

**Professionalisation, Policy Networks and the Development of French Health Policy: The Rise of Hospital Directors, the *Syndicat National des Cadres Hospitaliers*, 1976-1991**

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Submitted as partial requirement for the Ph.D in Government, London School of Economics and Political Science

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## ABSTRACT

### **Professionalisation, Policy Networks and the Development of French Health Policy: The Rise of Hospital Directors, the *Syndicat National des Cadres Hospitaliers*, 1976- 1991.**

As governments have grappled with the demands of cost containment policies in health care, a series of challenges have arisen to the 'privileged' position of medical professionals in public health care systems. Hospital managers and administrators have contested medical control of the health policy agenda and the allocation of resources. This managerial challenge raises important questions about how new groups or lobbies have emerged in health policy-making, and about the capacity of governments to induce change within professional policy networks.

The thesis explores these issues by analysing the development of French hospital management policy from initial measures towards cost containment launched in 1976 to the complete re-writing of previous legislation on public hospitals in 1991. The policy networks shaping hospital management policy have been transformed by the development of the French corps of public hospital directors and its largest trade union, the *Syndicat National des Cadres Hospitaliers* (SNCH). Through the 1980s, the SNCH evolved its own programme for hospital management reform, and its members rose to occupy pivotal positions during the decision-making process which led to the 1991 Hospital Law. The thesis highlights the role of politicians in transforming policy networks by making top-down changes in the regulation and financing of policy systems, and by fostering bottom-up changes in the balance of influence between professional groups and in the local management of hospitals. In addition to political influence and contingent professional changes, the study examines how policy systems can have their own logic of development, which powerfully shape long-run patterns of change in the health policy sector.

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## ABBREVIATIONS

AP-HP	The Paris hospital group, the Assistance Publique-Hôpitaux de Paris
BN	The national executive of the SNCH, the Bureau National
CDS	The centre-right party, the Centre des Démocrates Sociaux
CFDT	The socialist union federation, the Confédération Française et Démocratique du Travail
CFTC	The catholic union federation, the Confédération Française des Travailleurs Chrétiens
CGH	The abandoned general council for hospitals, the Conseil Général des Hôpitaux
CGT	The communist federation, the Confédération Générale du Travail
CHS	The consultative body, the Conseil Supérieur des Hopitaux
CHU	The regional teaching hospitals, the Centre Hospitalier Universitaire
CMC	The hospital medical commission, the Commission Médicale Consultative
CME	The reformed hospital medical commission, the Commission Médicale d'Etablissement
CN	The forum for regional delegates in the SNCH, the Conseil National
CNAMTS	The health sickness funds, the Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés
CNPF	The business federation, the Confédération Nationale du Patronat Français
DAS	The social action division of the Social Affairs ministry, the Direction de l'Action Sociale
DB	The budget division of the Finance ministry, the Direction de Budget
DCP	The public accounts division of the Finance ministry, the Direction de la Comptabilité Publique
DDASS	The departmental health boards, the Directions Départementales des Affaires Sanitaires et Sociales
DGS	The general health division of the Health ministry, the Direction Générale de la Santé
DH	The hospital division of the Health ministry, the Direction des Hôpitaux
DP	The economic forecasting division of the Finance ministry, the Direction de Prévision
DRASS	The regional health boards, the Direction Régionales des Affaires Sanitaires et Sociales
DSS	The social security division of the Social Affairs ministry, the Direction de la Sécurité Sociale
ENA	The national school of administration, the Ecole Nationale d'Administration
ENSP	The national school of public health, the Ecole Nationale de la Santé Publique
EPIC	The public enterprises of an industrial or commercial nature, the Etablissement Public Industriel et Commercial



<b>EPS</b>	The revised statute of public hospitals, the Etablissement Public de Santé
<b>FHF</b>	The public hospital lobby, the Fédération Hospitalière de France
<b>FO</b>	The trade union federation, Force Ouvrière
<b>GIE</b>	The economic partnerships, the Groupements d'Intérêt Economique
<b>HEC</b>	The elite business school, the Hautes Etudes Commerciales
<b>IEP</b>	The institutes of political science, the Institut d'Etudes Politiques
<b>IGAS</b>	The general inspectorate of social affairs, the Inspection Générale des Affaires Sociales
<b>IMNH</b>	The hospital doctor union federation, the Intersyndicat National des Médecins Hospitaliers
<b>PCF</b>	The French communist party, the Parti Communiste Français
<b>PMSI</b>	The programme of diagnosis-related groups, the Programme de Médicalisation des Systèmes d'Information
<b>PS</b>	The French socialist party, the Parti Socialiste
<b>RPR</b>	The gaullist party, the Rassemblement Pour la République
<b>SNCH</b>	The hospital director trade union, the Syndicat National des Cadres Hospitaliers
<b>TD</b>	The national guideline for hospital budget increases, the Taux Directeur
<b>UDC</b>	The centrist parliamentary group, the Union du Centre
<b>UDF</b>	The giscardian centre right federation of parties, the Union pour la Démocratie Française

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## CHAPTER ONE

### CHANGES IN THE MANAGEMENT OF HEALTH CARE

The post-war development of public health care systems has been characterised by three distinct periods of government policy priorities, evolving from expanding access, through imposing cost containment, on to increasing efficiency.<sup>1</sup> Governments expanded access on the back of a state-profession compromise. To ensure doctors' participation in public health care systems, they conceded control of the delivery of services to medical professionals.<sup>2</sup> The acceptance of clinical freedom ensured that fully-qualified doctors were not supervised in their clinical practice by managers or, for that matter, by other medical professionals. Such devolved regulation defined judgements about health treatments as a technical rather than a political issue.<sup>3</sup> It biased decision-making towards implementation, making the overall provision of health care services very sensitive to the aggregate of decisions made by individual physicians.<sup>4</sup> Indeed, governments withdrew from direct 'hands-on' intervention in the management of public hospitals. National policy networks institutionalised medical predominance and closed decision-making off from rival actors.<sup>5</sup>

Once governments sought to create public health care systems, they were caught in a complex web of resource dependencies with the medical profession. Hospital doctors required government to endorse their professional autonomy in the workplace. Yet, governments were dependent upon medical professionals to provide information and expertise in the provision of care and, ultimately, to allocate resources and ration care. Indeed, this dependency made health policy difficult to change as it obliged governments to enter into negotiated compromises with the medical profession.<sup>6</sup> The 'shared vision' of health policy-making in the UK National Health Service (NHS) characterised health care politics as the incrementalist outcome of a weak centre, with little operational control over the implementation of national policies, faced with both an entrenched 'defensive' medical profession and a complex health care system.<sup>7</sup>

The rising costs of health care were fuelled by rising demands, technological costs

and demographic pressures. In the stagflation of the 1970s, governments were obliged to renegotiate the boundaries of medical predominance. They ceased to accept the quality of outcomes produced by the task-oriented clinical model of care inherent within the devolved regulation of the state-profession compromise. In the first instance, governments imposed top-down controls on health care financing. Although placed under strain, clinical freedom remained free from any direct onslaught as doctors worked under the constraints of tightly controlled budgets. However, as governments were swept along on the rising tide of managerialism, the quest for efficiency began to contest the monopoly exercised by the medical profession over the setting of priorities, the allocation of resources and the nature of care. Changing priorities progressively called into question the boundaries of clinical freedom.<sup>8</sup>

These top-down attempts by governments to re-negotiate the terms of the state-profession compromise were not dissociated from the bottom-up emergence of rival lobbies within public health care systems. The work of self-help groups and their like brought to the fore patients as consumers who challenged the cultural authority of doctors.<sup>9</sup> Health administrators and planners, as well as health economists, rival professionals and paraprofessionals contested medical autonomy in the workplace. Within public hospitals, managers ceased to be just supports to medical professionals who resolved internal conflicts rather than encroaching into the reserved domain of clinical freedom.<sup>10</sup> Instead they attempted to assert their line-management hierarchy over medical professionals. Faced with such occupational challenges, the policy networks that institutionalised the influence of the medical profession and closed decision-making off from rival actors in other policy networks, 'exploded'.<sup>11</sup>

This radical change in health policy networks seemingly belied the entrenched position of the medical profession. That the moves towards cost containment were accompanied by the emergence of rival lobbies and the breakdown of professionalised policy-making was somewhat paradoxical in policy sub-systems supposedly characterised by medical predominance, closed access, resource dependency and incremental change. In the light of such stabilising forces as professional exclusion and resource dependency, how did new groups or lobbies emerge in health policy-making? The changes call into question our understanding of both the stability of professionalised policy networks and

the capacity of government to reconfigure health policy networks so as to answer the changing demands of cost containment.

This thesis analyses these changes through a detailed study of French hospital management policy, from the initial measures towards cost containment launched in 1976, through to the complete re-writing of the previous legislation on public hospitals in 1991. Like Britain, France has faced strong economic and social pressures to restructure health policy networks. However, in contrast to its 'weak' British counterpart, the French policy tradition has been that of a 'strong' state benefitting from a series of tactical advantages.<sup>12</sup> Indeed, the market and institutional framework of the insurance-based French health care system stands in marked contrast to the nationalised, free-at-the-point-of-delivery service of the NHS.<sup>13</sup> The evolution of health policy networks in France, within a distinct institutional framework, thus provides a valuable contribution to the understanding of the apparent convergence or internationalisation pressures in public health care systems.

The thesis focuses upon the emergence of hospital managers as new actors in French health policy networks. Hospital managers occupy a pivotal location within public health care sub-systems as both agents of the central state and local actors within decentralised hospital management coalitions. The policy networks governing hospital management have been transformed by the development of the French *corps* of public hospital directors and its largest trade union, the *Syndicat National des Cadres Hospitaliers* (SNCH). Through the 1980s, the SNCH evolved its own programme for hospital management reform, and its members rose to occupy pivotal positions during the decision-making process which led to the 1991 Hospital Law. The first half of the study analyses the evolution of the *corps* of hospital directors, its socialisation, growth and development in organised collective action. The second half provides a detailed analysis of how hospital directors in the SNCH interacted with policy makers in successive periods of hospital legislation through the 1980s and into the 1990s. The emergence of the SNCH took place against the background of the attempts by successive governments to reconfigure the health policy sub-system in France. Through these attempts at reform, politicians played a significant role in transforming the regulation and financing of policy systems, and inducing changes in professional groups and the local management of hospitals.

How health policy networks change has been the subject of much academic interest. The existing literature has focused upon the capacity of hospital managers and governments to challenge the professional dominance of doctors within the workplace of public hospitals. It has tended to ignore explanations of the emergence of lobbies and the evolution of national level policy networks.<sup>14</sup> In the case of France, existing studies of health policy change, like many traditional studies in public policy, tend to provide partial accounts, content on the whole to explain the content of legislation rather than the evolution of decision-making mechanisms.<sup>15</sup> There is no detailed decisional study of either the emergence of hospital managers as a distinct lobby or of the change within health policy networks in the period from 1976 to 1991. De Pouvourville has contributed interesting accounts of the specific development of the programme of Diagnosis-Related-Groups within France. But, this single case study remains confined to working groups within the Health Ministry throughout the 1980s, and does not address the emergence of hospital directors and wider theories of health policy change.<sup>16</sup> In a similar vein, Hassenteufel's comparative study of the French medical profession provides a partial account of hospital doctors' involvement in health care reforms, but exploits in greater measure the policy manoeuvres of specialists and generalist physicians in private practice and, says nothing of the emergence of hospital managers as a lobby in health policy networks.<sup>17</sup>

However, there are two exceptions to this pattern which provide valuable accounts of the implementation of hospital management reforms between 1981 and 1988. Wilsford, in *Doctors and the State*, compares the capacity of French and American states to reform the medical profession.<sup>18</sup> He argues that the French state possesses institutional advantages in its dealings with the medical profession. However, the study gives little attention to the emergence of hospital directors and the systematic analysis of detailed decision-making processes. It remains a macro-level institutional analysis where reference to general patterns of policy-making replaces the comprehensive study of each stage of the policy-making process. In contrast, Philippe Rollandin in *La Santé en Danger* provides a sporadic account of the decision-making process between ministers and pressure groups in health policy networks.<sup>19</sup> He provides interesting 'behind the scenes' insights into the decision-making process, but offers only an atheoretical account of health policy change.

The emergence of hospital directors is recognised, but treated as a side-issue. Neither work provides a satisfactory understanding of change in health policy networks and decision-making at the national level.

To outline a different strategy, the remainder of this chapter first evaluates competing macro-explanations of health policy change. The second section develops a framework for analysing health policy change and the emergence of new actors within health policy sub-systems. The final section deals with the organisation of the rest of the thesis.

## **1.1 COMPETING MACRO-EXPLANATIONS**

Health policy studies have employed a range of theoretical models to understand the breakdown of professional policy networks and the emergence of new actors in health policy sub-systems. This section analyses the assumptions of five such theories: neo-marxism, elitism and structural interests, new institutionalism, meso-corporatism and policy networks. It evaluates how far these theories both allow for open or closed decision-making arenas; whether they provide for a coherent dynamic of policy change; and how applicable each theory seems in a prima facie way to the study of health policy-making in France. I conclude that each of these diverse approaches captures different and valuable elements of health policy change. But all approaches confront major problems in dealing adequately with either the process of policy formulation or the interactions between structures and agents within the policy process.

### ***Neo-Marxism***

Neo-marxist explanations of the moves towards cost containment in health policy subsystems derive from the fundamental assumption that the state works in the long-term interests of capital and that the changing demands of capital accumulation determine the evolution of public policy.<sup>20</sup> In the first instance, the establishment of public health care systems simultaneously socialised the costs of the health services necessary for the reproduction of labour and increased the legitimacy of capitalist systems. Subsequent state moves towards cost containment are interpreted as the requisite response to the rising

unemployment and falling economic growth of the 1970s, which obliged the state to reduce the burden of public spending and taxation on business in order to maintain the conditions for capital accumulation. At the macro-level, health policy shifted from expanding access to top-down controls on hospital spending, increased planning and the centralisation of aggregate decision-making. At the micro-level, the state promoted the proletarianisation of doctors, instituting an increasing division of labour and promoting a managerial class to control the production of health care services. Somewhat like artisans during the Industrial Revolution, hospital doctors were deskilled to accommodate the needs of the production process under capitalism.<sup>21</sup> However, the measures destined to resolve the 'crisis of accumulation' raised a 'crisis of legitimation' whereby controls on the delivery of health services undermined the legitimacy which their provision was supposed to confer.<sup>22</sup>

Such determinist neo-marxist accounts hinge upon their capacity to prove that state managers worked deliberately in the interests of capital. Throughout the consultation process of the Seventh Plan, French business and its umbrella organisation, the *Confédération Nationale du Patronat Français* (CNPF) voiced its desire to impose controls upon rising health care costs.<sup>23</sup> Equally, a cursory glance at moves to cost containment in France demonstrates that politicians were concerned to protect capital accumulation. Valéry Giscard d'Estaing, elected to the presidency in 1974, publicly argued that France risked long-term structural evolutions in its society should public spending rise beyond the mystical figure of 40 percent of Gross Domestic Product (GDP).<sup>24</sup> The economic policy reversal undertaken by the Mauroy government in 1984, its endorsement of *le Franc fort*, a French Franc which shadowed the Deutschmark, and the constraints of competitive disinflation further point to the structural power of capital and the overriding demands of capital accumulation. The introduction in 1989 of the *contribution sociale généralisée* under the premiership of Michel Rocard aimed directly at lessening the burden of social security funding on employer-employee contributions by generating funds through central taxation.

However, that politicians were voicing concerns parallel to those of the business community is not evidence that the state was working expressly in the interests of capital. Even where policies correspond to the demands voiced by business, we cannot necessarily



infer the dominance of capital. Such an interpretation fulfils Dowding's blame fallacy since it assumes that because one actor acts in the interest of another actor it must be because of power exerted by the latter.<sup>25</sup> State managers will have their own distinct interests, although protecting these interests may lead them also to protect those of capital.<sup>26</sup> Indeed, that state managers are concerned with or constrained by economic performance is a common element in other rival accounts. Neo-pluralist accounts advance the privileged position of business.<sup>27</sup> Rational choice approaches such as the political-business cycle recognise that politicians have their own set of interests in the realm of economic performance, because macro-economic outcomes are significant determinants of general elections.<sup>28</sup>

Neo-marxist accounts do not easily handle the fragmentation of the state, or, for that matter, of capital. First, the French state is not a homogeneous entity, but a segmented collection of competing ministries and civil service *corps*.<sup>29</sup> This territorial competition between civil service *corps* and ministerial divisions means that we cannot simply see the emergence of hospital directors as a purposive state response to rising health spending. More importantly, elected and unelected state managers will have different interests and at times be tied to specific fractions of capital. In the realm of health policy sub-systems, state managers are socialised into professional ethos and place a relatively low emphasis on economic issues. There is consequently no obvious reason why all state managers will protect the general interests of capital.<sup>30</sup>

Second, not all fractions of capital will automatically support the introduction of cost containment measures. Pharmaceutical industries discourage controls over hospital doctors' rights to prescribe. Manufacturing and research and development industries are influential in sparking technological innovation, specialised services and more health care spending.<sup>31</sup> Within the Social Security funds, during the moves towards cost containment at the end of the 1970s, the business delegates from the CNPF were concerned with protecting the interests of the health 'industry' rather than with the general interests of capital accumulation:

'around those years, the CNPF changed a little, that is to say that instead of being the representatives of a policy which was very, very, very spending controls [...] it found itself to be the representatives of a policy which defended the health policy actors within the CNPF, thus, [...] defenders of pharmaceutical companies, defenders of private clinics,

defenders of biological laboratories.<sup>32</sup>

Overall, neo-marxist approaches suffer from the same weaknesses as all functional models of policy-making. They provide an explanation of policy change, but can explain neither the timing, the priorities nor the variations in health policies. Even if we accept that policy makers recognise external functional pressures, neo-marxism fails to explain in detail what takes place between the period of recognition by the state of external policy pressures and the implementation of its actual response to these problems. The formulation and nature of policy responses are deemed to be unproblematic. The actions of state managers are reduced to that of automatons working in the general interests of capital.

