. Third, the French hospital system is adopting managerial methods and moving towards competition between the public and private sector.

Through various measures, the trend has been the consolidation of the state’s role in universal basic insurance coverage while incorporating some market mechanisms in the name of efficiency along with the growth of a second-tier of market based coverage. The 1995-96 Juppé reforms, the 2000 Universal Health Coverage Act, the 2004 Douste-Blazy Health Insurance Reform and the 2009 Bachelot Law on Hospitals, Patients, Health and Territories—four highly visible structural adaptations, along with other incremental reforms under the general public radar, have been transforming the way French health care is organized and paid for.

While major pathbreaking changes in health and social are infrequent, a gradual evolution has occurred in the last two decades. For some, the incremental changes are merely designed to radically alter the system and to reduce collective coverage, slowly chipping away at solidarity, and are analogous to a frog in boiling water. The neoliberal discourse may not seem to be effective in the short-term and has provoked much public and organized opposition, yet despite the public distaste for the neoliberal market approach to health, the individual responsibility discourse and the repetition of the financial crisis rhetoric seem to be having a more lasting effect.

Moreover these incremental changes may be more transformative and eventually path-breaking than anticipated due to the overall, long-term cumulative effect and potential changes in mentality. The literature has often been preoccupied with the inability to change and overlooked this type of institutional adaptation. Furthermore, the path dependency of

252 The patient rights federation CISS held an online debate from November 16, 2009 to January 31, 2010, exhorting patients and users to “react before we are cooked” at http://santesolidaireendanger.org/ledebat/.
ideas and the rhetoric of opponents to change often reinforce the perception of immobility even in the case of underlying changes.

In the 1990s and 2000s, neoliberal prescriptions for both social protection and health provision, in the form of greater privatization of financing, experimentation with market mechanisms and adoption of managerial methods in the public sector have made their way into French reform debates and policy. On the other hand, traditional Republican notions of solidarity and equality have remained vastly popular in French public opinion. Many of the conflicts in health policy reform underscore this ongoing tension, rendering an explicit adoption of an outright neoliberal paradigm highly contentious. Instead, most policies reflect the acceptance of a moderate neoliberalism married with new notions of national solidarity.

While there has been a visible trend toward some liberal ideas and instruments, many measures also increased state-financing and control. The 1990s represents a break with old policy prescriptions by turning to supply-side measures as a means of cost control. The Juppé reforms were the first major attempt at structural reforms of the governance and finance of the system. The CMU instituted a means-tested state-financed logic to access to care for the poor and those lacking supplementary insurance. The establishment in 2004 of an obligatory gatekeeper physician with penalties for non-compliant patients constituted an effort to better coordinate ambulatory care and the first structural constraints placed on the otherwise free circulation of patients. Finally, the Hospital Plan for 2007 changed financing from global budgeting to a case-based system for both public and private hospitals, and the 2009 HPST reform took bold steps toward remaking the hospital system. These reforms have been mostly piecemeal and sometimes reflect ostensibly competing objectives, exhibiting the discursive dichotomies—between solidarity and freedom, between equity and efficiency. Nonetheless, these changes have introduced new mechanisms and new principles that alter the way actors think and position themselves within the system.
Increasingly, the National Health Insurance (NHI) funds have been shifting to general taxation, and the role of supplementary insurers has been expanded. Unlike in more command and control universal systems, supplementary insurance has been allowed to fill the gaps in order to prevent rationing of care. High coverage rates by National Health Insurance had been among the cherished *acquis sociaux* of the French social model. Therefore, decreased reimbursement rates, more copays, deductibles and higher complementary insurance costs constitute a regression in this regard. In effect, the state, drawn into health care policy by the fiscal imperative (Freeman and Moran 2000), has been the main agent of price and cost control. While the state has also continued in its role as guarantor of access, it has also effectively spawned the growth of an important second tier of complementary insurance.

