



(Making European Health Policy in) France

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Chapter Seven: France

France shares a paradox with the UK: its highly unified state and political culture has a tradition of independent action that often takes badly to European constraint, but that same highly unified state and political culture underpin an effective model of engagement in EU health policymaking. It is no surprise that both member states are regularly accused of hypocrisy. It is virtually written into their constitutions.

System and stakes

France is an "excellent ideal type... as an example [of] clashes of 'state-centric' national political systems with the pluralistic multi-level system that is the European Union" (Szukala, 2003) French concern with the integrity and sovereignty of its state, runs the argument, make the extension of European competencies is in itself something of a problem for many French policymakers. Expanding EU competencies reveal the basic tension between Europe as a strategy for French projection and Europe as a threat to French nationality (Sauger, 2008)

Of course, that picture is a bit too neat. France is changing, as many books have argued, with debate often focused on whether France is becoming less state-centric and nationalist, or whether the old pictures were overdrawn (Kassim, 2008; Smith, 2006). But relative to the other member states in this study, France is certainly distinctive for its generally diplomatic approach to EU policies, its centralization, and its effectiveness.

System

Health care in France is administered through a statutory health insurance model, mainly financed through payroll contributions and regulated through negotiations between

sickness funds, representatives of the medical professions and the state. 85% of the population belongs to single large fund, the *Caisse Nationale d'Assurance Maladie* (CNAMTS), placed under close state supervision. This specific institutional arrangement reflects a long history of compromise between the demand for universal coverage and specific claims from mutual aid societies that predated the demand for universal coverage in the post-war context (Dutton, 2007; Palier, 2005). Recent reforms have accentuated the state-controlled character of the French health system by creating a national union of sickness funds directed by a higher civil servant appointed by the government (Franc and Polton, 2004). There is also an increasing element of tax finance and universality in the French system, since the CNAMTS now provides means-tested basic and complementary coverage to the poorest part of the population on the basis of residence (Hassenteufel and Palier, 2005). The result is that power in the French health care system, as in many other aspects of French public administration, tends to stick to the centre, and local actors put a great deal of effort into finding ways to influence the decisionmakers at the centre.

The social insurance nature of the system, and the concomitant freedoms of providers, are also the basis of most of the problems France might face in health care. Patients' free choice of doctor is an essential aspect of health care which recent gatekeeping schemes have made more costly in some circumstances, yet left intact in principle. The private sector plays a crucial role in health care supply, as most ambulatory and specialist care is delivered by liberal practitioners, whereas hospital care is also delivered by publicly owned and privately owned entities. Traditionally, the Ministry of Health regulates and provides some capital and core funding to the hospitals while the sickness funds reimburse doctors and treatments directly.

Stakes

This system is obviously vulnerable to competition law, state aids, and public procurement challenges. A set of legal and associational rules constrains what providers can do and operate while there are variety of public sector subsidies to hospitals that make them competitive and cross-subsidize the less profitable or more costly services. Working out how to maintain solidarity – risk-pooling – under anything like EU public

procurement rules is a major headache for French policymakers. Patient choice of provider combined with local subsidies to the municipal hospital might make for a satisfactory health system, but it is basically open to the risk that alternative providers will try to open the market and challenge the subsidies or limits on medical entrepreneurship. Likewise, the French reliance on supplementary health insurance for co-payment means that an important part of its health care system is subject to EU regulation of private insurance (Thomson and Mossialos, 2009).

France is less vulnerable to the problems of patient mobility (formally, since the *Vanbraekel* case), although it has had to pay compliance costs because the simple French system of reimbursing providers does not translate easily across borders (for adaptation to date, Inspection générale des affaires sociales, 2006b:335-388). In the areas with a high degree of patient mobility – and every one of France’s land frontiers has a noticeable amount of it – there is a tradition of agreements governing cross-border mobility (Harant, 2006). Some of them date back decades, and many are overlaid with high-profile “Euroregions” that receive EU funding and publicity for their ability to surmount borders. French policymakers – and their German counterparts – thought these relationships were stable, technical, and not very interesting (relationships across the Pyrenees are interesting, and sometimes frustrating, but that is because of intergovernmental problems on the Spanish side).