### ***Structural Interests***

Structural interest theory defines interests in relation to the way they are served, or not served, by the logic and principles of existing institutions and structures. In health care systems, Alford identifies three broad heterogeneous coalitions of interests who share common structural locations: dominant professional monopolisers, challenging corporate rationalisers, and repressed community populations.<sup>33</sup> The dominant interests of hospital doctors as professional monopolisers are served automatically by the wider structures and logic of health care systems. While marxists see the dominant concepts of health as serving the bourgeoisie, structuralists see it as serving the medical profession, citing continued medical predominance in the workplace, despite attempts at organisational reform.<sup>34</sup> Doctors are united by their common structural location against the threats to the status quo posed by corporate rationalisers as exemplified by hospital managers, planners and politicians. Patients or the 'community population' are repressed interests, largely excluded by existing institutions.

The underlying dynamic of health policy sub-systems is that of competing elites, with corporate rationalisers sponsoring moves to cost containment to challenge dominant professionals. Indeed, Harrop evokes the driving antagonisms of the 'inherent antipathy' between rule-oriented bureaucrats and self-regulating professionals.<sup>35</sup> This dynamic of emerging corporate rationalisers taps into a fruitful seam of work which interprets policy-making in France as the bastion of technocratic elites.<sup>36</sup> For this tradition, the state-led

public works programmes of the Fifth Republic coupled with the widespread acceptance of the state as the agent of modernisation in the immediate post-war period provide evidence of the influence of the technocratic French civil service elite. Equally, the models of recruitment and pre-eminence and organisation of the elite civil service, the *grands corps*, which spread into the private sector through the operation of *pantouflage* (whereby public officials acquire employment in the private sector), all lend support and legitimacy to the vision of a technocratic state.<sup>37</sup> Indeed, studies by Thoenig, Suleiman and others have demonstrated how, by exploiting claims to possess general expertise, the *grands corps* pursue expansionist strategies in order to advance their interests across sectors.<sup>38</sup> This presence of *grands corps* across diverse policy sectors allegedly coordinates policy responses within the French state.<sup>39</sup>

However, positing a fundamental dichotomy between medical and administrative interests over-simplifies what is going on within health care systems. The configuration of interests will vary from issue to issue and the ‘play-off’ between professionals and corporate rationalisers cannot possibly account for all instances of health policy change. Jamous shows how the decision-making process surrounding the 1958 settlement between the state and hospital doctors (leading to the creation of regional teaching hospitals) hinged upon the emergence not of challenging administrative or political interests, but of a new category of young doctors from ‘new’ disciplines.<sup>40</sup> Even allowing for the fact that corporate rationalisers can at times ally with medical professionals, structural elitism retains a ‘broad brush’ approach which misconstrues the fragmentation and multidimensional alliances between hospital doctors and managers. French public administration and the medical profession are both characterised by fragmentation and internal competition. French hospital directors do not necessarily share the aims of their fellow corporate rationalisers in central government. They persistently ally with hospital doctors to ward off encroachments upon their managerial autonomy from core executive actors (see Chapter Two).

In fact, the assumption that changes arose from challenges by corporate rationalisers simply does not apply for most of the development of health care systems when managers and politicians were content to work as ‘diplomats’.<sup>41</sup> In France, as in the NHS, hospital directors developed an alternative administrative hierarchy which did not

encroach into the domain of medical freedom.<sup>42</sup> Indeed, as long as they were promoted from class to class according to the number of beds in their hospitals and could manage budgets to bear the costs of medical expansion, directors engaged in tacit alliances with hospital doctors.

This recognition of tacit alliances obliges structural interest accounts to explain why hospital directors began as diplomats but later became challengers to medical predominance. Alford ties the emergence of corporate rationalisers to the issues of wider economic, social and technological change. Yet, he qualifies this dynamic by accepting that challenges to medical predominance only occur when corporate rationalisers perceive a successful opportunity to undermine professional monopolisers, relegating social and economic developments to the realm of a 'clue' to understanding the timing of health policy change.<sup>43</sup> This position does not explain how corporate rationalisers have interpreted changes in the wider environment, believed them to provide a window of opportunity to challenge medical predominance, and have seized that opportunity.

Consequently, structural elitist accounts also hinge upon the translation of changes in the broader economic and social environment into health policy networks. The inherent dominance of the professional monopolisers means that any explanation of change is problematic, as external change pressures might always be distorted by the structural dynamic of health care systems. There are also difficulties in isolating the apparent logic and structural interests that exist.

### *New institutionalism*

New institutionalist accounts examine how formal institutions, informal rules, routines and procedures mediate the behaviour of actors within the decision-making process.<sup>44</sup> Structures, rules, and routines shape the goals and interests of political actors. They structure power relations, attaching benefits and constraints to different patterns of behaviour. Individuals will consequently process issues according to a 'logic of appropriateness' which fits issues into existing practices and underpins institutional stability.<sup>45</sup> Thus, the configuration of institutions within political systems biases the path and outcomes of policies, and influences the relative power of actors within the policy process. The degree of centralisation within policy systems, the relations between the

executive and the legislative, the rules of electoral competition, the nature of the party system and the relative strength of interest groups, will all have impacts upon the capacity of actors to induce policy change. Differences between institutional frameworks will make certain political systems less resistant to change than others.<sup>46</sup> However, in general, institutions, 'are believed to be inherently inert, rigid, and change-resistant. They impose structure and continuity on an otherwise changing world...'<sup>47</sup>

The general culture of the French state, which frames the values and norms of elite policy-makers, leads them to favour statist responses to health policy reforms.<sup>48</sup> Wilsford argues that the institutional framework facilitates the executive's domination of the policy-making process.<sup>49</sup> The French executive has several tactical advantages over the medical profession, which is both organisationally fragmented and poorly mobilised. These tactical advantages emerge from the French executive's extensive proposal and decree powers, its commanding position over a weak National Assembly, the tradition of powerful ministerial *cabinets*, an extensive and homogeneously trained bureaucratic elite, a judiciary of limited powers and the ideological fragmentation of interests. As a result, health policy changes mainly derive from a series of state-led initiatives which have diminished the influence of the medical profession:

Hospital reforms were introduced in 1958, 1967, and 1969 under the Gaullists and in 1983 under the Socialists. Each time physicians opposed them. Each time physicians lost. Indeed, a linear decline is evident in French physicians' political influence since World War II.<sup>50</sup>

However, Wilsford, inspired by the Crozier thesis of a 'blocked society'<sup>51</sup>, recognises that the 'strong' French state is vulnerable to direct action. Such vulnerability arises because the capacity of the state to over-ride interest groups leaves them with no option, but to try and mobilize their supporters to take direct action.<sup>52</sup>

Keeler offers support for this thesis, arguing that the structural assets and constitutional weapons at the disposal of the French executive overcame the legislative stalemate of the Fourth Republic.<sup>53</sup> The judicious use of these constitutional weapons enabled the minority Rocard government not only to survive in office, but to force its legislation through the National Assembly.<sup>54</sup> And Immergut illustrates how Parliament in the Fourth Republic acted as veto point for health care legislation, arguing that it was the extensive decree proposals attributed to government in the Fifth Republic which enabled the Debré government to push through the 1958 ordinances.<sup>55</sup> Equally, Dunn, in a study

of the highway lobby in France, shows how the bureaucracy was able to maintain policies opposed by the highway lobby because of the tactical advantages enjoyed by the state. Dunn attempts to refine Wilsford's work by assuming that, although tactical advantages exist across sectors, leaders will only exploit them in areas which they perceive to be core state functions.<sup>56</sup>

Yet, the same institutional arrangements which reinforce the dominance of the French executive attach constraints or incentives to decisions over time, thereby channelling policy along the same incremental paths. In his later work, Wilsford stresses the path dependency or 'lock in' which ties public policy in health policy sub-systems to previous decisions and the existing status quo of institutional arrangements.<sup>57</sup> Indeed, Wilsford accepts that radical policy change requires the existence of strong conjunctural forces, such as technological innovation, which alter incentives and disincentives, and existing balances of power, to enable policy actors to implement change and switch paths. These conjunctural forces are defined as unpredictable and rapidly changing 'fleeting comings together of a number of diverse elements into a new, single combination'.<sup>58</sup> In France, the departure from existing paths of hospital management policy induced by the introduction of the global budget was the result of such conjunctural factors - the presence of certain individuals and the economic difficulties of the Left, facilitated by the hierarchy and centralisation of the French state.<sup>59</sup>

However, Wilsford provides no explanation of how to predict the timing and actuality of changing conjunctures. By definition, they are unpredictable and brief windows of opportunity. Neither does he provide any extended discussion of why policy-makers might react differently to certain conjunctural factors and invoke change. Indeed, Wilsford tends to divorce individuals from any responsibility for managing events and manipulating preferences in order to create the necessary conditions for change. He suggests that policy-makers should recognise that patience is a virtue and, having prepared the ground for policy change, should wait for the new conjuncture that allows policy to overcome the existing barriers to change. Similarly, he accepts that fortuna is involved in the arrival of circumstance conducive to policy change.<sup>60</sup>

These difficulties raise the awkward relationship of how new institutionalist-inspired accounts of policy change can cope with its elevation of rules, routines and

procedures. Their focus upon acknowledged patterns of behaviour emphasizes the continuity of policies and structures and points to incremental change as the norm. External pressures will be mediated by 'organisational dynamics that imprints their own image upon the outcome.'<sup>61</sup> These accounts suggest that episodes of policy change are infrequent, with change path-dependent and limited, unless the result of rare moments of historical crisis and creative destruction.<sup>62</sup>

More importantly, Wilsford misconceives the resources at the disposal of the medical profession to combat the tactical advantages enjoyed by the French state. He argues that the organisational weaknesses of the medical profession, fragmentation and poor mobilisation 'cut across the generic imperatives embedded within the profession, such as technical expertise, which establishes the doctor as the key figure in the hierarchy of service providers.'<sup>63</sup> Yet, the medical profession gains its influence through its control of expertise and information at the grassroots where decision-making is implementational. The failure of the move towards departments within public hospitals in 1984 exemplifies this street-level autonomy of hospital doctors and undermines the conception of a 'strong' French state. Indeed, it is arguable that the alleged organisational weakness of hospital doctor trade unions actually hinders the capacity of the state to manage the implementation of policy, because it rids it of a credible interlocutor. Very differing conclusions can be drawn from Wilsford's observations. Suleiman concludes that the 'strong' centralised administrative structures of the French executive facilitate group capture of the state.<sup>64</sup> Pierson argues that institutions can produce different impacts upon policy-making when government priorities shift from expansion to retrenchment.<sup>65</sup> Kuhn argues that, in the broadcasting sector, the French state was never monolithic, but that the 'result was less an impotent than a confused state.'<sup>66</sup>

Overall, new institutionalist accounts provide valuable insights into how institutional actors take decisions and the development paths of public policies. They provide a foundation for explaining both policy continuities and the persistence of distinct patterns of decision-making within states. However, ultimately, the French state tradition and institutions, as highlighted by Wilsford, do not determine behaviour and policy outcomes. They structure the actions of agents and outcomes through determining the constraints and opportunities of the rules of the game.<sup>67</sup> New institutionalist approaches

assume that incremental change is the norm. The difficulty here is that radical change or policy innovation tends to be associated with the dislocation of structures, when existing rules no longer apply. Indeed, it is a recognition of the very inappropriateness of existing rules and norms in public health systems which lay behind the upheavals within health policy networks.

### *Meso-corporatism*

Meso-corporatists argue that the advanced capitalist state increasingly attributes monopoly representation to functional or producer groups in exchange for their co-operation in the formulation and implementation of public policies. Policy-making is, therefore, characterised as a closed process of mutually dependent bargaining, with its outcomes implemented through the channel of interest group leaderships who police their rank-and-file membership.<sup>68</sup> This acceptance of mutual dependency leads to a concentration upon the bargaining process between state managers and the leaders of peak organisations, especially the umbrella organisations of labour and capital. Thus, in contrast to 'strong' state approaches, meso-corporatist accounts recognise that producer groups place marked constraints upon the actions of state managers.

Such closed decision-making and mutual dependence between the state and producer groups was at the heart of the post-war compromise between the state and the medical profession in health care.<sup>69</sup> However, work on interest groups in France has tended to deny the existence of fully-fledged liberal corporatist systems of interest intermediation. Rather than the monopoly, hierarchically-ordered groups necessary for liberal corporatism, pressure groups in France have traditionally been seen as relatively weak and ideologically fragmented.<sup>70</sup> Yet, empirical work in this vein has not found refuge solely within a pluralist conception of state-interest group relations. Instead, it has pointed both to the interventionism of the French state in shaping the group universe and to the existence of more than one form of interest intermediation in France, invoking multiple models of state-interest group relations which include variants of liberal corporatism.<sup>71</sup> Even those who adopt a pluralist approach, such as Wilson, stress the state-led nature of pluralism within France.<sup>72</sup> As Hall points out, the French state subsidises between half and three quarters of the budgets of many interest groups, and each year it seconds



approximately four thousand public employees to work with interest groups.<sup>73</sup>

In his study of the changing relations between agricultural trade unions and the state, Keeler identified a pronounced degree of corporatist decision-making. The state eases policy implementation by exploiting the capacity of agricultural trade unions to police their members. He points to the existence of sectoral corporatism within France whereby the degree to which the state and interest groups develop corporatist ties varies from policy sub-system to policy sub-system.<sup>74</sup> Similarly, Jobert and Muller argue that sectoral corporatism and professional regulation of social activities is a fundamental element of French public services. They distinguish two models of sectoral corporatism: social and technical. The technical model involves the takeover of a policy sub-system's management by a technostructure or elite civil service *corps*. In contrast, the social model delegates control to professionals who negotiate with a technostructure or administrative hierarchy with little prestige.<sup>75</sup>

In the French health policy sub-system, Jobert and Muller recognise the apparent weakness of the sectoral corporatist approach because of the fragmentation amongst the medical professions' representative organisations.<sup>76</sup> Like Wilsford, they acknowledge that interest group fragmentation is compounded by low membership and the inability of professional elites to discipline the rank-and-file. These organisational weaknesses enable medical elites to mobilise defensively against external threats to the profession's self-regulation and expertise, but leave them unable to take charge of the regulation of the health care system as expected within corporatist bargaining structures.<sup>77</sup> Unlike Wilsford, however, Jobert and Muller conclude that the strength of the medical profession lies not in its organisational resources, but in its cultural authority over other policy actors and wider French society. It provided the dominant *référentiel*, the commanding policy discourse in health policy-making. As Dunleavy argues, such ideological corporatism, founded upon a dominant professional 'view of the world', integrates policy networks, guides policy and lessens the perception among decision-makers of a need to regulate professions - so that policy largely becomes what professionals in the field do.<sup>78</sup>

Meso-corporatist accounts are primarily static and unable to explain the emergence of rival groups within health policy networks. The fundamental assumption of mutual dependence implies that policy change will be incremental and adaptive. In fact, the

bargaining process between the state and interest groups partly depends upon whether the process can remain non-conflictual, closed and insulated from external actors. Cawson further minimises conflict between dominant partners and rival groups by arguing that vertical functional divisions within society mean that all actors in one sector will be linked by shared functional interests.<sup>79</sup> In health care systems, a 'vertical' grouping of health service employees can be expected to have a common interest in maintaining expenditure and expanding services. Equally, references to the ideological dominance of professionals accept the policy dynamic of professional trends, but they hamper a meso-corporatist explanation of emerging challenges to medical predominance. Why does not the shared professional 'view of the world' strangle the emergence of opposing viewpoints? And, such accounts would need to explain and accept the declining cultural authority of hospital doctors.

In their study of general practice in Britain, Klein and Day confirm the difficulties that meso-corporatist accounts experience when explaining policy change in public health care systems.<sup>80</sup> They argue that the evolution of policy towards general practice in the NHS should be seen as periods of distributional conflicts punctuated by constitutional conflicts, when the structure and processes of the health care system are called into question. However, they conclude that it is only distributional conflicts which are marked by meso-corporatist patterns of decision-making. Constitutional conflicts cannot be explained by reference to the assumptions of the corporatist model. Yet, it is these periods of innovation that are pivotal to the understanding of the evolution of public health care systems.

In conclusion, meso-corporatist approaches recognise both the mutual dependence that exists between the state and hospital doctors, and the closed decision-making processes installed by the state-profession compromise in public health care systems. However, the assumption of closed and essentially incremental decision-making precludes meso-corporatist accounts from drawing satisfactory conclusions about the emergence of rival lobbies within health care systems. As with new institutionalist accounts, the transforming 'constitutional' crises, necessary to our understanding of the emergence of groups, lie outside its explanatory grip.

### *Policy Networks*

Policy network accounts argue that policy-making takes place within relatively closed networks of government departments, interest groups and professional bodies, and stress the disaggregation of policy-making and the fragmentation of the state.<sup>81</sup> Networks vary across policy sub-systems with no consistent policy style or pattern of interest intermediation. Even within policy sub-systems such as health, the constellation of actors varies across the fields of services and between service and resource issues.<sup>82</sup> Marsh and Rhodes identify two primary meso-level policy networks which emphasise structural relationships between organisations at the sectoral level rather than relations between individuals. 'Policy communities' are characterised by stability, frequent consultation between members, restricted memberships, high levels of consensus and a balance of power among members. 'Issue networks' are atomistic, lack stability, have a large fluctuating membership with limited interdependence, and have an unequal spread of resources between members.<sup>83</sup>

Marsh and Rhodes argue that policy networks are brought together through resource dependency, with their boundaries determined by breaks in the resource structure, as identified by the 'centre' or produced by external pressures.<sup>84</sup> Networks subsequently emerge in policy sub-systems such as health, where governments are dependent upon professionals for information and expertise and where decision-making is ultimately biased towards implementation.<sup>85</sup> The unsatisfactory quality of coercion as a regulatory tool in such instances where the state depends upon groups for resources obliges governments to exploit the tools of exchange and shared norms and values. However, policy networks are also integrated through shared expertise or common belief systems. Hass points to epistemic communities, unified by common expertise and sharing normative and causal beliefs and common policy solutions.<sup>86</sup> Sabatier identifies advocacy coalitions in which groups and organisations share common basic values and belief systems, and operate with the same causal assumptions, problem perceptions and preferred policies.<sup>87</sup>

In the case of France, there is little specific policy literature on policy networks although Jouve draws parallels between the work of Marsh and Rhodes and that of Crozier, Freidberg and Jobert and Mueller which underlines the formulation of public

policies within stable networks marked by common values and frequent interactions.<sup>88</sup> Culpepper argues that the dynamics of French agricultural policy-making are best encapsulated by competitive policy collaboration whereby multiple independent groups operate in a privileged policy community marked by muted competition.<sup>89</sup> Equally, Hayward, in his study of economic and industrial policy-making, points to the existence of a semi-pluralistic elitist policy community which brings together business, public and private bankers and politico-administrative leaders.<sup>90</sup> Indeed, Cawson, Holmes and Stevens stress the disaggregation of the French state and the existence of sectoral policy networks in telecommunications and consumer electronics.<sup>91</sup>

In general, French public policy studies have focused upon political networks between individuals which act as mediating and co-ordinating mechanisms within a rather closed politico-administrative system.<sup>92</sup> In doing so, they have pursued a state-centred elitist analysis with the long-term cohesion and stability of networks produced by the ubiquitous presence of the elite civil service *corps* and their common training and socialisation processes.<sup>93</sup> For instance, Josselin stresses the dominance of state actors in financial policy networks in France.<sup>94</sup> However, the stability of such networks is increasingly questioned by destabilising effects, such as: the rupture of local networks built upon relationships between prefects and *notables*; the displacement of decision-making centres caused by the increasing interventions of Brussels in 'national' policy-making; and growing external constraints such as economic pressures.<sup>95</sup> Schmidt argues that in the sphere of industrial policy, the heroic policy of the French state has declined, as the state itself has sowed the seeds of the previous system's downfall through deregulation and privatisation.<sup>96</sup> Similarly, John and Cole suggests the convergence of patterns of decision-making between countries as the requirement of cooperation and coordination in the face of similar social and economic pressures leads to the creation of networks which bypass established institutional arrangements.<sup>97</sup>

Within the policy network literature, the evolution of health policy sub-systems is portrayed as the demise of a professional policy community which subordinated political and managerial influences as well as the needs of clients to the values and interests of dominant medical professionals.<sup>98</sup> In the French public health care system, Jobert has charted how the challenges of the Finance Ministry and the Social Security funds during

the formulation of French Plans threatened the privileged relationship of elite regional hospital doctors and the public hospital lobby, the *Fédération Hospitalière de France*, with the Health Ministry.<sup>99</sup> In the British NHS, Wistow and Smith argue that new groups infiltrated the closed health policy community as it moved to a much 'looser' network, coming under attack from government and hospital managers in the 1980s and early 1990s.<sup>100</sup> However, such explanations of health policy change are hampered by the inherent bias towards stability within professional policy networks which are the most resistant to change of all networks.<sup>101</sup> Such networks arise to reduce uncertainty and to facilitate the management of difficult tasks by imposing routine. By definition, they are static and closed, insulated from other actors and the external environment.