Despite being a *de facto* monopsony payer, the insurance funds, however cheaply administered by the social partners, were never able to stem rising costs. Thus the fiscal imperative was brandished as the main cause for reform, leading in the 1990s to important structural changes to health governance. The pattern shifted away from a corporatist arrangement put in place in the 1940s to an increasing encroachment by the state at the expense of the employers and unions (Genieys and Smyrl 2008a, 75). The roles of the principle actors—the state, the social partners, medical professionals and patients—have thus been changing in the dynamics of French health governance, guided by the three main benchmark ideas—cost-containment, equity and efficiency. This has been occurring through a process of silent privatization, state control over finance and the use of managerial techniques such as evidence-based guidelines and evaluation in medical practice (Hassenteufel and Palier 2008). While the social partners have been pushed aside, the state has been increasingly involved in finance and coverage, regulation, quality control and the organization of care delivery.
Table 7.1 More Public/State Involvement in the French Health Care System

- Establishment of numerous regulatory agencies
- Decline of employment-based insurance
- Institution of annual parliamentary vote over budget
- National health spending targets
- Universal health coverage rights based on residency
- Creation of regional health agencies
- Incentives or mandates for doctors to reduce geographical inequalities
- Creation of the UNCAM, the National Union of Health Insurers with a powerful political appointed director

In the new governance arrangements, both the state and the market have expanded roles to the detriment of the social partners. “In health care we encounter the wider paradox of public policies that try to strengthen market forces: markets need states, and strong markets need strong states” (Freeman and Moran 2000, 56). The state has sought tighter control over public financing in order to contain public expenditures, while allowing the market to take a greater role in the provision of insurance and care. In service of the market, the state has reigned in public spending on health and shifted more of the financial burden to the middle class. “This assertion of government authority reveals the paradox of reform in health care: an era when reform was pictured in the imagery of liberal economics was in truth one where state control was actually strengthened” (ibid., 55).

From the *State after Statism* (Levy 2006), it is evident that liberalization virtually always entails the double movement of market expansion facilitated by new state activities. However counterintuitive, most liberalization policies require state involvement and market-making, or at the very least, market supporting activities. The French health care market has experienced this same double trend. The enhancement of both the state and the market appears to be incongruent. It is an ostensible paradox that a seemingly strong state has pursued to both intervene and to privatize at the same time. A stronger regulatory state
has both tightened public spending and given more place to the market through cost-sharing and hospital financing reforms.

**Table 7.2 More Private/Market Mechanisms in the French Health Care System**

- More physicians, mostly specialists, in Sector 2 opting for the right to charge above standard fees
- Doctors illegally charging above standard fee levels
- New optional sector combining a mix of fee restrictions and fee freedoms with medical objectives
- Increased cost-sharing with patients through reduction of services covered by basic insurance and through copayments and deductibles
- Greater role for complementary insurers in financing and governance
- Higher supplementary insurance premiums
- Profitability and competition principles introduced into hospitals
- Expanded notion of the public service mission allowing for-profit participation

The dual reform movement towards both more state intervention and more privatization reflects the compromise between competing pressures and ideologies. The result is not a coherent overarching paradigm but rather a mix of ideas that informs policy decisions. It is difficult to assess the motivations behind these reforms, for a neoliberal program would allow total health spending to increase while tightening the social insurance budget and demanding a larger role for the market—both out-of-pocket expenses and private insurers.

Many fear the sediment of these ideas, and a total privatization of the public aspects of both insurance and provision. While some observers speculate about the risks of privatization, others tend to see a trend towards étatisation—more state planning and control (Barbier and Théret 2004). Still others assert that both state-control and privatization are two sides of the same coin, with the ultimate goal of privatizing most health insurance (Filoche 2004). As Hacker (2005) has warned, a political strategy of erosion of benefits can reduce
political support for the welfare state. Some intimate that the CMU was created in order make privatization more palatable. Oddly, in the neoliberal model, state-control and privatization of risk must go hand and hand, because solidarity with the most vulnerable would be a prerequisite for total privatization.

7.3 Ideational and Discursive Tools in the French Policy Debate: The Polemics of Crisis and Concept Stretching

In this pluralist, complex public-private system, multiple actors—medical professionals, international organizations, insurers (public health funds, mutuelles and for-profits), health economists, civil servants and government officials—compete to control policy frames and to set the policy agenda. Ideational and discursive tools in play in health policy debates have been used to both justify change (and also to resist it). In debates on policy paradigms, experts modify and manipulate the cognitive and normative frameworks of the polity. In doing so, they make use of the existing ideational and discursive repertoire to justify their actions (Damamme and Jobert 2001). Both crisis rhetoric and the evocation of underlying cultural paradigms are often meant for public consumption and to cajole the population into quiescence.