To what extent is the French constitution open to backdoor change? Probably not much. That is because so much power in health care is still in the hands of the central state. The problem for France and many of the French, however, is precisely the fit of EU politics with its traditional, “unitary” political culture, which is very state-centric and emphasizes access to and the use of state power (Grossman and Sauger, 2008; Smith, 2006). This means that Europeanization might feel more traumatic and produce more transformative effects on policy-making than in other countries that are more used to consensus and less accustomed to decisive action. That feeds into a much noted characteristic of French politics: France is a country where autonomy in itself is a particular value. French policymakers often deny the influence of even less coercive forms of Europeanization such as the Open Method of Coordination, although they can become strategic resources in domestic policy-making (Palier and Petrescu, 2007: 67-69).

French policymakers do not have a basic cultural conviction that they should learn from Europe; they prefer to think of France as a European policy-maker that influences the EU and other states, rather than as a policy-taker (Ehrel et al., 2005; Risse, 2001:228). The stellar performance of the French health system in international comparisons such as the WHO *World Health Report 2000* has led many stakeholders to conclude that there is no reason to get advice from their EU partners or the Commission.

Explaining French EU health policy

French engagement with the EU puts the emphasis on the effectiveness of the French state, putting considerable effort into coordination across not just ministries but also engaging in a heroic effort to coordinate and lead, or at least follow, all the various networks, interests, and lobbyists from France who engage with the EU.⁵⁹ In a complex environment such as the EU, with so many ways to fragment Member State governments and draw out professional and social networks independent of governments, this might be enormously effective. And while it will be ultimately futile, because both France and the EU are too complicated, the effort has contributed to French power within health policy and been squarely in a long French unitary tradition.

Constitution

The French constitution is famously centralized and the French State one of the most famous characters in the whole literature of politics. Believable, if apocryphal, stories abound of French education ministers knowing exactly what each eleven-year-old in the country would be reading at a given time. French centralization is easy to overstate, but in EU health policy France is centralized. Characterizing responsibility at the top can also be problematic in France's semi-presidential system, due to the possibility of "cohabitation" in which the President and the Prime Minister come from different parties. The dual executive model was essentially premised on a level of unified control that it did not create – it gives the Prime Minister (head of government, responsible to the

⁵⁹ For the classic discussion (Lequesne, 1993)

legislature) a different base than the President (head of state, elected through a two-round majoritarian system). The relationship between the President and the Prime Minister, who share executive power, is prone to instability when there Prime Minister and President are rivals or even of different parties (Bell, 2000). France went through three periods of such “cohabitation” between 1986 and 2002 (1986–88, 1993–5 and 1997–2002) but after changing election sequencing (so that parliaments are elected a month after the President) it reverted to Presidential superiority (Levy and Skatch, 2008). The President can lead cabinet meetings and therefore make forays into governmental policy even if he or she does not control the machinery of ministerial power or the legislative majority; the result can be conflict with the Prime Minister.

Public Administration

French public administration is a distinct and enormously influential approach in its own right, one that is little understood by those bred in other traditions but which influence shapes the operations of many states including almost the whole Mediterranean world. Its combination of hierarchy, a powerful state, elite self-preservation through networking, rules as the legitimacy of all activity, and democratic party politics create a state structure that can perplex outside observers. It includes a variety of seemingly contradictory elements: a powerful bureaucracy and a high degree of political influence and appointment; a small elite with a high degree of closure but also a high degree of fragmentation; distinct political and bureaucratic worlds but with considerable traffic across their border (Chevallier, 1997); bureaucratic *corps* united by education that stretch across politics and business such as the elite *énarques* (graduates of the *École Nationale d'Administration*); fierce party politics combined with very long careers that span many changes of government (Rouban, 1999); firm rules, and their flexible interpretation. The *énarques* must coexist with the pharmacist from *Madame Bovary*.

The pattern that emerges from the reconciliation of these contradictions is that France has a very clearly delimited technical level of officials in the ministry. Most of the officials in the Ministry who deal with the EU operate on this level. Their role is firmly subordinate, however, to the political level, which includes the ministerial *cabinet* as well

as some of the most politically engaged officials at the top. The key group of officials, whose careers tend to land on the political side of the line, are members of a bureaucratic body chosen by education. These *corps* appear throughout French public administration; the corps in health is the Inspectorate-General of Social Affairs (IGAS), as well as former members from the ‘social chamber’ of the *Cour des comptes* (Genieys and Smyrl, 2008)

Ministerial decision-making usually passes through specific cabinet members as well as through the minister, who are likely to be decisive policy players. *Cabinet* members are often young and from a variety of elite political and bureaucratic backgrounds. They can draw on the department but also have to develop wider networks through French politics, reflecting their position as political generalists rather than technical experts.