Policy network theory has primarily sought to explain change within policy networks by reference to a list of exogenous or network-environment pressures which produce instability within established policy networks. These pressures are deemed to emanate from four broad sources of change within the wider environment: economic/market, ideological, knowledge/technology and institutional.<sup>102</sup> These factors are not mutually exclusive, operating at times in tandem, although most case studies acknowledge the significance of economic change. Wistow, in his study of change in British health policy networks, points to both economic pressures upon health care funding and the ideological challenges to medical predominance posed by the Thatcher governments.<sup>103</sup> This argument is echoed by Jackson whose comparative study of the German and British coal industries concludes that the source of instability was primarily economic, but that the ideological platform of the Thatcher governments explains the heightened degree of change witnessed in Britain.<sup>104</sup>

The primacy of exogenous explanations runs the risk of reducing policy network theory to a 'simple environmental stimulus-policy network response model' which tells us little of the either the timing, nature or process of policy network change.<sup>105</sup> As John and Cole argue, networks in such explanations do not provoke change; instead, external changes in the environment affect the resources of actors in networks.<sup>106</sup> However, endogenous pressures cannot be entirely divorced from explanations of policy network change. Change in policy networks can be the result of a shifting balance of resources within the governing coalition of the policy network in question. Equally, policy networks

mediate the extent and direction of change, particularly in their capacity to minimise external pressures, although it does not follow that policy networks will necessarily act as a brake on change.<sup>107</sup> Indeed, Döhler argues that the structures of networks lend themselves to different policy paths.<sup>108</sup> Hassenteufel, and Thatcher, go as far as to argue that although policy networks cannot be made accountable for changes in the environment, they can determine the direction of policy change. Such observations, Hassenteufel argues, can be married to a new institutionalist approach with the rules and practices of policy networks structuring the direction of policy change.<sup>109</sup> However, as Atkinson and Coleman claim, the recognition that networks may channel the direction of policy change has remained a neglected topic in policy network theory.<sup>110</sup>

The recognition of endogenous change does not challenge the importance of exogenous pressures upon policy networks. Rather, it adds a supplementary set of endogenous variables to already existing explanations and maintains a troublesome dichotomy between external and internal change. Smith draws up a comprehensive list of both exogenous and endogenous variables which threaten the stability of policy networks. It ranges from changes in external relations, new problems, despotic power, and economic and social change through to challenges between rival networks and emergent challenges within policy communities themselves.<sup>111</sup> For good measure, Rhodes and Marsh stress that we should not forget that chance and opportunism play a part as do political crises in explaining policy network change.<sup>112</sup>

The compilation of such all-encompassing lists raises different problems. It fails to conceptualise the relationship between exogenous and endogenous change. Challenges between actors in policy networks are more often than not the product of wider changes in the environment. New problems, which have to be recognised by actors within networks, emerge because of broad social, economic and ideological change. More significantly, any list of variables remains exhaustive only for as long as it takes new case studies to isolate additional key variables (see for example the now common reference to the impact of European Union institutions as a catalyst for policy network change). Such an approach substitutes 'empirical breadth' for 'theoretical depth', adding to our understanding of the context of change rather than the actual process of change.<sup>113</sup>

Dowding argues that policy network accounts of policy change lack a theory of

power, and he casts doubt on the explanatory significance of policy networks.<sup>114</sup> For him, networks are merely labels with no existence outside the resources at the disposal of actors within the policy process; they reflect the wider distribution of power within society. However, whilst Dowding consequently calls for the use of micro-level theories to explain policy network change, Smith demonstrates how ‘traditional’ state theories or macro-theories might be applied to meso-level policy networks.<sup>115</sup> Neither of these views are disputed by Marsh who calls for the marrying of policy networks with both macro- and micro-theories.<sup>116</sup> As Marsh argues, structures such as networks cannot be solely reduced to the preferences of actors. And, whilst there is a need to understand the relations of power within networks, there is also an need to understand the wider nature of relations between state and civil society.<sup>117</sup> However, Mills and Saward argue that applications of macro-theories have resulted in the unsatisfactory argument that policy networks are a multi-theoretic field.<sup>118</sup>

The debate raised by Dowding illustrates the weakness of policy network theory which, as Marsh and Smith point out, is its failure to conceptualise the interactions between structures and agents.<sup>119</sup> They argue that Dowding misguidedly reduces structures to the preferences and actions of agents. Indeed, individualist approaches to networks share Dowding’s mistrust of the influence of structures. However, they conclude that Knoke and Lauman and Marsh and Rhodes over-emphasise the role of structures. In fact, Marsh and Smith view policy networks as structures within which agents operate: ‘Agents are, in a sense, “bearers” of those positions, but they interpret, deconstruct and reconstruct these structures...’<sup>120</sup> Thus, the relationships within policy networks are both structural and interpersonal. As John and Cole point out, networks can be ‘dependent in the sense that social and political factors affect the shape of the network [and] independent because the process of networking affects policy.’<sup>121</sup>

Overall, policy network accounts isolate the resource dependency that brings actors together within the policy process. They recognise the fragmentation of the state and the distinct nature of the configuration of networks across sectors. Indeed, the nature of the policy network will affect policy outcomes. However, policy communities are, by definition, closed and biased towards stability. They manage routine decision-making. So, they cannot explain change within policy subsystems adequately, and analysts fall back

upon change in the environment of policy networks, failing to conceptualise the relations between structures and agents.

In conclusion, all the accounts examined so far capture certain elements of the process of policy change in health care systems. Neo-marxist approaches isolate the macro-economic pressures for policy change. Structural elitism recognises the competition between rival elites. New institutionalist explanations identify the institutional configurations, routines and norms which influence the direction of policy change. Meso-corporatist explanations stress the mutual dependency between the state and the medical profession and the closed decision-making at the heart of the state-profession compromise. Likewise, policy network accounts, which allow for the fragmentation and disaggregation of the state, recognise the resource dependency that ties the state to the medical profession. Indeed, policy networks as political structures constrain and encourage certain decisions and thereby contribute to explanations of policy outcomes.

These competing strengths suggest that explanations of health policy should draw on different theories to construct a composite explanation.<sup>122</sup> This multitheoretic approach argues that individual theories are hierarchically ordered, operating at either the macro-, meso- or micro-level. Macro-theories such as neo-marxism offer 'a higher level of generality'<sup>123</sup> within which to fit the less comprehensive micro-theories. However, such composite explanations have their own limitations, deriving often from the combination of theories with contradictory assumptions. Whilst such limitations may be avoidable, Saunders argues that the distinction between macro- and micro-levels is unsustainable and that these distinctions have a tendency to reduce the micro-theory to the macro-theory.<sup>124</sup> Harrison, Hunter and Pollitt thus rely extensively upon neo-marxism at the macro-level as an explanation of policy change, which tends to over-rides the contribution of structural interest theory to their composite explanation.<sup>125</sup>

In fact, existing accounts all fail to deal adequately with the process of policy change, failing to allow for both open or closed decision-making arenas and a coherent dynamic of policy formulation and implementation. Structural elitism, new institutionalism, meso-corporatism and policy network explanations demonstrate an inherent bias towards routine and stability, conceptualising a relatively closed policy-



making process which nonetheless relies upon external social and economic pressures to explain policy change. In contrast, neo-marxist explanations, whilst taking full account of the structural pressures for change within capitalist systems, deem the formulation and nature of policy responses to be unproblematic. The interactions between structures and agents is poorly conceptualised by both policy network and neo-marxist accounts. One particular objective of this thesis is to investigate how best to conceptualise both the intermediating mechanisms of policy formulation, largely ignored by neo-marxists and, the dynamic of public policies, underplayed by network analysis. To do so, it examines the role of politicians in managing policy networks. Most accounts fail to conceptualise the interventions of politicians in policy-making, either reducing political actors to automatons or, placing them in straitjacket of resource dependency and the cultural norms and routines of institutions.

## **1.2 A FRAMEWORK FOR ANALYSING HEALTH POLICY CHANGE**

The significance of interventions by politicians and their capacity to pursue goals which are not simply reflective of the interests of social groups or classes has been widely recognised.<sup>126</sup> This section builds upon the assumption that the strategic choices of politicians will help to shape the environment rather than adapt to it.<sup>127</sup> It assumes that the emergence of hospital directors, although partly due to changes within the group itself, is best explained by the top-down interventions of politicians in the policy process. The first part examines the entry of 'new' groups into policy networks from the individual group perspective. The second introduces a framework of possible paths open to politicians in the management of policy networks.

### ***Change from the individual group's perspective***

The often-affirmed closed boundaries of policy networks and communities militate against the entry of new actors into the decision-making process (see above). The membership of policy networks depends upon the product of the resources and bargaining strategies employed by actors within the decision-making process. Within professional policy networks such as health, claims to authoritative information and technical expertise can

be expected to provide initially both legitimacy and access to the inner core of policy-makers. Groups deficient in these areas or with little social or outcome power will be excluded.

However, strategies and resources evolve as actors respond to changing circumstances and events. An individual group seeking to gain entry into a policy network from which it has previously been excluded may make some headway because of its bargaining strategies, but its progress will depend much more on increasing the resources at its disposal. Progress here can result from either a reevaluation of existing resources or an addition to the stock of resources at the disposal of the group. Groups activate latent resources they already possess, or develop new resources. But, in addition, both reevaluations or additions to the stock of group resources can themselves be the product of either a top-down process where group actors are in some way selected for influence by higher-level decision-makers, or the product of a bottom-up process where group leaders or members are in some way self-started, creating their own success.

Taking into account the origin and nature of resource change, we can point to four broad explanations of the entry of new actors in policy networks (see Table 1.1). First, the resources at the disposal of a group can take on increased utility or salience for other actors. This can be result of changes in the environment which mean that dominant actors need resources at the disposal of a previously excluded group. Second, groups may be *advantaged* whereby they benefit through the actions of another actor. For example, Dutch welfare professionals took on a more prominent role within policy-making not because of their fundamental challenge to the then corporatist modes of decision-making, but as ‘a result of other choices that unintentionally made professionals more important.’<sup>128</sup> Third, the costs of collective mobilisation can decline, thus enabling group leaders or members to exploit previously untapped resources. Finally, groups may seek to develop new resources themselves, which can be subsequently employed to advance their aims or interests.

**Table 1.1: Resource Change: the Individual Group Perspective**

<b>Top-Down Exogenous-Led Change</b>			
<b>Revaluation of resources</b>	1. Exogenous increase in salience	2. External boosting (advantage)	<b>Change in stock of resources</b>
	3. Cost of mobilisation falls	4. Organisation develops new resources	
<b>Bottom-Up Endogenous-Led Change</b>			

To explore these distinctions in more detail, I begin with top-down influences. Politicians devote substantial time and effort to organising and reorganising policy arenas to support the formation and implementation of policies.<sup>129</sup> Politicians will often intervene in the management of policy networks because policy networks privilege certain policy outcomes, shaping roles and behaviour, specifying acceptable issues and defining rules of the game.<sup>130</sup> They are able to do so because governments possess legitimacy and greater opportunities for conditional and unconditional incentives than other actors within policy networks: ‘at the end of the day, the material power and legitimacy of elected government can ride roughshod over any policy community.’<sup>131</sup> Rhodes argues that it would be misguided to under-estimate the asymmetric nature of the resources within policy communities and thereby devalue the capacity of governments to manipulate policy communities.<sup>132</sup>

Policy network theorists have characterized the arrival in government of politicians with distinctive ideologies or policy initiatives as the ‘grit’ in the routine business of the network’s internal actors.<sup>133</sup> Rhodes attributes to government the capacity to manage access to policy networks, decide the rules of the game within policy networks and determine the scope and timing of consultation.<sup>134</sup> Smith contends that Presidents and Prime ministers can employ their despotic power to ‘force new issues onto the agenda, [...] take decisions themselves, [...] give access to different groups, or [...] change the institution which is responsible for making a decision.’<sup>135</sup> Indeed, politicians can create a new group whilst seeking to erode or compensate its rivals. However, politicians can also manipulate the strategies and preferences of existing interest groups to foster bottom-up

changes in the balance of influence between professional groups. So, politicians can manipulate the strategies and preferences of interest groups, alter the definition of issues and information flows, tampering with tensions and the balance of resources between groups, and thereby facilitate or impede collective action. Specific policies also create incentives by generating 'spoils' that help group leaderships to overcome collective action problems.<sup>136</sup>

Involvement within a policy network, even a consensual policy community, does not mean that core executives will necessarily develop policies in harmony with the interests of the wider membership of the network. Thompson argues that the attacks by Thatcher governments on welfare professionals and the Thatcherite reforms of the welfare state illustrate that 'core executive actors (especially ministers) can and will develop interests independent of those responsible for policy implementation.'<sup>137</sup> The formulation of the 'internal market' within the NHS and the 1987 NHS Policy Review were carried out by a small team of ministers with minimal external contributions from the existing professional policy communities in the NHS.<sup>138</sup> Similarly, the Thatcher government excluded the water boards, the pivotal actors in the existing policy network, from a period of internal government decision-making during the privatisation of the water industry.<sup>139</sup> Indeed, the French President and Prime minister excluded agricultural trade unions and high-ranking officials in the Agriculture Ministry from decision-making during the 1991-1993 GATT negotiations.<sup>140</sup> Ministers can thus often choose between working alone or with policy communities.<sup>141</sup> However, policy network theory has generally underplayed the importance of traditional variables such as political leadership and partisan choice.<sup>142</sup>

The interventions of top politicians will be fundamental to explanations of policy network change. But this proposition says little about the nature or timing of their interventions, except to raise the prospect of some more all-encompassing lists of the possible actions politicians could take. The next section develops a framework to examine the interventions and paths open to instrumental politicians in a specific situation where they are faced with a decline in the quality of outcomes produced by existing networks.

### ***The limits of exit and voice: politicians and network restructuring***

As long as the 'routine business' of policy networks produces an acceptable quality of

outcomes, we can assume that rational politicians will have little or no reason to intervene in how the networks are run. But, some form of intervention will be triggered if politicians perceive a 'crisis' in terms of the declining quality of outcomes produced by a policy network. When the quality of outcomes is falling or decreasingly acceptable, politicians will confront costs measured primarily in terms of actual or potential lost support both from voters and client groups. Once the costs of these dysfunctional policies are deemed too high to bear, the core executive will intervene as long as it has a solution in prospect to the drop in the quality of outcomes. With no acceptable solution, it can decide to do nothing.

Declines in the quality of outcomes, as perceived by politicians, can occur for a multitude of reasons. The discovery of new solutions to problems previously accepted as non-issues or as *faits accomplis* often induces the perception of declining quality and occasion interventions. Equally, issues can be cognitively reconstructed through changing 'word formulas' and symbolic constructions which produce new approaches. Lastly, qualitatively new problems can simply emerge. 'Crises' tend to be conceived as the results of unforeseeable or contingent events, limited in time, and outside the boundaries of the policy network.<sup>143</sup> However, crises can be quasi-permanent, produced by the inherent tensions of the wider economic and political system.<sup>144</sup> Within health policy sub-systems, many authors have argued that government is engaged in perpetual crisis management as it seeks to balance the legitimacy of expanding care and the constraints of economic management.

Hirshmann identified 'exit' and 'voice' as the two primary mechanisms which actors can use to redress short-term declines in quality.<sup>145</sup> Through 'exit', actors escape from dysfunctional outcomes or declining quality by choosing an alternative product or organisation. Losing clients or members may subsequently lead the organisation involved to redress declining standards or dysfunctional policies. Through 'voice', actors express their dissatisfaction with the product or organisation. They remain as consumers of the product or members of the organisation in the expectation that complaints will force management to change its practices. The choice of either exit or voice is determined by the availability of alternatives, channels of influence, and the extent of 'loyalty' to the organisation. Loyalty, the degree of attachment to an organisation, will delay the use of

exit and increase the likelihood of recourse to voice. Actors strongly influenced by loyalty stay with the organisation and remain silent about their dissatisfaction. However, voice is also likely to be used both in the earlier stages of quality decline as an alternative to exit, and at later stages in combination with exit - those who depart protesting may have more impact in accomplishing organisational change than those who exit without voicing the reasons why. Actors can exit an organisation in more than one way: transferring to a rival group, taking up a completely different issue, or switching out of collective action altogether.<sup>146</sup>

Voice options are often the most significant channels of influence within the political domain. In the management of policy networks, voice equates to initiatives designed to change the culture of policy networks or to encourage actors to voluntarily alter their behaviour. People may try to influence the nature of the interaction processes between actors through the 'selective activation' of actors, the mobilisation of resources, the exploitation of the rules governing the network and communication strategies aimed at changing the perceptions of actors.<sup>147</sup> In the British NHS, the voice function can be seen as being used with the whole series of management initiatives beginning with the Cogwheel reforms. In France, we can point to government publicity and information campaigns seeking to reduce rising drugs bills through encouraging changing patterns of prescriptions. However, most voice options have a weakness, because they accept the structure of the network as given. And, for voice to be effective, it often must be accompanied by the realistic threat of exit or sanction. If government actors have no alternative source of information and expertise or provision in health care, and cannot realistically back out of their current responsibilities for public health, doctors may not feel that threats to exit the sector or cutback funding are realistic, and so may not change their behaviour.