Core beliefs about macro-economic objectives and the need to limit public spending, reinforced by comparative health studies and the international health policy consensus, coupled with the goal of universality have largely driven French health policy and the push towards structural change and efficiency since the 1990s. While health policy reforms were mostly forged by a narrow welfare state elite, a legitimating discourse was often propagated through the politicization of government reports, with a large echo in the media. In the public discourse, the issues of excessive spending, the “trou,” waste, fraud, abuse and individual
responsibility have been conflated (deliberately or not) as a way to justify actions taken often to the detriment of collective financing and hence solidarity.

The cognitive and normative processes of ideational acculturation occur through both elite and popular diffusion of ideas. The media play a large role in the propagation of the elite discourse. After several years of political frames emanating from governing circles about the unsustainability of the French health system and the need for people to be held responsible, public opinion increasingly mirrors this attitude, showing expectations of diminished public coverage and a deterioration of the system (TNS Sofres and Générale de santé 2009). As Vail (1999) has shown, the institutional autonomy of the French state can inhibit its ability to make and implement change. Because autonomy attracts blame, an elite discourse often seeks to deflect and neutralize this blame, especially in retrenchment politics. Under such conditions, both greater consultation with relevant non-state actors or the appearance thereof and an effective legitimizing discourse become more crucial in order to avoid resistance and protest. With regard to health system reforms, the elite discourse that has accompanied reforms has helped to shift public attitudes toward the type and level of solidarity to be achieved and the need to better organize in order to control costs and to change physician behavior.

This is not to say that there has been no reaction to the individualizing discourse and policy changes. Raising the specter of the privatization of social protection in France, an observer affirmed “If we are not careful, in ten or fifteen years, a French Michael Moore just might be doing a remake of Sicko only this time in France” (Renaud 2007). The debate over the future of the French health care system is often characterized by hyperbole and polemic claims from all sides. For some, the Sarkozy government was turning health into a commodity, privatizing the system and shifting too much responsibility to the individual.
While neoliberal prescriptions emanating from employers’ groups, insurers or prominent think tanks have not been wholly embraced or adopted, the neoliberal paradigm has been essential in setting the agenda, identifying problems and prompting experts to offer other alternative solutions. In the 2000s, both the expert and public discourse shifted away from the prevailing view of health spending as a burden. The health sector was increasingly recognized as a job, wealth and growth creation sector (Kouchner 2001; Mamou 2006; Palier 2007a). In a counter movement, many sociologists and economists have tried to recast health and social protections in a different light, revisiting the question of whether the welfare state is harmful for growth and a burden to the economy—a basic tenet of the international neoliberal consensus. In effect, the ideas and discourse used to delegitimize the old order and to legitimize new actions have been put in question. On the part of publicly known scholars like Bruno Palier, Gosta Esping-Andersen and Dominique Meda, there has been a concerted attempt to reembed liberalism in a neo-Keynesian philosophy and language of social investment, restoring the view of social protection as a positive factor in the economy.

Changes may be pulling in two directions, but the French system has always been a hybrid, pluralist system functioning within the tension between individualism and collectivism. It is difficult to find evidence of a hegemonic coherent policy paradigm. Policy compromises are often made in a process of *bricolage*, drawing on ideas from coexisting paradigms. Furthermore, broad cultural notions can be sticky and malleable enough to be imbued with varied content. When there is an emotional attachment to frames as values such as solidarity, policy entrepreneurs can draw from a cultural and ideological reservoir to justify policy action. The discourse and the policies oscillate between two poles—between individual responsibility and freedom and collective responsibility and solidarity, legitimizing the proposed public/private policy mix. This dichotomy has long been part of the French cultural and ideological social protection repertoire and been exploited to frame policy debates.
In this instance, solidarity, a major symbolic resource, has been stretched to enable the layering of path-breaking reforms in the era of the new politics of the welfare state. 

“Culturally resonant ideas that have a long history can serve as effective discursive resources through framing processes that celebrate these ideas while altering their meaning” (Béland 2009a, 452). As part of a strategic adaptation, giving new meanings to the old repertoire, new policies like the CMU can be couched in the path dependent idea of solidarity. As central values from the existing ideological and cultural repertoire, solidarity and universalism prove to be useful evolving and malleable concepts that can be redeployed and redefined in health policy reforms. In effect, a new hybrid broad cultural paradigm seems to be emerging out of these ideational struggles. Both the social and the liberal having become equally important, a new social liberal cognitive and normative framework is being forged by marrying some ideas from both neoliberalism and from the solidarity tradition.