The other well-documented, much-lamented, generally overblown, and endlessly confused problem in France is the relative weakness of civil society relative to the state (Rosanvallon, 2004). If French domestic politics encourages interests to develop influence within central bureaucracies in Paris, they might not develop the habit of investing in autonomous lobbyists. Instead, there is a tendency for French interests of all sorts to invest in relationships, formal or informal, with the state (Keeler and Hall, 2001), and French public authorities to be suspicious of professional lobbyists (Grossman, 2005). This is not necessarily a bad thing because it is not at all clear why one would want professional lobbyists. It is just that they are an undeniably important feature of the EU, and that means that a reluctance to lobby means overreliance on the French state. The lack of French lobbying appears to be particularly striking in health; the IGAS, doctors, and other dominant players in the French health system are slow to engage with the EU as lobbyists.

Health ministry

The very success of the French health care system – which scores well on most indicators and is seen as satisfactory at elite and public levels – is part the reason that the health ministry is weak. Within the State, the fragmented organization of public health services, also a historical constant in France (Ménard, 2006) and fierce competition between

agencies means that ministerial capacity over health issues is shared by several structures, among which “the Ministry of Health is not the sole player, and sometimes not even the most prominent one” (Cour des Comptes, 2004:143).⁶⁰ Despite their heightened control over negotiations of medical fees, health care is not directly administered by state authorities. The Ministry itself enjoys direct control over only a residual part of the total health care budget, since health providers are reimbursed by sickness funds directly. As a consequence, it has been constantly dwarfed by ministries with larger budgets, resources, and political visibility.

Minister of Health is a low-ranking post and the Ministry’s place in the bureaucratic structure of the French state is also low-ranking. The Inspectorate-General of Social Affairs (IGAS), the relevant corps for the ministry, is low-status as French bureaucratic *corps* go, and the National School of Public Health (ENEHSP) often thought to be the school for those whose test scores were not good enough to get them into the *École Nationale d’Administration* (a perception as important than any truth). Furthermore, the Ministry’s implementation administration at the local level is staffed by public health inspection doctors who are kept in low esteem by their clinician peers (Inspection générale des affaires sociales, 2006a).

Fluctuating ministerial boundaries reflect this weakness; the Ministry of Health alternates between being paired with worthy issues that ordinarily do not receive enough attention (such as the needs of the disabled or voluntary sector activities) and being paired with social affairs. Social affairs is another area that the state does not always directly administer and that the bureaucratic elite perceive as a “professional dead end” (Eymeri, 2001; Genieys and Smyrl, 2008)(BOX 7.1). Between 1997 and 2002, health was left to junior ministers who were subordinated to an overarching (and, under a left-wing government, prominent) Ministry of Employment and Jacques Chirac did not include a health minister in his first government, in March 1986.

BOX 7.1 ABOUT HERE

⁶⁰ The dilution of responsibilities and mandates entailed by such vague ministerial frontiers plays a role in explaining the occurrence of major public health scandals in France, such as blood contamination (Chevallier, 2005; Morelle, 1996; Steffen, 2000)

The French EU model in health

The French model of centralized public administration combines with a very clear geopolitical stance that emphasizes the state's power, autonomy, and international figure. Not only does the French approach to administration emphasize hierarchy and unity (even if it is latent); the French approach to international and European affairs emphasizes the unity, coordination, and effectiveness of the state. To a large extent, French policymakers tend to adopt a more “diplomatic” approach, jealous of sovereignty, disinclined to view the EU as just another layer of lawmaking, and prone to act as a unified state on the European and world stage (Balme and Woll, 2005; Drake, 2005).