Exit is open to political actors either by withdrawing state intervention and support for service delivery, or by abandoning the established policy network. In public health care system, the withdrawal of services could be promoted over time through the development of the private sector care, simultaneously running down public services and providing incentives for clients to exit the public health care service.<sup>148</sup> However, this exit option is only politically tenable for those political parties whose supporters do not demonstrate any

significant degree of allegiance to public hospitals - usually because they either have, or could develop, a satisfactory private sector alternative for themselves. Even so, the costs of such a long-term withdrawal are bound to be high, with politicians enduring long-term unrest in the health policy network and risking electoral dissatisfaction from worried voters.

Second, whatever the alleged degree of resource dependency between government and groups, politicians can simply by-pass established policy communities. There is no obstacle to the use of internalised decision-making as long as the government is ready to incur the costs of new patterns of policy-making. However, these excursions outside the realm of policy networks can usually only be short-term or temporary. Governments can rarely maintain the level of sustained political intervention necessary to secure long-term changes in a field where implementation rests with professional decision. Short-term or intense interventions to redress an unacceptable decline in the quality of existing outcomes are feasible, but politicians will normally be obliged to return thereafter to periods of routine or acceptable containment within networks. Indeed, political actors' interventions will also be deflected over time by institutional actors as they reassert pre-existing norms and practices, and exploit the resource dependency between groups and governments.

With these constraints on the successful deployment of voice and exit options, neither route offers political actors mechanisms which are guaranteed capable of redressing the falling quality of outcomes of policy networks. Such constraints lead politicians to manage networks through the paths of network restructuring. These paths lie in between voice and exit. Unlike voice or game management strategies, they do not accept the structure of the network as given. Instead, network restructuring techniques seek to influence the distribution of resources, rules of the game and the norms, values and perceptions within the network in favour of government objectives.<sup>149</sup> Unlike exit, they do not provide for government to disengage from the provision of services, nor do they try and internalise policy-making in the core executive or central government. The two key reshaping choices are between expansion or consolidation. Consolidation reduces the number of actors in the network and closes the boundaries of the network to external actors. Expansion involves either the introduction of new groups, or the opening of barriers to other policy sub-systems, in order to dilute opposition to policies or to create

new coalitional possibilities and dynamics.

When placed alongside exit and voice, expansion and consolidation provide a framework within which to discuss how politicians can (try to) reconfigure policy networks. Seven network restructuring paths are open to politicians when policy networks enter into crisis (see Figure 1.1), all of them top-down strategies. First, they can expand the membership of the policy network, perhaps by pushing a policy community into something more like an issue network. Second, politicians can reduce the membership of the policy network, moving towards a policy community set-up by privileging one dominant group. Third, politicians can seek to alter the balance between competing advocacy coalitions, where they are present. Fourth, governments can enter into corporatist arrangements with key actors in the policy network, creating a two-tier policy network with a core of key actors and a periphery of weaker actors.<sup>150</sup> Fifth, politicians dissatisfied with a quality decline can develop a rival policy network to invade the areas of competence devolved previously to the policy community in question. Sixth, politicians can maintain the structure of an existing network, but progressively introduce top-down controls to increase 'stress' in the system, or remove certain aspects of the existing network's responsibilities. Finally, politicians can introduce new institutional mechanisms such as quasi-markets to guide implementation structures and decision-making process. Following any of these paths will redistribute resources between interest groups and facilitate new entrants or exclusions from the decision-making policy process. They will also encourage bottom-up changes within professional organisations in response.

Recognising that these paths give politicians an active role in designing policy subsystems, does not necessarily mean that they can force through controversial policies. Faced with long-term decline in outcomes' quality, politicians will often move from path to path as they seek to redress their problems. Policy innovation will often be a process of experimentation, of trial and error, as politicians interpret policy feedback and respond to past choices.<sup>151</sup> Equally, top politicians' interventions will stimulate new strategies by individual groups which rebound on the original top-down strategies.



**Figure 1.1: Politicians and Top-Down Strategies of Network Restructuring**

T O W A R D S	Consolidate Network Strategy	Reduce network membership		Impose top-down controls	T O W A R D S
			Move to two-tier networks		
V O I C E		Rebalance coalitions		Introduce Quasi- Markets	E X I T
	Expand Network Strategy	Expand Networks	Boost Rival Networks		
Continued involvement in network		Disengagement from network			

Summarizing this discussion, I argue first, that politicians will intervene actively in the management of policy networks, and that their interventions will be pivotal in any understanding of policy network change. Second, change is most likely to take place when there is a crisis within the policy network produced by declining quality of outcomes, or a dislocation in the existing structures of policy networks. Third, when politicians intervene, they will characteristically do so using a series of short-term moves from one of seven options, often with a trial and error approach. Fourth, politicians' actions are always constrained in some way. Long-term policy developments will take place as top-down strategies impact upon individual group strategies, but will often depend on effecting changes in the relevant interest group universe. Which of the paths outlined here are followed by top politicians in government will depend upon a number of variables, not least the institutional structure of the policy subsystem in discussion.

### 1.3 THE ORGANISATION OF THE THESIS

This study focuses upon the emergence of hospital directors as a new and influential actor in French health policy debates. The first half of the analysis adopts an individual-group perspective. It begins with a detailed analysis of the bottom-up changes inside the *corps* of hospital directors and its major trade union, the SNCH. Chapter Two begins this approach by outlining the organisational map of policy-making in French hospital management, specifying the relevant policy network and its cleavages and potential alliances. Chapter Three analyses the anatomy of the hospital director *corps*, its integration and expansion within the national school of public health, the *École Nationale de la Santé Publique* (ENSP). It also looks at the entry of ENSP graduates into the SNCH. Chapter Four analyses the collective mobilisation and professional development of hospital directors within the SNCH.

The second half of the study examines the process of hospital management reform in the 1980s, and the involvement of hospital directors in successive policy initiatives. It looks in particular at how hospital directors within SNCH sought to influence decision-making as government reconfigured the health policy sub-system. Chapter Five analyses the positions adopted by the SNCH leadership on the reform of hospital financing, looking at the introduction of the global budget. Chapter Six examines the hospital directors' evolving positions on the push for internal organisational reform in public hospitals, with the failed attempt to introduce medical departments. Finally, Chapter Seven examines how hospital directors lined up on the issue of planning and macro-control of public hospital development, focusing on the 1991 Hospital Law.

The case studies cover both distinct functional tasks and a timescale of more than ten years, allowing full analysis of the policy network's complex dynamics. The trials of the global budget accompanied initial moves towards cost containment in 1976. The introduction of global budgets in 1983 ran parallel to the push for departments which went hand in hand with financial reform and the changing statute of hospital doctors. The reorganisation of hospital wards into departments was reversed in 1987. The issue of internal organisational reform declined in salience, and became overshadowed by that of hospital planning with the formulation of the 1991 Hospital Law. The development of

diagnosis-related groups by the Health Ministry, the *Programme de Médicalisation des Systèmes d'Information* (PMSI), took place throughout the period of the case studies (see above). However, its formal introduction was only concluded in 1996 and its development was more or less confined to the Health Ministry and selected trials through the 1980s.

The conclusion of the thesis returns to the framework for analysing health policy change developed above. It examines how the progressive professionalisation of hospital directors, and the active management of health policy networks by top politicians, worked in tandem with each other to produce a complex but undeniably important process of change in French health policy-making.

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**PART I**

**A NEW ACTOR IN HEALTH POLICY DEBATES**

## CHAPTER TWO

### THE ORGANISATION OF PUBLIC HOSPITALS IN FRANCE

The compromise between the French state and the medical profession which provided the foundations for the expansion of the public health care system was pieced together over more than 25 years. Legislation in 1941 and 1943 provided a framework for the internal organisation of public hospitals which was subsequently cemented by the 1958 Debré ordinances. They paved the way for the full-time entry of hospital doctors into regional teaching hospitals.<sup>1</sup> This negotiated compromise blurred responsibility for the management of the health care system between the French state, the Social Security funds and the medical profession.<sup>2</sup> The 'strong' French state thus emerged somewhat weakened from its negotiated settlement with the hospital doctors.

This chapter begins by examining the system of managing the public hospital service which developed from this pact, and the second section analyses the administrative hierarchy of national government ministries. The third section looks at how public hospitals are organised as professional bureaucracies. The final section focuses on the *corps* of hospital directors, and how they fit into the hospital management policy sub-system as a whole.

#### 2.1 THE OVERALL PATTERN OF HOSPITAL SERVICES

The French health care service is based on a national health insurance scheme whose key elements are health sickness funds, financed primarily by employee-employer payroll contributions, which partially reimburse the medical costs incurred by patients.<sup>3</sup> The founding decisions to set up the service were permeated by the organisational principles of 'liberal' medicine which enshrined the right of the patient to choose her doctor, privileged direct fee-for-service payment of doctors, and allowed for the free negotiation of fees between doctors and patients.<sup>4</sup> Over time, the foundations of these organisational principles were eroded by the state's increasing intervention in running the health care

service. However, the fee-for-service insurance foundations of the French health care service placed it in marked contrast to Britain's nationalised NHS providing services free-at-the-point-of-delivery and funded by central taxation.<sup>5</sup>

With the expansion of the Social Security funds and the concurrent institution of third-party financing in October 1945, the general social insurance scheme (the *Régime général*) progressively extended its coverage to workers in business and industry.<sup>6</sup> However, initial plans for a single social insurance scheme for all workers floundered when pre-existing occupation-based schemes (such as those for the self-employed and farmers) refused to integrate into a single general scheme. The 1967 Social Security reforms then split the general social insurance scheme into three separate branches: health, pensions and family allowances.<sup>7</sup> This division gave birth to the health sickness fund, the *Caisse nationale de l'assurance maladie des travailleurs salariés* (CNAMTS). Approximately 80 percent of the population is covered by this one health sickness fund, the CNAMTS.<sup>8</sup> Yet, despite the predominance of the CNAMTS, over 30 insurance schemes continue to provide health care insurance under the auspices of the Social Security funds.<sup>9</sup>

The October 1945 ordinances enshrined the principle of management by the insured in the system of French social insurance, delegating the regulation of the health sickness funds to representatives of trade union and business federations. Indeed, the 1967 reforms made the governing bodies of the funds responsible for balancing the budgets of their respective branches, endowing the funds with the formal capacity to fix the level of health sickness contributions. However, the trade union and business representatives on the national administrative council of the CNAMTS never exploited its formal managerial controls over public hospital spending. Nor did they manage the use or level of resources at its disposal through setting contributions or the rates paid to doctors.<sup>10</sup> These rights remained the prerogatives of government as it usurped the functions of the CNAMTS in a 'Yalta' of the health care system which saw government gain control over public hospitals and the CNAMTS take control of private clinics and ambulatory care.<sup>11</sup> Public hospitals were managed at the departmental level by the departmental health boards, while private clinics were managed at regional level by the regional offices of the health sickness funds. The French state, more attuned to a Beveridge model of welfare delivery, competed

with the Bismarckian social insurance of the Social Security funds, with the CNAMTS acting more as a 'relay' for the initiatives of the state.<sup>12</sup>

The absence of the third party financier from the system (that is, the health sickness funds) was matched by open-ended financing, embodied in a clinical task-oriented system of public hospital payment. The *prix de journée*, a standard patient-day rate for the various medical specialisms within hospitals, did not allocate a finite sum of resources to public hospitals. Instead, it determined a unit of payment to balance the hospital budget, calculated as it was through the retrospective division of the total amount of spending for the previous year by the number of days spent by patients in the hospital.<sup>13</sup> Deficits at the end of the financial year were simply carried over into the following year and perpetuated in the budgetary process, although hospitals could alter the patient-day rate and gain supplementary budgets in the course of the financial year.<sup>14</sup> This arrangement was an inflationary mechanism: the more days spent by the patient in hospital, the larger the hospital's income:

'You even saw documents, very clumsy memos from certain hospital directors telling the doctors that: "Given the budgetary difficulties of the hospital, you are invited to keep patients longer than necessary. Signed the director".'<sup>15</sup>

In any case, any reduction in the number of patient bed days over the course of the financial year penalised hospitals rather than rewarding them for increased efficiency. However, this capacity to massage the length of patient stays devolved control over financial aggregates to the hospitals themselves. Its inclusive nature even allowed the cross-subsidisation of medical costs by hotel costs.

In fact, there were no developed mechanisms for resource allocation or top-down control of hospital development. The 1970 Hospital Law introduced the Health Map, dividing France into 284 health sectors and setting national quotas for the maximum provision of hospital services in each sector. However, in practice, it operated more as a means of identifying deficiencies in the provision of hospital services than as a means of redistributing existing hospital services from one area to another.<sup>16</sup> The Ministry of Health lacked adequate information on local needs and operational policy tools to enforce any system of quotas. The number of hospital beds in the public sector actually increased by over 61,000 between 1972 and 1978.<sup>17</sup>

Equally, general practitioners and specialists in the ambulatory care sector or

departmental health boards did not act as gatekeepers for hospital care. The purchasing function remained firmly in the hands of the individual patient who exercised the right to freely choose not only her doctor, but also her hospital or private clinic. Such consumer sovereignty meant that patients could literally shop around for the best care available in either the public or private sector. The health sickness funds picked up the bill for treatment. Private medical insurance was held by one-third of the population in 1960, but this proportion rose to over two-thirds of individuals by 1980, and 80 percent at the end of the 1980s, and obligingly covered any shortfalls in public provision.<sup>18</sup> Such ‘voting with your feet’ was dependent on a conjunction of factors, not least the necessary time, motivation and ability to gather information before entering hospital. Yet, hospitals which ignored the demands or perceived demands of clients did so at the risk of losing patients.<sup>19</sup>

This consumer sovereignty provided the foundations of a competitive market between public hospitals and private clinics. However, it was an imperfect market with both inequalities within the public sector and, limited competition between hospitals and private clinics in certain sectors and specialisms. First, the French public hospital service counts in its ranks a diversity of institutions from local hospitals to the regional teaching hospitals (see Table 2.1). However, it is bisected by the cleavage separating the 29 regional hospitals<sup>20</sup> from general hospitals: ‘the French health care system could be considered to be a galaxy whose central point is the regional teaching hospital.’<sup>21</sup> These regional teaching hospitals were the product of the 1958 Debré ordinances which merged regional and teaching hospitals with medical schools to establish *Centres Hospitalo-Universitaires* (CHU). They spearheaded public hospital development, combining the roles of teaching and research with their status as designated centres for technically-advanced medicine. In 1987, these 29 hospitals accounted for approximately 40 percent of public hospital spending, or 26 percent of all public and private hospital spending (against 30 percent of public-private spending for all other public hospitals).<sup>22</sup> Three hospital groups, the *Hospices civils de Lyon* (HCL), the *Assistance publique de Marseille* (APM) and the *Assistance publique-Hôpitaux de Paris* (AP-HP) sat at the summit of the public hospital service. The AP-HP alone accounted for over ten percent of hospital beds in France and 12.5 percent of public hospital spending.<sup>23</sup>



**Table 2.1: The French Public Hospital Service<sup>24</sup>**

<b>PUBLIC HOSPITALS</b>			
<i>Type</i>	<i>No</i>	<i>Beds</i>	<i>Average Beds</i>
Regional Hospitals	29	105,490	3,640
General Hospitals and Hospitals	493	241,230	489
Local Hospitals	316	50,050	158
Medium and Long-Stay Centres	123	22,240	181
Specialised Psychiatric Hospitals	99	65,500	661
Others	9	830	92
<b>TOTAL</b>	<b>1069</b>	<b>485,340</b>	<b>454</b>

Second, in the private sector, private-for-profit clinics compete alongside non-profit-making institutions and clinics participating ‘within’ the public sector, providing in total 204, 900 hospital beds or approximately one-third of all beds in France (35 percent of spending on hospital care).<sup>25</sup> However, only ten to fifteen private clinics compete on equal terms with regional hospitals. The average multidisciplinary clinic has approximately only 150 to 180 beds. Chains of private clinics such as *Alphamed* and *Médifutur* did not emerge until the 1980s, but, even then, the 64 clinics within these chains accounted for only 5,800 beds.<sup>26</sup> Yet, the specialisation of private clinics means that they compete on equal terms with public hospitals in certain sectors and specialisms. For example, approximately 25 percent of treatment in private-for-profit clinics is day-surgery, compared to only 2.5 percent in public hospitals (mostly in the psychiatric sector).<sup>27</sup> In the general specialism of surgery, and the general category of medium-stay beds, private clinics have more beds than public hospitals.<sup>28</sup> Similarly, private clinics are virtually absent from the long-stay sector, but account for approximately half of births and surgery.<sup>29</sup>

So what emerged from the state-profession compromise in France was a market for health care services characterised by an established private sector, and marked by its singular absence of gatekeepers and fragmented lines of responsibility.<sup>30</sup> The consumer sovereignty inherent in the market, coupled with established private clinics and medical

insurance, produced a 'safety exit' for clients if governments sought to close off hospital spending. Bolstered by the open-ended patient-day rate, which reinforced a medical task-oriented model of service delivery, a 'hospital management cold war'<sup>31</sup> developed between the state and health sickness funds, 'two worlds which bait[ed] each other all the time.'<sup>32</sup> This pattern produced irresponsible management, with contributions to the health sickness funds set to meet deficits rather than to place any overall constraints on spending<sup>33</sup>: 'as if the funds were put in a bag which you kept dipping into as long as there's money in it.'<sup>34</sup>

## 2.2 NATIONAL GOVERNMENT MINISTRIES

The Health Ministry was originally a junior ministry within the established hierarchy of the French central administration. Successive governments integrated Health into the framework of a wider ministry of Social Affairs, combining the dossier with that of managing the social security funds. This lack of autonomy sprang from the fact that Health had not been annexed by one of the elite administrative *grands corps*, and consequently lacked an institutionalised lobby to defend its administrative territory. One civil service *corps* captured the health and social affairs sectors, the *Inspection Générale des Affaires Sociales* (IGAS). Auditors of social policies and institutions, they did not defend the interests of the sector, export ideas or promote dossiers in the manner of a *grands corps* such as the *Inspecteurs des Finances*.<sup>35</sup> So Health remained

'a quite weak ministry from the point of view of its human potential, its competence. There are relatively few people, few in regulatory roles and qualitatively quite weak. It is not a ministry which is very highly rated when leaving ENA [National School of Administration]. People don't make their careers here for long, the best leave.'<sup>36</sup>

In 1986, for example, the low bonus schemes and lack of career 'outlets' attracted only five candidates for the 13 posts in health and social affairs offered to graduates from the national civil service school, the *École Nationale d'Administration* (ENA).<sup>37</sup> However, this absence of a *grands corps* in health cannot be divorced from the fact that regulation of the sector was effectively devolved to the medical profession. The legitimate *grands corps* was outside the Ministry.