7.4 Future Prospects for State-Led Managed Care and Managed Competition in France?

*La médecine libérale* is a socially-constructed philosophy about the best way to govern doctor/patient relations. The principles upon which it has been based are now under pressure from endogenous ideational and discursive forces that purport to alter the way ambulatory care is delivered and financed in France. The traditional principles have long held together because of a self-reinforcing belief in the sacrosanct doctor/patient relationship guaranteed by *directe entente*, fee-for-service direct payment. Doctors and patients behaved as if this were a law of medical economics and ethics that was a guarantee of responsibility and quality in ambulatory care. The belief in this principle made actors behave accordingly. New medical realities and belief systems have come to question and deconstruct this principle and to replace it with other ideas.
It is precisely because of these pressures that some doctors—mostly the most privileged physicians—are clinging even harder to these principles in an effort to stave off ideational and institutional change sought by other actors in the system. Specialists in a predominantly biomedical curative model of health care wield a considerable amount of power. Yet there are other forces at work as well, including a growing awareness of the need for primary care specialists who can work on promoting good health and preventive measures. The potential erosion of a model should not be confused, however, with the erosion of physicians’ power, especially if measured by their incomes and political influence.

The conservative physicians who advance freedom of fee-setting as the fundament of quality liberal medicine, the major employers organized in the Medef and for-profit insurers had never truly been willing parties to the post-war Keynesian “consensus” in favor of high levels of socialized financing of social protections. The doctors in this neoliberal discursive coalition place their billing freedoms above the goals of equality of access in the name of quality of care. Although there is no indication that Sector 2 physicians provide better care, they do better financially. Whether a cynical discursive tool or a genuine belief in the superior offerings of Sector 2 physicians, the notion that Sector 2 doctors merit better fees has served as the ideational basis for the existence of two regimes, and continues to compete with alternative views.

As the economic view of health has gained adherence, physicians’ behavior is viewed increasingly as inflationary. Meanwhile with the concomitant goals of equity and efficiency, the new French-style managed care and managed competition paradigm is taking shape. Some doctors—mostly specialists—have chosen to align with private insurers and the business class in a discursive coalition in favor of limiting public spending while allowing total expenditures to grow and giving a greater role to the market. On the other hand, another
coalition, including many more left-leaning GPs, is in favor of a managerial approach to control total spending and to ensure efficiency and equity.

After the attempt of the Juppé reform to regulate the ambulatory sector through spending caps, the neoliberal coalition reacted and prospered, for it was able to both brandish the threat of state-takeover in the public discourse and wield considerable electoral clout. The state treaded lightly thereafter when dealing with ambulatory policy, and seemingly is taking a more incremental, subtle approach. Nevertheless, the paradigm of *la médecine libérale* long cherished by all in France has come to be seen as a source of problems for equity. In the managerial philosophy, budget austerity can create efficiencies and innovation which runs counter to the conventional wisdom about doctors’ and patients’ freedom being the best guarantee of quality. There is a growing belief that budget controls and market mechanisms combined with equity and solidarity objectives guaranteed by a strong state regulation can generate efficiencies creating better value for money for all.

Health spending is bound to increase. However, policy decisions made about how the future system will be financed respond to a societal, moral question about what will be covered collectively and how much will be left to the individual. As Dominique Polton (2002) asserts, the French health system, which has been a unique compromise between values of solidarity and equity, freedom and efficiency, is undergoing a transformation whose direction is still unclear. She envisages three possible scenarios: 1) a high level of protection for all with more restrictions on patient benefits and freedoms, 2) a fragmentation into means-tested public coverage and private coverage for the well-off and 3) collectively-financed insurers (purchasers) providing access to health care networks in a competitive system. While Robert Launois’ HMO style *réseaux de soins coordonnés* were rejected in the 1980s, the ideas have taken some time to take root, but many continue to be considered as viable alternatives to the single payer fee-for-service system.
In many ways, there seems to have been a discursive preparation to reduce the collective portion of spending. Imported by economists, reinforced by the international organizational discourse and echoed by politicians, the disengagement of the public health insurance system now seems inevitable to a majority of the French population. It appears quite probable that there will be further pressure and evolution toward an erosion of national health insurance potentially exacerbating inequalities in the face of health risks. The question to be answered then becomes what level of inequalities are the French willing to tolerate and how will this bode eventually for the republican ideals of equality and solidarity?


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