Diplomatic

This emphasis translates into one of Europe’s most sophisticated and determined coordinating mechanisms at the diplomatic level. At the bottom are the officials of the Ministry of Health (and Solidarity). The international affairs unit of the Ministry, the Délégation aux Affaires Européennes et Internationales, collects and organizes information about proposals, impact analyses, and possible political issues as well as keeping a watch on implementation. But in keeping with the role of political, rather than civil service, appointees at the top, the ministerial *cabinet* engages with strategic, political issues and is able to draw on kinds of political power and connections that technical officials lack. So interministerial conflicts in the formulation of an EU line might get picked up at the technical level, but unless they are simple misunderstandings they are likely to be referred to the political level.

The next body in the chain linking the ministry to the EU is the Secretariat-General for European Affairs, the SGAE⁶¹. The SGAE is a central unit attached to the Prime Minister that is responsible for coordination- i.e. collect information about all events that might influence France and determine French goals and strategies. However surprising it might be to those accustomed to the British and French administrative

⁶¹ "Le SGCI est donc un de ces lieux aux où se bricolent dans les routines du quotidien ces objets sacralisés ont pour nom “intérêt général”, “volonté de l’État”, “politique de France”". The appeal should be obvious. (Eymeri, 2002:150).

traditions, a powerful and relatively autonomous central coordinating agency such as the SGAE, with a serious claim to handle all EU policy is the exception, not the rule in Europe.

The SGAE predates the EU itself, but it was reorganized in 2005 (Lanceron, 2007) in response to problems with implementation of EU law and the general discontent discussed in a report led by Admiral Lanxade (Commissariat général du Plan, 2002) that described the situation as “acceptable, but with more and more difficulties.” The report criticized France for many of the same things that other member states reproach themselves: problems of communication with Permanent Representation, badly organized priorities, bad use of experts, and “a deficit of strategy”. The subsequent changes did not fundamentally alter it; many of them simply increased clarity about what it actually did (including its new, and much more understandable name SGAE).

The SGAE does what most EU coordinating units aspire to do. i.e. coordinate between ministries, provide expertise on all aspects of the EU (including access to personal networks), transmit information, and encourage strategy if not formulate it. It also has a role, more salient since 2005, in tracking the transposition of directives. That was in large part the motive for action; Lanxade’s “acceptable” situation might not have deserved change had it not been for embarrassment with the poor French transposition and implementation record, and the SGAE has a relatively large unit tracking implementation of EU legislation.

The SGAE is an elite administrative unit, made up mostly of officials on short-term secondment from across the different ministries (mostly finance and economics) who are gaining central experience as part of rapid career progression or who were unhappy in their home ministries (Lanceron, 2007). It distributes papers about EU developments and hosts constant meetings at which ministries agree the French position on diplomatic-level questions; if no agreed position emerges, it will refer the question to political levels.

The specific arrangements that connect the SGAE, Prime Minister, President, and various ministries including Foreign Affairs tend to change at the top with each President and Prime Minister. Analyses of diplomatic-level French EU policy tend to focus on the different configurations of President, Prime Minister, and head of SGAE (whose title

changes) (Hayward and Wright, 2002; Lanceron, 2007; Lequesne, 1993). Paying attention to personalities and the political power of each individual is crucial in this kind of very elite analysis.

So far, cohabitation and tensions between Matignon (the Prime Minister) and the Élysée Palace (the President) have not spilled over directly into health. The main reason is that specific EU health issues have not received much attention from Presidents. EU health policy might have begun with a “Europe Against Cancer” initiative proposed by French President Mitterrand, but most health issues have not been sufficiently high-profile to engage presidents. But even if the bureaucracy does not change much, the effect of changes in the President or Prime Minister “changes everything”, as one interviewee said. It does this because these are small units that are closely tied to top politicians, and so the autonomy and efficacy of coordinators and ministries is affected by the presence or absence of unpredictable countervailing, or even dominant, powers across the river in the Élysée palace.

These problems do not normally affect the everyday flow of paper and work on ordinary EU law. The SGAE is the guardian of the French state’s views and votes, and is good at coordinating and forcing meetings to resolve issues on which there is divergence; beyond that, it is able to coordinate a wide range of general policy stances. Finally, day to day coordination is ensured by the simple fact that the SGAE transmits all the formal papers (emails) to the Permanent Representation. Naturally this volume of email allows some issues to slip, but the SGAE takes its gatekeeping role seriously enough to prevent most nontrivial contradictions.