Three central administrative divisions dealt directly with health care dossiers: the *Direction de la Pharmacie et du Médicament* (DPM), the *Direction Générale de la Santé*

(DGS), and the *Direction des Hôpitaux* (DH). The Barre government merged the DGS and the DH in 1979, but this experiment lasted for only 18 months and was ended by the Mauroy government in 1981. The DH, the largest of the three administrative divisions, controlled all hospital management dossiers, except for the education and training of hospital doctors which it co-managed with the Education Ministry. Approximately 250 staff worked in its 27 offices, the largest of which were the offices of construction-equipment and personnel.<sup>38</sup> Its treatment of hospital dossiers rarely brought it into contact with the DPM, but it had more contact with the DGS which monopolised public health dossiers and all that was not hospital management. These contacts revolved around the dossiers of new technologies, psychiatry, and care of the elderly. Conflicts, if any, emerged because of the DH support for hospital care and the DGS support for public health-orientated policies. Finally, the care of the elderly, and that of the disabled, involved the *Direction de l'Action Sociale* (DAS), one of the administrative divisions within the Social Affairs Ministry. Relations between the DH and the DAS were rarely conflictual.<sup>39</sup>

Partly due to its weak status, the Health Ministry faced difficulties in promoting its dossiers at interministerial level and was unable to prevent the intervention of external ministries in the regulation of its dossiers.<sup>40</sup> For instance, over six other ministries, including the ministries of the Interior, the Civil Service, Education and Finance, participated in interministerial discussions at Matignon during the formulation of the 1991 Hospital Law (see Chapter Seven). The leading participants from outside the ministry were the 'accountants', the *Direction du Budget* (DB) in the Finance Ministry and the *Direction de la Sécurité Sociale* (DSS) in the Social Affairs Ministry. The DSS exercised administrative 'control' over the Social Security funds, although the Finance Ministry exercised greater control over dealings between the funds and government. From its creation in 1945, the DSS was marked by a legal administrative practice which meant that it was preoccupied with the definition of the right of the insured and duties of the funds. This administrative tradition meant that 'lawyers' from the Council of State headed the DSS. However, under the Barre government (1976-1981), the DSS developed a predominantly financial orientation, concerned with the need to balance the accounts of the Social Security funds. This evolution was marked by the nomination at the head of the DSS of budgetary and financial administrators from the *Cour des Comptes*, the court of

accounts. It brought the DSS into conflict with the division of hospitals, the DH, as hospital spending accounts for approximately half of the spending undertaken by the Social Security funds.

Together with the *Direction de Prévision* (DP), the *Direction de Budget* (DB) shared the broad public spending orientation of the DSS, and represented the primary interministerial adversary for the DH. In many ways, the DSS and the DB operated in tandem, as the DSS pre-empted the positions of the DB from within the narrow circle of health and social administrative divisions. The DB was omnipresent, with the DH obliged to seek its approval on all dossiers even those without direct budgetary implications.<sup>41</sup> Since the ministries of Health and Social Affairs had no 'home' *grands corps*, their inability to fend off external interventions enabled the DB to invade health policy issue areas:

'It (the DB) is more powerful in terms of quality than the social administration and well, that introduces [...] a certain imbalance in the way of dealing with problems.'<sup>42</sup>

However, the DB could cloak its interventions in health policy-making, if necessary, in two legitimate concerns. First, it conducted direct budgetary negotiations with the Paris hospitals' organization, the *Assistance Publique*, because of its distinct management structures. Although these talks provided the Finance Ministry with a Parisian-influenced view of the problems of hospital management (see Chapter Seven). Second, the DB straddled both the national and local levels of public hospitals, for it had under its hierarchical control the *corps* of *comptables*, public accountants who managed the funds of public institutions (see below). This civil service *corps* existed as a result of the traditional separation within French public services between those who decided the objectives of expenditure (in this case, hospital directors) and those who authorised it (in this case, *comptables*).

The weakness of the health ministry was mirrored at the local level by its external services. The *Directions Départementales des Affaires Sanitaires et Sociales* (DDASS), the external services of the Health Ministry at the level of the French departments, exercised a wide-ranging administrative control over public hospitals in each area. These Departmental Boards of Health and Social Affairs were created in 1964 by the merger of the Boards of Population, Health, Social Assistance and Tarification. They formally set

the budgets of public hospitals and supervised the financial management and policy decisions of public hospitals. They were complemented, at the regional level, by the *Directions Régionales des Affaires Sanitaires et Sociales* (DRASS) which were created in 1977 from the merger of the regional boards of social affairs with the regional boards of social security (the government bodies supervising the management of the funds). They operated as centres of policy analysis and forecasting concerned with planning and statistical or epidemiological studies.<sup>43</sup>

Although both were external services of the Health Ministry, the regional DRASS had no hierarchical authority over the departmental DDASS. The two boards were formally headed, not by an official directly responsible to the Health Ministry or the DH, but by the departmental Prefect in the case of the DDASS and the regional Prefect in the case of the DRASS. Prefects owed their allegiance to the Interior Ministry, although they were only nominal heads of local health boards. However, despite their distinct roles, there was a nascent conflict between the two health boards, locked in a dispute over their respective attributions and functions. The Rocard government's MIMOSAS<sup>44</sup> project, involving the management consultants, *Arthur Andersen*, sought to decide the optimal division of labour between the DDASS and the DRASS. Later on, a September 1991 government decree instituted trials of the transfer of the function of administrative control of public hospitals to regional health boards (in Auvergne, Haute-Normandie and the Midi-Pyrénées).

In fact, the 1983 decentralisation reforms transferred approximately three-quarters of the personnel and the social policy responsibilities of the departmental health boards, the DDASS, to the elected assembly of the department, the *Conseil Général*. Given the obligations of cost containment, public hospitals remained within the auspices of the DDASS. However, the stripping of their attributions cannot be divorced from:

‘reasons relating certainly in part to their institutional weakness. In fact, their political weight was absolutely not comparable to that of the departmental divisions of equipment, agriculture and indeed, education.’<sup>45</sup>

Indeed, the DDASS were relatively under-staffed with as few as three inspectors in one DDASS to cover 112 institutions.<sup>46</sup> This under-staffing and the accompanying lack of resources meant that the DDASS did not lead a voluntarist hospital policy at the departmental level. Most DDASS units formally applied the directives from the DH, whilst

granting common budgetary increases to all public hospitals.

Equally, the external services of the Health Ministry were locked in a 'phoney war' with the local offices of the health sickness funds (see above).<sup>47</sup> The CNAMTS was far from a monolithic structure, composed as it was of one national, 16 regional and 129 primary offices. Regional offices exercised no authority over primary offices. Whilst they dealt with negotiations with private sector hospitals and scrutinised the budget of public hospitals, the primary offices were in daily contact with public hospitals because they assumed the practical role of transferring budgets to public hospitals. Regional directors were consequently engaged in territorial battles with the directors of the primary offices.<sup>48</sup> In addition, three aggregate groups of policy actors operated throughout the various structures of the funds: the trade union and business representatives who sat on the Administrative Boards of each office; the bureaucrats or officials who administered the funds; and the *médecins-contrôleurs*, doctors who provided an 'in-house' medical expertise.

The health insurance funds were formally managed by the administrative boards; the principle of management by the insured being embodied in the 1945 legislation (see above). Following the 1967 social security reforms, the administrative boards came under the influence of an alliance between the anti-communist trade union federation *Force Ouvrière* (FO) and the French business federation, the *Confédération Nationale du Patronat Français* (CNPFF). This alliance was forged after the 1967 reforms introduced parity of representation for unions and business on the administrative boards, replacing the election of union representatives with a system of government-determined quotas which artificially reduced the weight of the previously dominant communist *Confédération Générale du Travail* (CGT). However, the alliance later survived the return to elections and the ending of parity of representation in 1983 under the Socialist government. Indeed, in alliance with the CNPFF, FO held the presidency of the national administrative board of the CNAMTS from 1967. In addition, it took the presidency of nine of the 16 regional offices and 79 of the 129 primary offices.<sup>49</sup>

However, over time, the administrative directors of the CNAMTS gained their own formal management attributions in conflict with the initial principle of management by the insured. As early as May 1960, responsibility for the daily management of the funds

began to be transferred, as directors took control of personnel management issues.<sup>50</sup> Trade union and business delegates thus found their responsibilities ‘hollowed out’ from within the CNAMTS by the rise of administrative directors, and from outside the CNAMTS by the state intervention in the management of the health sickness funds. This dual erosion of its role reduced ‘the council of administration to a simple registration room for acts and debates of limited scope.’<sup>51</sup> The CNAMTS bureaucracy was headed at the national level by a director appointed by the government. Directors of the regional and primary offices were appointed by the relevant administrative boards, but they had to be chosen from a national register established by the Social Affairs Ministry. Roughly 80 percent of directors on this register have passed through the national centre for advanced studies in social security, the *Centre National d'Études Supérieures de Sécurité Sociale* (CNESS) - although, given the nature of the nomination process, membership of FO was also considered to be an advantage.<sup>52</sup>

Working alongside the CNAMTS bureaucracy and the administrative boards were approximately 2,500 *médecins-contrôleurs*. These ‘in-house’ doctors were the counterparts of the *médecins inspecteurs de la santé*, the public health officials who worked for the DRASS and DDASS. However, whilst the *médecins-inspecteurs* were typically concerned with co-ordinating public health programmes or promoting measures to improve hospital hygiene, the *médecins-contrôleurs* were preoccupied with the budgetary implications of hospital treatment. Their role evolved from individual examinations of selected patients dossiers (in order to ascertain the legitimacy of claims to reimbursement) to the analysis of the actual treatment decisions taken by hospital doctors. In 1984, they gained the right to examine the running of medical services within public hospitals, implementing a series of *coupes transversales*, statistical photographs of the treatment within a hospital ward on a given day. However, the *médecins-contrôleurs* did not impose corrective measures on hospital doctors. They subordinated such interventions to the ultimate aim of expanding the function and professional status of the profession.<sup>53</sup> Since 1967, they have organised in their own formal hierarchy parallel to that of regional and primary offices, and pursued their own professional strategy divorced from other policy actors both within and outside the CNAMTS: ‘the gang from the CNAM[TS].... they don't leave the health sickness funds, it's a regiment.’<sup>54</sup>

Thus, health policy administration in France was fragmented and weak with limited resources and personnel in its external services (in marked contrast to the 'strong state' conception of French policy-making). With the Health Ministry ranking low in the hierarchy of central ministries, the DH was unable to insulate its dossiers from the interventions of other ministries and in particular, the DB. Its weak external services were unable to pursue an interventionist managerial policy in their dealings with public hospitals. Indeed, the DH did not possess the necessary information to calculate the actual delivery costs of hospital services. Despite progressive controls on bureaucracy of the CNAMTS, the health sickness funds retained control over its internal management and the development of its own statistical and analytical services - limiting the role of the DSS which was squeezed between the CNAMTS and the predominance of the DB. However, even the health sickness funds, fragmented and shorn of their responsibilities in public hospital management, provided information on the evolution of costs which was always months behind and based not on actual costs, but on the reimbursement of patient treatment.<sup>55</sup> Such weakness emanated in part from the absence of a *grand corps* which defended its territory and prerogatives within central government. In health, the effective equivalent of the *grands corps* was external to the administration. Hospital doctors were entrenched in the operating core of public hospitals.

### **2.3 PUBLIC HOSPITALS AS PROFESSIONAL BUREAUCRACIES**

Combining the social justice of reactionary catholicism with the corporatism of fascism, the Vichy government established the principle of a national public hospital service open to all and laid down a framework for the internal organisation of public hospitals.<sup>56</sup> However, it was another twenty years before the implementation of the 1958 Debré ordinances generalised full-time salaried status for hospital doctors within the newly merged regional and teaching hospitals. This section analyses the organisational structure of French public hospitals which emerged from the compromise between the state and the medical profession,<sup>57</sup> employing the Mintzberg typology of organisations in which public hospitals are categorized as 'professional bureaucracies'.

Mintzberg isolates five components common to all organisations (see Figure 2.1).<sup>58</sup>



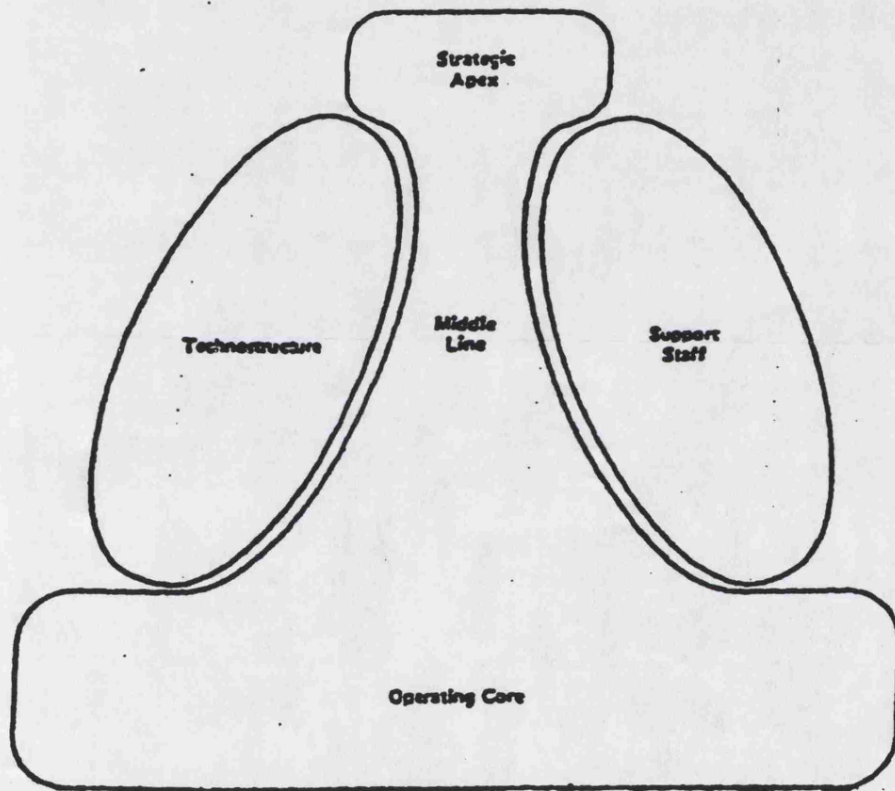
At their base sits the operating core which performs operational tasks needed to produce goods and services. It is connected by the middle-line hierarchy which represents the chain of middle-line managers stretching up to the strategic apex. The strategic apex determines how the organisation serves its mission and, in the public sector, ensures that it meets the needs of its external funders or controllers. The technostructure consists of many different kinds of control analysts who work towards the standardisation of tasks, improvement of technologies or containment of costs. Finally, the support staff provide discrete sets of services ancillary to the organisation's central purpose - such as the canteen, the laundry or public relations units in the case of hospitals.

Mintzberg classifies public hospitals as professional bureaucracies because their organisational arrangements typically place a high value on professional expertise. Control of the delivery of services is extensively devolved to key members of the operating core - in this case, the medical profession. Co-ordination derives from the training and professional norms adhered to by professionals and produced outside the organisation by self-governing professional associations and networks. Within professional bureaucracies, the technostructure and middle-line management play relatively minor roles, and even the strategic apex will often be very small. Alongside the operating core, the most developed part of professional bureaucracies are the support staffs, but they are very tightly managed and subordinated to the dominant professional group's priorities.

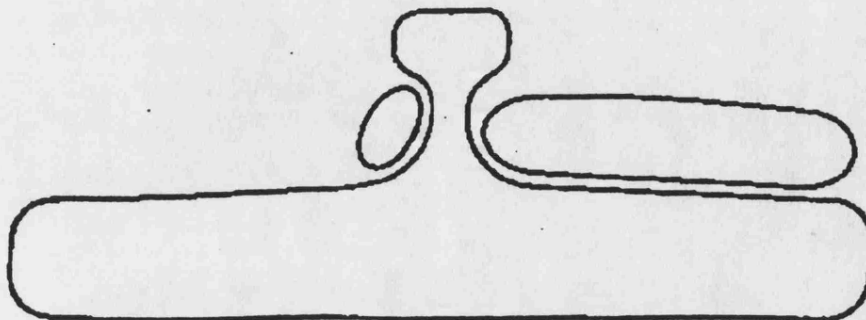
In French public hospitals, the dominance of the operating core was enshrined in the 1941 legislation and its accompanying 1943 decrees. This legislation installed *services* as the fundamental unit of medical organisation within public hospitals. Each service was the approximate equivalent of a hospital ward in the NHS. It centred on a medical specialism and was managed by a head doctor, a *chef de service*, who was appointed for life, and assumed full-responsibility for the delivery of medical care. Junior doctors, medical assistants and nursing staff worked under the supervision of head doctors for any tasks involved in the administering of treatment to patients. Indeed, in the spirit of professional bureaucracy, junior doctors were informally co-opted onto medical teams by senior doctors. Thus, the state recognised the collective autonomy of the medical profession, with *chefs de service* benefiting from: 'all the independence necessary for the exercising of his art, notably in the choice and execution of treatments and, more

generally, for all that which concerns medical acts.<sup>59</sup> With the boundaries of clinical freedom thus drawn, *chefs de service* were free from managerial supervision to decide resource allocation, the nature of service delivery and technical development. The right to treat private patients, enshrined in the 1958 settlement, ensured that doctors could determine their own mix of work.<sup>60</sup>

**Figure 2.1: The Professional Bureaucracy**



**The Five Components of Organisations**



**The Professional Bureaucracy**

Notes: H. Mintzberg, (1983), Structures in Fives: Designing Effective Organisations, Eaglewood Cliffs, NJ: Prentice-Hall, Fig 1-2, Fig 10-1

Inside hospitals, there was little in the way of a developed middle-line of professional administrators. The hospital medical commission, the *commission médicale consultative*, renamed the *commission médicale de l'établissement* in 1987, provided, in principle, an arena for consultation between hospital doctors on the distribution of resources and the medical policy pursued within the hospital. However, its composition was unrepresentative and reinforced the professional hierarchy by allocating the majority of seats to head doctors. In practice, hospital medical commissions operated more as a rubber-stamp for choices taken in more informal discussions and limited themselves to questions of promotion.<sup>61</sup> Chairs of the commissions avoided systematic intervention in the daily running of wards, acting more as an occasional 'troubleshooter' dealing with problems surrounding, for example, new projects or the boundaries between existing services. In fact, public hospitals operated as a collection of autonomous fiefdoms, each developing their own parallel structures:

'hospital activity appears then more like the juxtaposition of the activities of decision-making centres only having in common the use of certain resources than a co-ordinated and coherent [response] to the objective needs of health care.'<sup>62</sup>

Eleven different working schedules were identified in one service in a Strasbourg hospital in 1982. The same enquiry claimed that the management at Lille regional hospital did not know either the distribution of personnel throughout the institution or the level of absenteeism.<sup>63</sup> Such fragmentation was accentuated by the moves to create more services as a means of overcoming the promotion bottleneck that life-long appointments of head doctors created.<sup>64</sup>

The absence of a tradition of medical information programmes squashed the development of a technostructure within public hospitals. Hospital doctors kept their own records using their own classifications.<sup>65</sup> It was not until the 1980s that younger doctors, particularly in high-spending specialities, espoused a pro-managerial discourse, increasingly following management training and economics of health care programmes. The hospital training organisation, AFMHA<sup>66</sup>, organised 64 management training courses for 2600 hospital doctors in 1991 - an increase from a few hundred doctors in 1987.<sup>67</sup> However, these fragmented initiatives did not signal the emergence of a medical 'technostructure'. A grassroots coalition of doctors united around a pro-managerial

discourse did not emerge within public hospitals, despite moves towards the implementation of diagnosis-related-groups and medical information departments in the 1980s (see Chapter Five). One nascent grouping was the head doctors of the *Département d'Information Médicale* (DIM), hospital departments aiming to collect and analyse information on health care and patient treatment within hospitals, who became prominent after an August 1989 circular foreseeing their creation. But, by the early 1990s, they had failed to overcome their collective action difficulties, remaining an ineffectual national lobby. Indeed, although over 90 percent of hospitals created or planned to create DIMs, their effectiveness was curtailed by the lack of computerisation of medical services (averaging only 25 percent of hospitals).<sup>68</sup>

The strategic apex which progressively emerged was that of a tandem composed of the mayor and hospital director. Mayors were the chairs of the *conseils d'administration*, the Board of Trustees of public hospitals, which remained legally attached to local government. Hospital directors were the civil servants, formally appointed by the Minister of Health, who sat at the head of the administrative hierarchy within public hospitals. The relationship between the two was an uneasy alliance or cohabitation. The development of hospital directors as a *corps* of French civil servants was at the expense of the Board of Trustees which gradually lost its responsibility for general management of public hospitals to the newly-recognised hospital directors. The *corps* came into formal existence with the legislation of 1941 and 1943 which recognised the posts of hospital directors and endowed them with a formal job description.<sup>69</sup> Hospital directors in hospitals with over 200 beds received their own formal attributions (such as appointing non-medical staff), but the *corps* remained administrative secretaries and bursars dominated by the Mayor:

‘the corps of hospital directors was in fact only a strict executive of collegiate decisions. It was the equivalent today of Mayors' general secretaries who are the implementors for the deliberative power which is the municipal council.’<sup>70</sup>

The 1958 Debré ordinances subsequently transferred the formal nomination of hospital directors from the local Prefect to the Minister of Health.<sup>71</sup> In addition, directors in hospitals with over 200 beds were made responsible for signing external contracts and further empowered to ratify spending, albeit on the basis of a budget established by the Board of Trustees. However, it was the 1970 Hospital Law which transferred

responsibility for general management of hospitals to the directors, who obtained the legal foundation for their own formal authority.<sup>72</sup> It attributed hospital directors with the right to regulate all issues outside the limits of a series of formal attributions, not least the voting of the budget, held by the Board of Trustees. So, although the Board maintained its series of formal attributions not least the voting of the budget, its influence in the running of hospitals declined:

‘What is the use of a Board of Trustees except to rubber-stamp it's true, all the documents that go before them. The budget?...It goes through, it goes through...’<sup>73</sup>

However, Mayors could not be divorced from the management of what is often the largest employer in a town; electoral considerations dictate intervention.<sup>74</sup> First, local politicians appropriated from the Social Security funds the role of defenders of the general interest. Clients were represented on the Board of Trustees by delegates of the Social Security funds and local politicians. Of these two groups of actors, it was local politicians, led by the Mayor, who most successfully exploited the opportunity to pose as defenders of the general interest. Social Security delegates were hampered by the sectional identity of trade unions and business organisations.<sup>75</sup> Second, the opinion of mayors was pivotal in the appointment of hospital directors (see Chapter Three). This role and their oft-quoted legitimacy and national stature ensured that a director was bound to her mayor in such a way that their future depended on gaining, and maintaining, the confidence of the Mayor. If there was a disagreement on hospital policy, it was the director who departed not the Mayor. The ‘sacking’ in 1991 of Christian Dutreil from the head of the *Hospices civils de Lyon* after disagreements with the Mayor, Michel Noir, over his plans for the renovation of the hospital group demonstrated the directors’ dependence on the continued confidence of their Mayors.<sup>76</sup> However, the ties between hospital directors and mayors are not necessarily interpreted as a constant constraint on the actions of the director. At times, the organisational ties with mayors are one of the primary resources at the disposal of hospital directors (see below).

Support staff (ranging from technicians through to cleaners, cooks, receptionists and administrative staff) composed the largest category of personnel within public hospitals, with non-medical personnel including administrative staff, accounting for 640,000 employees of the 740,000 employed in public hospital system in 1991. ‘Caring’

occupations formed the largest single category of these personnel (444, 000) with nurses accounting for over 140,000 posts (67 percent of the nursing occupation as a whole). The majority of nurses, approximately 85 percent of whom were women, were ward nurses rather than operating theatre nurses or the senior echelons of the profession.<sup>77</sup> Although defined, like directors, as support staff to the medical profession, they were firmly anchored within the operating core. Nurses were para-professional, not associated with the running of services, and doctors organised the delivery of care in line with their own professional requirements.<sup>78</sup> The 1991 Hospital Law was partly concerned with creating a nursing voice within public hospitals. The office of nursing care in public hospitals, the *service de soins infirmiers*, was the Rocard government's response to the previous exclusion from influence (see Chapter Seven).

French public hospitals thus conformed closely to Mintzberg's professional bureaucracy type, with a predominant professional operating core, an embryonic middle-line, and a strategic apex headed by mayors keen to protect their electoral interests. Management and medical hierarchies developed as two parallel arenas which avoided excursions beyond the narrow confines of their respective boundaries of influence.<sup>79</sup> Hospital directors functioned more as support staff minimising the difficulties of professionals rather than challenging the boundaries of clinical autonomy of head doctors.<sup>80</sup> Hospitals functioned as fragmented collection of medical fiefdoms.

## **2.4 INTEREST GROUPS, PROFESSIONAL ASSOCIATIONS AND ALLIANCES**

This section examines the constellation of interest groups and professional associations which emerged within the health policy sub-system at a national level, focusing on the *corps* of hospital directors and their coalition strategies with other actors in the networks. Auxiliary staff are not considered, because their representative organisations exercised little influence within policy-making on hospital management, confining their actions to the narrow interests of pay and conditions.

The French medical profession is fragmented. At the end of the 1980s, there were 25,250 full-time public hospital doctors, to which must be added some 5,000 part-time doctors and more than 30,000 *attachés* (who mostly work less than five three-and-a-half

hour shifts per week).<sup>81</sup> The elite of the profession were the *mandarins*, the *hospitalo-universtaires* who combined the duties of university medical professors with those of head doctors in regional teaching hospitals. Their dual status marked them out from the *mono-appartenants* in regional hospitals who exercised only medical duties. However, the prestige attached to medical practice in regional hospitals divorced both *hospitalo-universitaires* and *mono-appartenants* from all doctors working in general hospitals. Cross-cutting these horizontal cleavages were the vertical cleavages of specialisms and 'administration' which isolated heads doctors and divided the profession into its multiple disciplinary sub-groups. Indeed, over time, increasing specialisation<sup>82</sup> and the different statutory conditions and responsibilities attributed to hospital doctors produced a loose collection of competing elites, marked by their 'deep divisions, not only political, but also between specialisms, between chapels, between clienteles; it's a bit tribal, it's a bit feudal.'<sup>83</sup>

There has long existed a mosaic of trade unions which defend the narrow interests associated with such different statutory or disciplinary sub-groups. Each grade or speciality had its own trade union, if not several, because political divisions and cleavages between doctors in general and regional hospitals often led to the creation of several trade unions within one discipline. By the early 1980s, over 50 hospital doctor trade unions were classified as 'active' lobbies at the national level.<sup>84</sup> Many of these unions were born as part of a defensive reaction to the hospital management reforms engaged by the Mauroy government in 1982. In fact, trade union membership among hospital doctors was low; estimated at only ten percent, once allowance was made for the fact that doctors often joined more than one trade union (one according to their discipline, another according to their grade or political persuasion).<sup>85</sup> Such low rates of mobilisation, coupled with the narrowness of their individual interest bases, meant that no individual trade union could legitimately claim to represent the interests of hospital doctors:

'all these people say that they are representative, but they represent very little.... They are big mouths, that's all. They represent 500 doctors in the best of cases... if that ...if that.'<sup>86</sup>

However, despite these conflicts of internal organisation and ideological divisions, by the

late 1980s, two umbrella organisations had emerged:

- the managerialist *Intersyndicat National des Médecins Hospitaliers* (INMH) which brought together 14 unions from regional and general hospitals, but whose members, not part of the medical elite, tended not to exercise the dual responsibilities of teaching and medical responsibilities ;
- and, the larger, looser and more reactionary *Coordination Syndicale des Médecins, Biologistes et Pharmaciens des Hôpitaux Publics*, which brought together 13 unions representing 70 percent of doctors elected to national commissions.<sup>87</sup>

Hospital doctor trade unions were not entrenched within the organisational structure of public hospitals. The collective voice of doctors within public hospitals was the hospital medical commission (see above). The chairs of the hospital medical commissions were grouped nationally in two consultative bodies, the *Conférences des Présidents des Commissions Médicales d'Établissement*, one for regional teaching hospitals and one for general hospitals. These two national consultative bodies were joined by a third, the *Conférence des Doyens* which groups together the deans of the medical faculties. These three consultative bodies, not the trade unions, provided an aggregate medical discourse for government, although, ever respectful of the hierarchy within the medical profession, the consultative body for general hospitals did not exercise the authority of its regional teaching hospital counterpart. Claiming to be divorced from the political struggles of their colleagues within trade unions, they acted as 'sounding boards', providing 'technical' advice for the government concerning hospital reforms and the difficulties faced by hospitals.<sup>88</sup> As Edmond Hervé, Junior Minister for Health in the Mauroy and Fabius governments between 1983 and 1986 explains:

'In the spring of 1984, we counted 60 trade unions representing hospital doctors, thus, fragmentation. This said, what I have just said must be corrected because [...] there are also very strong representative organisations and, in the case of the regional teaching hospitals, you have a power [...] which was called at the time, the *Conférence des Présidents de CMC*, today, the *Conférence des Présidents des CME* and that was a real power and the other was the *Conférence des Doyens*.'<sup>89</sup>

Indeed, these bodies progressively upstaged the *Ordre des Médecins*, the professional regulatory body which was founded under the Vichy government and of which all doctors are members. Its work concerns primarily ethical and disciplinary matters and it remains on the fringes of most policy debates, its authority contested within the ranks of the



medical profession.<sup>90</sup> However, like the trade unions, these national medical commissions were not structured so as to discipline rank-and-file hospital doctors or to participate in top-down management measures. They refused to act as global regulators of the public hospital system.<sup>91</sup> The hospital doctor elite used its influence to promote individual dossiers, such as ensuring that the 'right' candidate was appointed to posts in their wards and facilitating demands for medical equipment. At best, they acted as a negative anti-reform lobby for the medical profession.

However, to focus on the representative organisations of the *corps* of hospital doctors is to by-pass the influence of *mandarins*, who exploited the access to politicians created by common social and personal networks. It is not a banal statement to say that every politician has a personal doctor. Indeed, senior officials in the Health Ministry were convinced that the family doctor of Laurent Fabius, Prime minister (1984-1986), had an important influence on the policy decisions of the PS government at the time of the departmentalisation reform.<sup>92</sup>

'It's this world. They [politicians] get themselves treated by them, and that counts enormously - you can do nothing about it, but it's like that. First, they have them [doctors] in their family and then, they get treated by them.'<sup>93</sup>

Each *mandarin* had his or her contacts in ministerial divisions and political parties. Some even had direct access to the ministerial *cabinet*, the Prime minister's office at Matignon and that of the President at the Elysée.<sup>94</sup> The *corps* of hospital doctors was organised

'a little like the show business environment, that is to say that there are stars, stars who, because of their own notoriety, intervene directly not only to ministers, but also constantly to the Prime minister or the President of the Republic [...]. The well-known doctors intervene directly, short-circuit everybody and, then, it comes down like a torrent from above'.<sup>95</sup>

All political parties established formal ties with the medical profession and hospital personnel. Hospital doctors constituted a significant lobby within Parliament itself, with 41 doctors in the National Assembly and over 46 in the Senate in 1991.<sup>96</sup> Multiple channels existed between hospital doctors and the right-wing gaullist *Rassemblement pour La République* (RPR). Informal channels born of individual connections were supplemented by both RPR *missions-santé* (party associations in each department uniting doctors, nurses and dentists), and its *Action Ouvrière et Professionnel* (party sections, organised on the basis of occupation and profession).<sup>97</sup> Similarly, the *Parti*

*Socialiste* (PS) developed its own workplace party sections, *groupes d'entreprises*, within public hospitals, although these were strongest in Paris where they were dominated by nurses and care assistants.<sup>98</sup> The predominant health policy lobby within the PS before its arrival in office in 1981 was the 'external' *Santé et Socialisme* association, dominated by card-carrying hospital doctors.

However, the medical profession generally supported right-wing parties. No party had the ties with the medical profession enjoyed by the RPR: of the 50 doctors elected to the National Assembly in 1986, 22 were members of the RPR, over a third more than the various parties grouped together in the centre right giscardian *Union pour la Démocratie Française* (UDF), and almost three times the number in the PS. Indeed, the PS, more likely to be labelled the 'party of teachers', could only muster 8 of the 50 doctors in the National Assembly.<sup>99</sup> At elections in the 1980s, approximately 40 percent of doctors voted for the RPR, with only approximately 27 percent voting for parties on the Left<sup>100</sup>:

'Doctors' trade unions are right wing [...] it's a right wing arena [...] therefore the problem for the PS and the left is rather to woo the medical unions and the hospital environment to make them understand that we are quite reasonable interlocutors.'<sup>101</sup>

The politicisation of health policy networks was accentuated by the capacity of mayors to straddle local and national political arenas. Mayors of large towns were national figures, and party leaders traditionally used local strongholds as a springboard for national office (for example, Mauroy in Lille, Chirac in Paris and Chaban-Delmas in Bordeaux). Indeed, the practice of *cumul des mandats* (combining more than one political office at a time) meant that the chairs of boards of trustees more often than not also held a seat in the National Assembly.<sup>102</sup> Such multiple office-holding had two primary influences on the patterns of interactions within health policy networks. First, given the electoral considerations attached to management of public hospitals, mayors operated as an entrenched institutional veto group against radical reform within the legislative process. Successive governments repeatedly raised and subsequently dropped plans to remove the presidency of hospital boards of trustees from mayors.<sup>103</sup> Second, in areas of daily management, mayors with sufficient political weight could help other actors to short-circuit the administrative hierarchy:

'Each time that I asked him for an appointment with the minister's

*directeur du cabinet* or with anyone, his network of contacts was such that he got it for me. We'd go and sort out our problems directly with the minister.'<sup>104</sup>

In fact, the *Fédération Hospitalière de France* (FHF), cemented this relationship by bringing directors and politicians on the boards of trustees of public hospitals together in a cross-party lobby in defence of public hospitals. Created in 1924, the FHF was imbued with a public service ethos, considering itself to be 'the guardian of the temple of public service.'<sup>105</sup> Officially recognised, it was present in such diverse consultative forums as the national planning commission, the *Commissariat général du Plan*, the higher council for mutual insurances, the *Conseil Supérieur de la Mutualité* and the consultative body for public hospitals, the *Conseil Supérieur des Hôpitaux*. Indeed, it included within its national executive at the end of the 1980s high-ranking politicians from all political parties (except the PCF) - for example, former prime ministers such as Pierre Messmer, and former as well as future health and social affairs ministers as Jacques Barrot and Claude Evin.