The French Permanent Representation in Brussels, then, provides the personnel who attend key meetings and handle the work of the diplomatic level. The health desk officer at the French Permanent Representation is seconded from the Ministry of Health. This increases the technical skill and connection with the ministry of the Permanent Representation, which in principle improves the connection of France with health debates at all levels. Like all Permanent Representations, its members pick up tactical and policy information that allows them to influence decisions in Paris. But their autonomy is relatively limited because Paris is more capable than most member states of formulating a *detailed* line and imposing it. Some EU representatives attend Councils with only vague

(or sometimes no) orders. That is very rare in France. The machine does its job; there will be a *dossier* and a position and the Permanent Representation can focus on promoting it.

This diplomatic effectiveness, and tendency to view the EU as a creature of states with France as a leader, also affects the French response to EU legislation once it is passed. France is a habitual non-implementer. An extensive study found that there was serious variation between groups of countries in their approach to implementation; while a few Scandinavian countries were fast and faithful in implementation, most countries would use their margin to delay or alter directives in response to domestic political pressures. France was one of a small number of countries that would, essentially, ignore major EU legislation (Falkner et al., 2007). This partly reflects technical problems in transposition, and partly struggles by and within the French legal establishment (Mangenot, 2005), but the existence of technical problems of transposition reflects a traditional French skepticism about implementing EU law. It appears that the SGAE's increased role in following transposition and changes in the balance of power within the French legal profession has improved the situation with regard to legislative compliance, but that does not mean that France does well or has lost its tendency, relative to the other states in this study or the EU as a whole, to forget transposition and implementation.

Departmental

As with all countries, the departmental level increases the difficulty of coordinating because the informational advantage enjoyed by each ministry justifies a relatively high degree of ministerial autonomy. Without the discipline of the Council vote and other formal institutions of the diplomatic level, the role of the central coordinators at the SGAE is much smaller.

When health policy is at the departmental level, the Ministry is in the lead. It is the home of the technical civil servants who can assess the impact of EU policy ideas and who will often have ideas for their improvement, and it is the source of many of the experts and officials who represent France in all the various health policy forums, such as the High Level Group, Open Method of Coordination proceedings, and the Platform on Diet, Nutrition, and Physical Activity. French theory as well as practice emphasizes the

formal distinction between departmental and diplomatic activity. In a given meeting of the High Level Group or the OMC, it is ministries speaking, not the French state. As with other states, the demands on central coordinators would be overwhelming if the SGAE and Permanent Representation had to be interested in every meeting across the EU. Further, the value they would add would be very low because, as generalists, they would be incompetent in specialized meetings of experts in agriculture, telecommunications- or health.

The Ministry seeks internal coordination in departmental affairs as well- which above all means more effort than other member states put into trying to keep officials from "going native" in Brussels networks. The same ladder of people responsible for EU affairs, who are found quite far down in the bureaucratic hierarchy, leads to the Ministry's coordinating unit. That unit nurtures the EU experts and tries to interest the rest of the ministry in its work, facilitates experts' trips to Brussels for EU committees and meetings, and identifies the French representatives and experts to attend meetings of groups such as the OMC or Platform on Diet, Nutrition, and Physical Activity.

The coordination process means that the ministry officials and associated experts all know the French "line" and might have clear guidance- both as an overspill from the high-level coordination and also because the presence of a European advisor in each ministerial cabinet, and a ministry of health official in the Permanent Representation connect the ministries and the general French approach. The problem of the French ministry is that like every other health ministry it has a relatively parochial culture shot through with the technocratic internationalism of scientists or other professionals. This means that the international specialists can be an irritation to others, one more group asking for time for issues whose importance might not be clear. It also means that there is a permanent tendency for there to be a gulf between international and line officials. There is ultimately no way to get rid of the tension between EU knowledge and health knowledge, or between time spent on the EU and time spent on the health system itself (which might be easier to justify to politicians). The French model invests relatively heavily in EU specialists within the health ministry and thereby tries to snuff out the problem of officials who focus on substantive policy and undercut diplomatic aims when

they are in Brussels. In other words, it tries to resist the centrifugal tendencies states experience at the departmental and deliberative levels.