The 'privileged' access of the *mandarins* to political elites was, therefore, partly countered by hospital directors, who could exploit the working relationship with 'their' mayor, upon whom their career closely depended. Similarly, directors were able to draw upon the organisational resources derived from a pivotal role within local political and economic networks:

'When I was director at Lorient, I was the key-man of the Lorient local networks, that is to say that I knew all the entrepreneurs, the fishing ports, the chambers of commerce, industry, all the politicians, all the journalists.'<sup>106</sup>

However, unlike doctors, only one hospital director was elected to the National Assembly between 1981 and 1991.<sup>107</sup> In addition, the FHF was traditionally viewed as an organisation associated with *Force Ouvrière* (FO); the minority trade union within the *corps* of hospital directors. Within the FO federation, a tacit agreement left the management of public hospitals to its directors' union and the FHF:

'There was a division within the trade union FO itself whereby FO was contented to keep [the health sickness funds] the CNAMTS to doctors and ambulatory care and delegate to hospital directors its influence in hospitals.'<sup>108</sup>

In fact, hospital directors designated the CNAMTS to be little more than a passive

'banker' for public hospitals, despite its over-riding funding of hospital investment programmes and FO's persistent defence of patients' rights.<sup>109</sup> And, for the CNAMTS, hospital directors remained tied to the alliance of 'spenders' which it sought to oversee in its limited management of health policy networks. These functional roles weakened the likelihood of any alliance between organisations within the *corps* of hospital directors and those within the CNAMTS. In practice, hospital directors decried the legitimacy of the CNAMTS, labelling it as a private organisation and fearing that the expansion of its role would create a second administrative control of public hospitals alongside that of departmental health boards:

'The Social Security funds, a private organisation, must only be considered as a collector of funds, a redistributor of incomes. It must not in any circumstances set itself up as a *de facto* overseer of public hospitals.'<sup>110</sup>

Yet, whilst the *corps* remained wedded to the legitimacy of government to intervene in the management of public hospitals, it had few alliances with the actors in the fragmented public administration. The most frequent interlocutor of hospital directors in the central administration was the *Direction des Hôpitaux* (DH). Hospital directors occupied posts in the DH, but the ability of the *corps* to capture this administrative division was weakened by the statute of the *corps*. Apart from the post of Director of Hospitals, the terms and conditions of the *corps* only permitted hospital directors to hold posts in the central administration as technical advisors in, for example, the *cabinets* of ministers or the Director of Hospitals. Consequently, the *corps* did not benefit from an established lobby at the level of the ministry - whereas in the case of the *grands corps* (such as the Bridges and Highways) such lobbies served to protect the interests of their members.<sup>111</sup>

The defence of these interests, in the case of hospital directors, was hampered paradoxically by the absence of a *grand corps* within health and social affairs, which apparently left hospital directors with no 'in-house' competition, but facilitated the Finance Ministry's *Direction du Budget's* 'invasion' of the national policy arena due to the absence of a bulwark against their territorial expansion. The *Inspecteurs des Finances* within the DB classified hospital directors as members of a local cost-maximising cartel; a judgement which justified, in its eyes, centralised control of public hospital development.

In fact, hospital directors were not part of a hierarchical line-order bureaucracy. Formally appointed by the Minister of Health, directors managed public hospitals which were legally attached to the *commune* and whose board of trustees was presided over by the local Mayor. They were consequently neither central nor local agents, but ‘hybrids’ who were able to draw their legitimacy from both central and local administrations. Indeed, they exploited this dual source of legitimacy to proclaim their independence from external control:

‘Operating as a hinge [between centre and local], he [the hospital director] can play on one or the other ... where he gets his autonomy. When he spoke to the Board of Trustees and to their presidents [the mayor], he was then representing the ministry. Since he is appointed by the minister, he could thus bring out changes in regulations or directives. But in relation to the *tutelle* [the DDASS], representing the State, he could exploit his political responsibility, since he had to manage a local institution.’<sup>112</sup>

In addition, an alliance between hospital directors and the DB was hindered by the belief held by the *Inspecteurs des Finances* that the *corps* of hospital directors was ‘not up to the level of the stakes, the financial stakes, the stakes in terms of management difficulties, the stakes in terms of relations with the medical lobby.’<sup>113</sup> This impression was coloured by the fact that the *Inspecteurs* viewed public hospitals as a possible area of future expansion for their own *corps*. To this end, leading personalities within the ‘financial’ *corps* such as Jean Choussat, former Director of Hospitals and General Director of the *Assistance Publique* in Paris, advocated the opening of the posts of general directors of regional hospitals to the *grands corps*. Hospital directors closed external access to these posts by negotiating a requirement for a minimum of five-year experience as a hospital director before nomination as the head of a regional hospital - except that this requirement did not apply for the posts of General Director at Paris, Lyon and Marseille (see Chapter Three).

The competition for posts between the two *corps* was further complicated by the dependency of the *comptables*, the local treasurers who authorised local public spending, upon the Finance Ministry. Any expansion of the attributions of directors, which weakened the traditional division in the civil service between those who decide the objectives of expenditure and those who authorise it, threatened the interests of the ‘employees’ of the Finance Ministry. Indeed, the extension of managerial freedom fitted

poorly with the administrative culture of the *corps* of *comptables* - which questioned managerial autonomy, seeing it as contradicting the control of hospital spending.<sup>114</sup> Such policy stances were relayed nationally by the DB and cut into negotiations between *Inspecteurs* and hospital directors.

At the local level, the 1500 Inspectors of Health and Social Affairs who staffed the regional and departmental health boards, the DDASS and the DRASS, were a junior *corps* of civil servants. They were neither a serious rival nor a possible ally for hospital directors in the national policy-making process for two reasons. First, although trained at the same institution as hospital directors, the Inspectors followed a shorter training programme (two years) and their initial level of recruitment was lower (minimum of two years further education). So, 'a candidate who is a bit ambitious and a little capable has more tendency to choose the hospital director route than the other (that of an Inspector).'<sup>115</sup> In 1990, there were not a sufficient number of suitable candidates to fill the places offered on the training course for student Inspectors. Second, the Inspectors failed to mobilise around a common programme of occupational mobility, creating their own professional association as late as 1991.<sup>116</sup> However, whilst its aim was to achieve improvements in their statutory and working conditions, the Inspectors had not attached improvements in their statute to global reform of hospital management. As a *corps*, they still had to formulate a specific platform of hospital management reforms; their model for reform of their statute was that of hospital directors.

In fact, the *corps* of hospital directors was 'caught' between the medical profession and the *corps* of *Inspecteurs des Finances*. Hospital directors had not forged an alliance with the DB and the *Inspecteurs des Finances*. Although they presented themselves as the 'natural' allies of central administrators, their conception of such an alliance hampered its coming into being. They looked for an alliance which increased their professional independence, in the sense that they sought to be empowered by central administrators to determine public hospital development. Such an alliance was precluded by the low esteem in which the DB held hospital directors and their inter-*corps* rivalry between the hospital directors and the *Inspecteurs des Finances*.

In addition, despite divergent conceptions of their concrete forms, the widespread allegiance of hospital doctors to clinical freedom and self-regulation provided insufficient

common ground to unite hospital doctors against the interference of administrators and other external actors in the domain of medical practice. Consequently, hospital directors were brought into conflict with hospital doctors over the 'frontiers of control'<sup>117</sup> that exist between the administration and the medical profession: 'If certain directors want to eat doctor, it's also true ... that certain hospital doctor trade unions want to eat director.'<sup>118</sup> This clash of interests over the internal organisation of public hospitals dictated that there could be no open and formal alliances between the leaderships of their respective trade unions. In fact, if hospital directors were to extend their control over the budgetary and planning process, they had to seek to integrate doctors into the administrative hierarchy within public hospitals. Hospital doctors could not be left to manage freely 'their' wards: 'responsibility cannot be shared within the hospital.'<sup>119</sup>

Against this background, nurses provided hospital directors with a possible stepping-stone into the medical environment. They worked directly in the heart of the medical operating core. Nursing *cadres* who espoused managerial functions were behind the construction of an autonomous identity within the nursing profession. However, nurses, like the medical profession, remained internally fragmented, with over 100 associations and trade unions which were far from representative of the occupation as a whole (with only approximately 6 per cent of nurses belonging to the main trade union federations).<sup>120</sup> The strikes by nurses in October 1988 were led by a spontaneous grassroots organisation of activists in opposition to the alleged inadequacies of the trade union leadership.<sup>121</sup> This grassroots *coordination* voiced demands for improved pay and conditions rather than the demands for organisational change which could have provided a bridge between directors and nurses: 'they stopped at the idea of doing their job "well".'<sup>122</sup> In fact, the administration enjoyed low levels of legitimacy among the massed ranks of the nursing occupation. Hospital directors were held responsible by nurses for a system of unresponsive bureaucracy which was overly preoccupied with budgetary questions:<sup>123</sup>

'a system which they hate. From this fact, if the struggles of other actors still possess a certain legitimacy, the director can very easily be the object of a pure rejection.'<sup>124</sup>

Even nursing managers were themselves rejected by their fellow nurses who, in an effort to distinguish their own contribution to the hospital workplace, stressed the global needs

of the patient, psychological, social as well as physical, and the importance of 'human contact' with the patient<sup>125</sup>. 'if, therefore, it is possible to talk of a nursing logic, it appears to be defined at the opposite end of what could be an administrative logic.'<sup>126</sup>

This rejection of hospital directors by nurses, coupled with the subordination of nursing personnel within medical services, undermined any possible bridge between the administrative and medical territories. However, hospital doctors and directors were not two hermetically-sealed groups. Interpersonal contacts established through the hospital workplace forged informal personal networks.<sup>127</sup> Indeed, the unidimensional juxtaposition of the interests of hospital directors and doctors fails to portray the tacit alliances that existed between the professional operating core and the strategic apex. Hospital directors shared the interests of the medical profession in maintaining the managerial autonomy of public hospitals. For hospital doctors, a 'strong' director was a necessary first line of defence against the encroachments of central administrators in their hospital's management. In addition, both groups sought to maximise the technical development of medical services within their hospitals in order to compete with the services provided by other hospitals, both public and private. As such, when faced with external constraints: 'a collective reaction occurs. Leading actors, who are often considered to have relatively opposed interests, [move] to an increasingly *de facto* convergence.'<sup>128</sup>

Thus, there was a changing pattern of interest configuration depending upon the nature of the issue under consideration. The issue of managerial autonomy and the imposition of external controls upon the development of public hospitals mobilised the *corps* of hospital directors against the health sickness funds, the CNAMTS, and the central administrative divisions of the *Direction des Hôpitaux* (DH), the *Direction de la Sécurité Sociale* (DSS) and the *Direction du Budget* (DB). However, it also united hospital directors with the massed ranks of hospital doctors who joined in a defence of managerial autonomy of public hospitals often supported by local politicians and the nursing profession. By contrast, issues surrounding the internal organisation of public hospitals brought hospital directors into conflict with the medical profession and nurses. Yet, the hostility of the *corps* of *Inspecteurs des Finances* to the expansion of the *corps* of hospital directors, coupled with the control exercised over resource allocation by the medical profession, did not guarantee hospital directors the support of the DH, the DSS



or the DB. Indeed, the legitimacy of the medical profession led government to encourage doctors to adopt a managerialist discourse, rather than to promote the interests of hospital directors within public hospitals.

These cleavages cross-cut the traditional axis of centre-periphery and administrative-professional divisions within health care systems. The configuration of interests in the health policy sub-system left hospital directors without any fixed alliances or partnerships. Alliances with the medical profession were hampered by the weakness of the representative organisations of hospital doctors and the conflicting interests of organisational reform. As for the nursing occupation, directors suffered from a distinct lack of legitimacy. Within the administrative hierarchy, directors had formed no alliance with the DB, had a competing corps in the *Inspecteurs des Finances*, possessed limited footholds in the DH, but faced only a junior *corps* within departmental health boards. However, directors remain wedded to the public sector with no consistent relationship with the health sickness funds. And, public hospital directors relied on trying to exploit their privileged relationship with local politicians, albeit in competition with other groups, not least from the medical profession.

## CONCLUSIONS

The structure of the health policy sub-system which emerged from the state-profession compromise in France was marked by weak centralisation. Whilst the patient-day rate gave control over budgets to public hospitals, the organisation of public hospitals as professional bureaucracies decentralised control over the delivery of services to doctors. In addition, the weakness of the Health Ministry and its external services, blighted by its weak statistical support and inability to ward off the DB, precluded its strategic intervention at the subnational level. On the contrary, it encouraged across-the-board regulatory measures behind centralising budgetary controls. However, the politicisation of health policy networks, underpinned by multiple office-holding mayors, short-circuited such standard administrative hierarchies.

Weak centralisation was buttressed by a form of governance which privileged the market over planning and removed responsibility and its concurrent risk from any single

actor. The consumer sovereignty inherent in the French health care system reinforced competition between public hospitals and private clinics. In certain areas, private clinics competed on an equal footing with the public sector, although the level of competition varied with types of treatment. In addition, it discouraged medical professionals from acting as gatekeepers (in the mould of general practitioners in the NHS). Neither the medical profession, the health sickness funds nor the state had clear responsibilities:

‘The CNAMTS finances health care expenditures without exercising management controls on what is provided; the central government, through the Ministry of Health, exercises a titular control over all public hospital spending, even though it finances only a small fraction of total health expenditure; physicians determine the mix and quantity of resources used even though they share no financial responsibility, either in hospitals or in private practice.’<sup>129</sup>

Hospital doctors, entrenched in the operating core of public hospitals thereby installing a high degree of vertical dependency within the policy sub-system, were not prepared, or able, to enter into any corporatist arrangement with the Health Ministry. The social partners within the CNAMTS, particularly the FO, were more concerned with protecting the rights of patients to access care than to manage the rising health care budgets. Equally, the bosses’ movement, the *Confédération Nationale du Patronat Français* (CNPF), although an advocate of cost containment, was weakened by its internal contradictions (see Chapter One). This impotence left the state to occupy the regulatory space created by the absence of the medical profession or social partners.

Nor were the boundaries of the health policy sub-system closed. The absence of a health and social affairs *grands corps* and the low relative standing of health and social affairs ministries could not prevent the ‘invasion’ of the policy sub-system by other ministries - in particular, the DB and the *Inspection des Finances*. The constellation of actors within the policy sub-system was fragmented, with divided hospital doctor trade unions and entrenched groups within the health sickness funds, political parties and the administration. However, although fragmented, hospital doctors in regional teaching hospitals, entrenched within the privileged *conférence*, worked until the mid-1970s in alliance with the FHF and the DH in a dominant pro-hospital spending coalition.<sup>130</sup> This coalition was backed by local mayors with one eye on their electoral fortunes, as well as by the health sickness funds who financed much of the hospital investment programmes. Nurses, hospital personnel and, for that matter, the CNAMTS were, nevertheless,

divorced from decision-making arenas.

Hospital directors occupied a 'buffer zone' between a pro-spending lobby of hospital doctors, the FHF, the DH, nurses and personnel on the one hand, and the anti-spending DB on the other, albeit progressively more in tune with the initially ambiguous health sickness funds and the DSS.<sup>131</sup> This location offered the leadership of the *corps* a dual strategy because, depending upon the issues and its tactical ambitions, the hospital directors could switch alliances from one camp to the other. First, hospital directors could present themselves as the defenders of the local autonomy of public hospitals. This strategy cultivated support from hospital doctors and nurses and local mayors. It divorced hospital directors from its supporters within the departmental and regional health boards, the DDASS and the DRASS and the DH. Alternatively, they could present themselves as the sole actors capable of delivering cost containment and improved management within public hospitals. This strategy cultivated an alliance with the DH and the Health and Finance Ministries at the expense of the local support of hospital doctors and nurses.

However, inherent in this juggling of strategies was the weak identification of the *corps* with either camp. Conflict over organisational boundaries within public hospitals weakened the foundations of alliances between hospital directors and doctors and nurses. Likewise, both its 'hybrid' statute and competition with the DB lessened the stability of the *corps'* ties with a coalition of 'financiers'. So hospital directors retreated to their privileged relations with local mayors and strategic positions within local political networks. Attaching oneself to a 'good' Mayor complete with a national profile was an astute career move for an ambitious hospital director. I now turn to the professionalisation of the *corps* of hospital directors and the emergence of the ENSP generation.

## ENDNOTES TO CHAPTER TWO

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103. *Le Monde*, 09 June 1981.
104. C. Anastasy, interview, 03 February 1992.
105. Rollandin, *La Santé en Danger*, p.190.
106. L. Omnès, interview, 26 February 1992.
107. Jean-François Michel was elected to the National Assembly at the 1986 legislative elections whereas Dominique Paillé, former national delegate for the SNCH, was elected in March 1993.
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109. For the role of the funds in the expansion of hospitals, see M. Rozier (1984), 'L'hôpital et la Sécurité Sociale', *Revue Hospitalière de France*, no. 368, pp. 93-124.
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111. J-C. Thoenig (1973), *L'ère des technocrates*, Paris: Éditions d'organisation, p. 48.
112. A. Halbout, interview, 17 March 1992.
113. J. Choussat, interview, 24 January 1992.
114. The Ministries of Finance, Budget and Social Affairs commissioned, in October 1990, a series of reports on the relationship between *comptables* and hospital directors. *La revue du Trésor*, no.6 June 1991, p.359.
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116. *Espace Social Européen*, 31 January 1992, p. 14.
117. Harrison., *Managing The NHS*, p.1.
118. M. Buisson, interview, 23 March 1992.
119. J. Coz, *Le Quotidien du Médecin*, 10 April 1990.



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121. For history of the struggle, see M. Schachtel and A. Rebours (1989), *Ras la Seringue*, Paris: Lamarre.
122. D. Kerhoat (1991), 'L'infirmière coordonné', *Futur Antérieur*, no.6, pp.76.
123. M. André, *Mission Dialogue dans les Hôpitaux*, p.19.
124. L. Visier and M. Frybes (1991), 'De l'expérience infirmière à la mobilisation', *La Revue de l'IRES*, no.5, p.108; Schachtel and Rebours, *Ras la Seringue*, p.32.
125. Visier and Frybes, *La Revue de l'IRES*, pp. 105-108; Schachtel and Rebours, *Ras la Seringue*, p. 30.
126. Visier and Frybes, *La Revue de l'IRES*, p.105.
127. Gérard Vincent, president of the SNCH from 1982 to 1990, is, for example, a personal friend of Bernard Debré, co-founder of *Solidarité Médicale*, the vocal opponent of the hospital management reforms engaged by the Mauroy government in 1982.
128. Engel, Moisdon and Tonneau, *Sciences Sociales et Santé*, p.25.
129. Rodwin, *The Health Planning Predicament*, p.115.
130. See, B. Jobert (1981), *Le Social en Plan*, Paris: Editions Ouvrières.
131. Groupe régulation de l'activité et des dépenses de santé, (1983), *La Santé Choisie. Préparation du 9e Plan*, 1984-88, Paris: Documentation Française.