Deliberative

At the deliberative level, the lack of a European culture in the ministry dovetails with the relative weakness of non-state French lobbying, and, one interviewee said, a general lack of a “European culture” in France or at least French health policy. Compared to some countries (Germany, the Netherlands, the UK), or compared to the French presence in other policy areas, the French are not very visible or present at informal or semi-formal EU health policy events. This is especially the case with events conducted in English. The effect of common French non-participation in the broader Brussels health policy debate is to heighten the centralization of French representation; the state is what speaks for France.

The traditional response is to rely on networks of French citizens in the EU institutions. This is a well-developed system for placing French citizens in important positions and keeping in touch with them and is run out of the Permanent Representation and the SGAE. In health, it has had some important members including a long-lived Director of DG EMPL and the head of the Cabinet of the Health Commissioner in 2008 (as other member state representatives noted when I asked about French influence on health legislation).

But this kind of individual lobbying, however effective at steering the Commission, has its limits in influencing broader debates. This means that the lack of a general European culture in France creates problems at this level. No health ministry sends officials to every seminar and debate in Brussels; no health ministry would write the kinds of papers or lobby Commission officials in the way that works so well for lobbyists and experts at the deliberative level. French officials attend high-level conferences and participate in Brussels debates, but their ability to participate in the clash of ideas is limited by the special treatment that a representative of a member state will always receive (it is easy to watch: at public events, they are constantly approached by questioners trying to infer the state’s thinking). The real problem is simply that French

health organizations are, perhaps because of statism, and perhaps because of reluctance to lobby, not major actors in Brussels health lobbying. And statism at the deliberative level is always a problem.

Perhaps the issue that captures the strengths and weaknesses of the French approach to EU health policy is the issue of Services of General Interest. From the original Article 16 that underlies the concept to the continued prominence of the idea, France has been important in holding it up and promoting it as a general solution to a number of problems as diverse as utilities and health care regulation. An attractive idea, its political plausibility has often come from only two sources: DG Employment and Social Affairs (which otherwise cedes the internal market more completely), and France. Some interviewees from other countries laughed when I asked about the whole concept and made jokes about it being a French device to subsidize its giant utility companies. The idea lives on, in large thanks to France, but it is not winning the battle of ideas or setting the agenda. Again, that might be partly due to the weakness of the French outside of their state. Services of General Interest has a much harder time as a concept if it lives only at the diplomatic and occasionally departmental levels, simply because that is not where the clash of ideas happens in the EU. The clash of ideas is in the fluid and often time-wasting deliberative level, and that is where France is not very visible.

Conclusion: Informed, Coordinated, Nimble?

France demonstrates something simple but important: it is possible to develop a unified system that will have a worked-out position on almost everything and allow a high level of tactical action and strategic calculation, though it takes a great deal of management and work. The Ministry of Health has a chain of people working on EU issues that reaches further down its internal hierarchy than in any other state we studied, because that is required to gather information necessary to formulate a good dossier on any issue. The result is that French officials are less likely to "go native" in Brussels, the French state has more knowledge of what the French are doing in Brussels- and the French develop a characteristic hard-bargaining style that some of their own EU specialists called "arrogant" or even "autistic" (Costa and Daloz, 2005). Among other benefits, it

means that France is unlikely to accidentally move favored Commission agendas—the scarcity of significant initiatives during the French 2008 presidency was not just a sign of French skepticism about EU health policy, but also of French effectiveness at making sure it, rather than the Commission, controlled the agenda (as shown by the general agreement in the Council on its end of Presidency statement on the patient mobility directive).

The French weakness is, rather, in its reliance on formal, diplomatic and departmental, methods on one hand and French networks on the other. This translates to a lack of influence on agenda-setting and the framing of debates, and reliance on high-level diplomatic interventions transparent (in Council) and opaque (lobbying the French head of the Health Commissioner's *cabinet* or important French officials in DG EMPL). This is something common to many member states, and a problem that, of the countries in this study, affects Spain badly. The difference is that a lack of French presence at deliberative levels is largely balanced out by its effectiveness at the diplomatic level. Interviewees from the EU institutions, the UK, and Germany, ranked it as tied with or close to the UK as the most effective member state. There might be questions about whether the broadly intergovernmentalist French approach is the best long-term approach or suited to shaping the basic parameters of EU health policy, but in the short term it unquestionably has an impact.