## CHAPTER THREE

### HOSPITAL DIRECTORS: THE ENSP GENERATION

The post-war professionalisation of hospital directors was a collective attempt by the members of a specialised and differentiated occupation to achieve self-regulation in both their organisation and working practices. Amongst other groups the degree of success in such endeavours has been associated with the acquisition of a series of traits - notably a developed body of expertise, reputation for altruistic service, demonstration of an extensive training and establishment of a professional code of conduct. These traits are said to characterise 'core' professions, such as doctors and lawyers.<sup>1</sup> However, there is little in these traits that is inherent to professions or professional tasks. Professional self-regulation, marked by collegiate control over recruitment and conduct, and autonomy in the workplace, is often underwritten by the state and is the product of an evolving bargaining process between a profession (seeking official sanction for its autonomy) and a government (seeking collaboration in the provision of services).<sup>2</sup> In this view, traits are no more than the tools used by professionals to justify their self-regulation externally; a form of social closure to ward off competition and restrict access to the profession and thereby maintain its market superiority. And a profession is a 'state-backed monopolistic supplier of a valued service.'<sup>3</sup>

This chapter examines the professionalisation of French hospital directors. This emergence of a new actor in health policy networks is best summarised as the assertion of an organisational profession within the pathway set down by French civil service structures. First, hospital directors are not one of the 'core' professions, but are dependent on state patronage: their emergence has been generated by the expansion of the apparatus of the state. They are also a techno-bureaucratic occupational group, or an 'organisational' profession.<sup>4</sup> Larson identifies two categories of organisational professionals which are differentiated by their use of expertise and the presence or absence of a client orientation.<sup>5</sup> Some organisational professions (such as school superintendents whose roles are generated by the concentration of administrative and managerial functions

of the state), exploit the general ideology of professionalism not to assert independent professional status, but to justify their technobureaucratic power. Other aspiring occupations such as social workers, whose roles are also generated by the increasing functions and attributions of the state, nonetheless employ their claims to expertise to acquire countervailing power within the large organisations within which they work. Hospital directors clearly belong with the first group of organisational professionals who borrow from the ideology of professionalism to assert the legitimacy of their technobureaucratic functions.

Second, as one of the approximately 1800 functionally distinct *corps*<sup>6</sup> which make up the French civil service, hospital directors borrowed from the ideology of the *grands corps* at the summit of the service. They exploited and moulded their actions upon the rules and norms of the *corps* structures imposed by the French state at the turn of the 1960s. Each *corps* monopolises a specific task or set of tasks, with all its members enjoying the same terms and conditions of service.<sup>7</sup> However, the seven *grands corps*<sup>8</sup> at the summit of the French civil service possess claims to a monopoly of expertise as well as possessing a degree of self-management with their own councils managing internal affairs. They are characterised by their historical origins, their small membership with limits on annual entries, their interministerial controls, and their mobility and ability to traverse public and private sectors under the practice of *pantouflage*.<sup>9</sup> Their expertise rests in part upon a certain generalism qualifying them for leadership posts and allowing them to define a conception of national interests and to manipulate multiple discourses.<sup>10</sup>

The *corps* structure induces a balkanisation of the civil service, symbolised by competition and rivalry for territorial control of services and functions.<sup>11</sup> Fuelling this balkanisation are the distinct identities which are attributed to *corps* along with an *esprit de corps* which 'is first the awareness of belonging to a specific group; it is next to have a sense of solidarity with this group; it is finally the tendency to adhere to the objectives that it pursues, to identify with it.'<sup>12</sup> *Corpsards* are part of the same elite with common values and identities enforced by success at national *concours*, and training at a common institution where personal networks which tie individuals together are forged. Indeed, Thoenig<sup>13</sup> showed how members of the Bridges and Highways corps, who shared common training, entrance examinations, and 'language' and traditions, demonstrated group

cohesion and a certain 'homogeneity'. In a study of industrial policy, Schmidt alludes to *corpsards* as a 'small club of like-minded, arrogant, but competent individuals.'<sup>14</sup> 'Like-minded because like-trained'<sup>15</sup>, the *corps* allegiance brings individuals together beyond the ties of substantive policy interests, political allegiances and recruitment from a narrow social and educational base.

Allegiance to the *corps* can claim to reduce the difficulty of collective action because 'belonging to the *corps* takes on almost metaphysical connotations. It is the integration into a continuum which transcends the individual, integrates him into a chain which gives understanding to his actions.'<sup>16</sup> The *corpsards*' common backgrounds and *corps* identity helps substitute *corps* interest for the motivational diversity common in other groups. In addition, the *grands corps* have created an ethical code which governs the behaviour of individuals without any direct pressure upon individuals. However, this latter variable sits uneasily alongside both the individual strategies open to civil servants (such as promotion through ministerial cabinets) and the internal conflicts within *corps*. The homogeneity of the *corps* is questionable. As with other professions, they are not immune to ideological differences or internal factions, although they may be perceived externally as a coherent whole. Also, the pervasive culture of the state, and the general interest behind which the elite civil service ply their trade, does not diminish territorial clashes between *corps*. Functional roles are pre-eminent.<sup>17</sup>

This chapter shows how the French civil service model imposed a certain dynamic upon the emergence of the *corps*, acting as a trigger to the formation of a group identity for hospital directors. It examines the management of the young *corps* from the beginning of the 1960s through to the imposition of cost containment in the late 1970s and 1980s. This period saw the emergence of a generation of hospital directors trained in the national school of public health, the *École Nationale de la Santé Publique* (ENSP), as French governments both expanded the occupational group and progressively aligned its administrative organisation with that of other civil service *corps*. These decisions produced their own logic of development which affected the trade union membership within the *corps*, particularly the SNCH, the sole occupation-based trade union for hospital directors. As the SNCH swung progressively towards the development of a health policy platform in the late 1970s, the first generation of graduates from the expanded

training programme created by the government at the ENSP arrived in the *corps*.

The first section of the chapter examines hospital directors as an occupational group and how the institution of the ENSP structured the *corps* in 1991. The second plots the emergence of ENSP graduates from the beginning of the 1960s, and changes in the *corps*' training, mobilisation and development. The third section of the chapter discusses the changing balance of support for different trade unions as ENSP graduates integrated the *corps*. The final section examines the group identity and motivations of those graduates who entered the SNCH.

### 3.1 THE ANATOMY OF A CORPS

Public hospital directors formed collectively in 1991 one of the category A 'management and conception' *corps*<sup>18</sup> of the French public hospital civil service. They exercised a virtual monopoly over all public hospital management posts. All but three hospital management posts were automatically reserved for members of the *corps*. Of the remaining three posts, hospital directors had 'captured' those as general director at the *Hospices Civils de Lyon* and the *Assistance Publique de Marseille*. Only the general director at the *Assistance Publique - Hôpitaux de Paris* remained outside the control of the *corps*. This position has been a 'private hunting ground of *Énarques* [graduates of the elite civil service school, the *École Nationale d'Administration* (ENA)].'<sup>19</sup> Its single omission in their monopoly removed approximately ten percent of the capacity of public hospitals from the control of the hospital directors' *corps* (see Chapter Two).

As a category 'A' *corps*, public hospital directors were part of the leading 27 percent of French civil servants recruited at graduate level or above.<sup>20</sup> However, the *corps* did not have either the history, self-management, the monopoly of expertise or cultural authority attached to the *grands corps* such as the *Inspection des Finances* (see Chapter Two). First, its entrants came not from ENA and the *Ecole Polytechnique*. Instead they were trained at the less reputed ENSP, 'a school for second lieutenants.'<sup>21</sup> Many entrants there also sat the ENA entrance examination, with the ENSP relegated to a 'safe-bet.' Nor had members of the hospital directors *corps* developed the generalist reputation which had allowed the *grands corps* to spread their influence beyond their allotted realm of technical

expertise. The hospital directors did not straddle public and private sectors, and *pantouflage* (transferring to the private sector) remained uncommon despite the appearance of organised chains of private clinics.

However, the *corps* did exercise a degree of self-management, at least in terms of promotion through the posts within the *corps*. This influence was exercised through the *corps*' trade union representatives on the *commissions paritaires*, the representative commissions which, along with the *commissions de classement*, co-manage the *corps*' relations with government. Most importantly, the *commissions de classement* assessed the appointments of individual hospital directors to vacant posts. The commissions were composed of trade union delegates, with mayoral and ministerial representation. In the case of the appointment of head directors, the commissions and the local Mayor listed candidates in order of preference. The formal decision remained with the Minister of Health, but the appointment normally resulted from the negotiations between the Mayor, trade unions and the Ministry. This trade union contribution provided union leaderships with the opportunity to offer their members the selective benefit of trade union support for their individual promotion dossiers (see below). In 1991, approximately 75 percent of hospital directors<sup>22</sup> were trade unionists (roughly four times the national average estimated at 15 to 20 percent).<sup>23</sup> However, the concentration of trade union support was such that the SNCH commanded majority support, consistently winning a majority of seats on the *commissions paritaires* from as early as 1972. This dominance placed the control of representation on the consultative standing committees in the hands of the SNCH. Two *conférences* for hospital directors shadowed those of hospital doctors, one for directors of regional hospitals and one for general hospitals. As well as the seats of hospital directors on the formal consultative bodies, the *Conseil Supérieur des Hôpitaux* and the *Conseil Supérieur de la Fonction Hospitalière*, these *conférences* were held within the network of the SNCH.

The *corps* totalled over 4,100 hospital directors<sup>24</sup>, a membership on a par with the 3600 members of Bridges and Highways, but significantly more than the 227 members of the financial inspectorate, the *Inspection des Finances*.<sup>25</sup> These directors were divided administratively into four separate classes, ordered hierarchically from First to Fourth (the Fourth and Fifth classes having merged in 1985). The largest class was the Fourth and

lowest class (see Table 3.1) which included approximately one third of all hospital directors. The four classes, for those directors *en plein exercice* as head directors of public hospitals, were determined according to an assessment of the activity of the hospital (its treatment of acute illnesses, emergency services and out-patients etc). As a rule-of-thumb, this meant that Fourth Class hospital directors could expect to manage hospitals with up to 200 beds. Third Class directors ran hospitals with up to 400 beds, while Second Class directors controlled hospitals with up to 1000 beds. First Class directors headed hospitals with over 1000 beds. At the pinnacle of the *corps* were the 29 posts as general directors of the regional hospitals and the *Hospices Civils de Lyon* and the *Assistance Publique de Marseille* (see Figure 3.1). These posts stood above the posts as head directors, assistant general directors, directors of central services, assistant directors and attachés in the rest of the *corps*.

**Table 3.1: The make-up of hospital directors in 1991<sup>26</sup>**

Classes	Number of Directors	Percent of <i>corps</i>
First	386	9
Second	1,220	30
Third	1,026	25
Fourth	1,474	36
<i>Total</i>	<i>4,106</i>	<i>100</i>

Aspiring hospital directors largely entered the *corps* as student directors in either the Fourth or Third Class. Entry was by way of two sets of national competitive examinations, known as *concours*, which were open to both members of the public and existing civil servants (see below). Promotion then came after both six years in a class and satisfactory assessments by the DDASS, the departmental health boards. One quarter of hospital directors entering the *corps* were expected to reach the First Class following the upgrading of the *corps* in 1988.<sup>27</sup> However, promotion to the 29 posts as general directors was open only to directors with a minimum of four years professional experience in the First Class. This supplementary requirement was negotiated by the *corps* as a safeguard

against access to these posts by other civil servants.

The *concours* to the Third Class offered two paths for candidates: the *interne* open to civil servants from other *corps*<sup>28</sup> and the *externe* open to the general public.<sup>29</sup> The majority of candidates were selected from the *externe* which accounted for 65 percent of the annual ENSP intake, with the remaining 35 percent coming from the ranks of existing civil servants competing at the *interne*. The *externe* was dominated by graduate students from the seven political science institutes, the *Instituts d'Études Politiques* (IEPs). These *Sciences Po* students represented approximately one quarter of candidates who entered the examination. They were outnumbered by candidates with qualifications in law who represented roughly half of the candidates to the examination. However, they accounted for two-thirds of successful candidates (see Figure 3.1). Two Institutes alone, those at Paris and Bordeaux, provided respectively 22 percent and 14 percent of successful candidates between 1986 and 1991.<sup>30</sup>

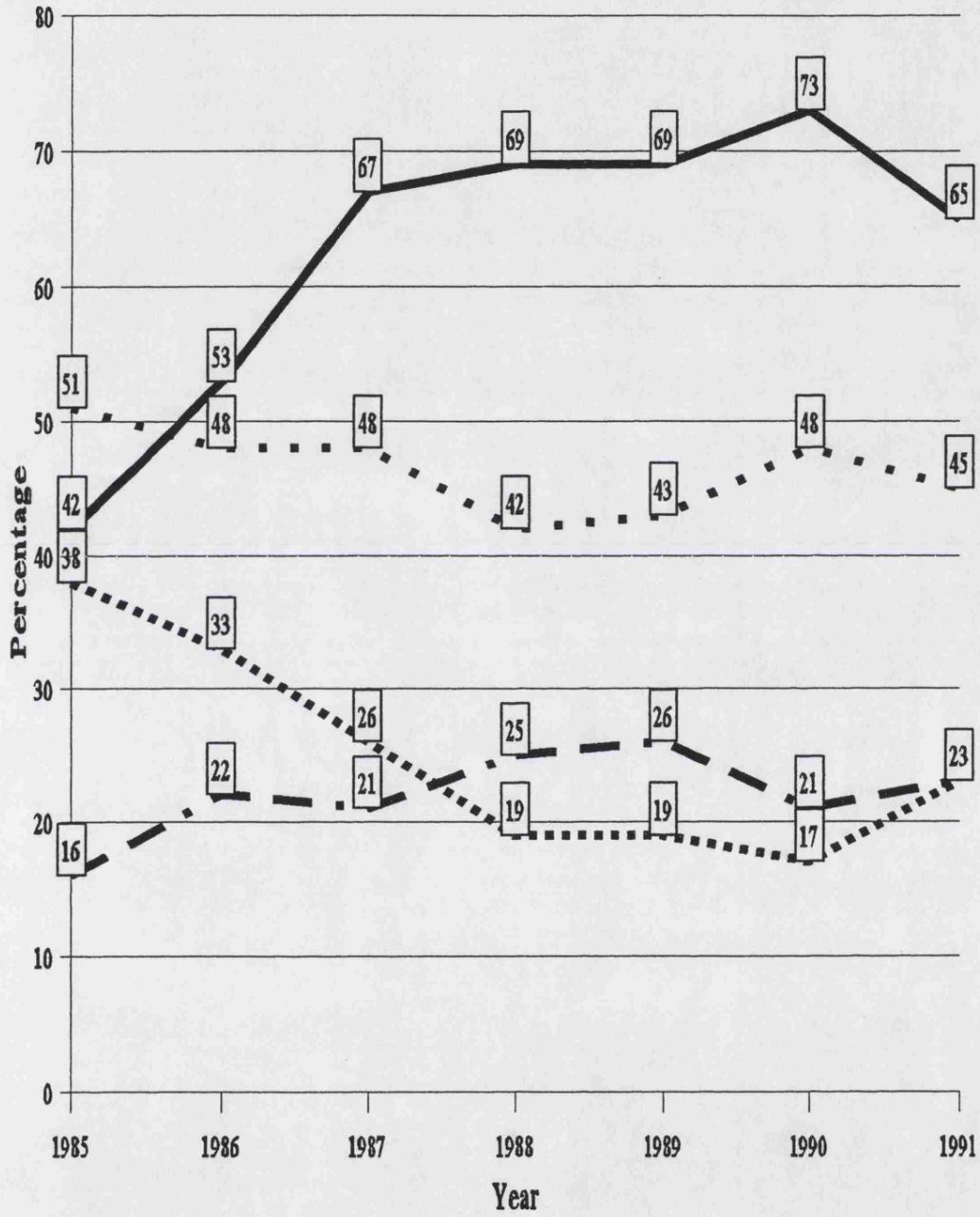
This dominance of *Sciences Po* graduates contrasted with the profile of candidates at the *interne* (see Table 3.2). First, as might be expected, candidates at the *interne* were older: an average of 33 years old against 24.5 years old for the *externe*. Second, they generally had lower academic qualifications. More than half of the successful candidates at the *interne* did not possess the university degree level education which was necessary to sit the *externe*. Finally, candidates at the *interne* came from diverse occupational backgrounds, ranging from inspectors of health and social affairs through to teachers and post office inspectors. However, two occupations, *adjoints des cadres*, the administrative support staff within hospitals, and nurses regularly provided one third of candidates (on average, 23 percent and 15 percent of successful candidates respectively).<sup>31</sup>

**Table 3.2: The number of successful candidates at the *interne***<sup>32</sup>

	1985	1986	1987	1988	1989	1990	1991
Successful candidates	29	33	26	14	28	28	35
With a degree or above	16	11	12	5	11	10	15
Nurses	6	5	3	2	2	7	5
<i>Adjoints des cadres</i>	5	10	7	2	4	9	8



**Figure 3.1: The dominance of Sciences Po graduates at the *externe***  
 (Notes: Direction des Hôpitaux, Health Ministry)



- - Political Studies Candidates
- Political Studies Entries
- - - Law Candidates
- Law Entries

In short, the *corps* of hospital directors had all the traits of a *petit grand corps*. It monopolised some of the highest paid jobs in the French civil service, but not the top post in the field, the head of the *Assistance Publique* in Paris. It was a Category 'A' *corps* with an above average level of unionisation, but although its trade unions influenced appointments, it lacked the self-management and standing which characterised the *grands corps*. Even the dominance of *Sciences Po* graduates deserved qualification. Paris, the most prestigious of the seven Institutes prepared candidates for ENA, and their top students took positions there. Although Paris graduates dominated the entry into the hospital directors *corps*, this option was often their second choice. Too often the *corps*' influence was reduced by internal shortcomings, of which a key problem was the cleavage between the Third and Fourth Classes.

#### *A corps within a corps*

The primary cleavage within the *corps* was that which separated Fourth Class hospital directors from the top three classes. Few hospital directors from the Fourth Class gained entry into the first three classes despite meeting the criteria for promotion to a higher class. In 1989, 43 percent of Fourth Class directors met the conditions for promotion to the Third Class.<sup>33</sup> In 1991, 80 percent of directors in the Fourth Class had more than the six years seniority required for promotion to a higher class.<sup>34</sup> However, on average, only 40 Fourth Class directors a year entered new posts within the Third Class.<sup>35</sup> Consequently, in 1991, only 13 percent of hospital directors in the first three classes originated from the Fourth Class (see Table 3.3). Only 10 of these directors had climbed from the Fourth to the First Class. The majority had progressed no further than the Third Class.<sup>36</sup> Indeed, the Fourth Class only belatedly joined the 'category A' *corps* of the civil service in 1988.<sup>37</sup>

This absence of integration stemmed from the different selection and training programmes which governed the entry of student directors into the Fourth and Third Classes. The entry requirements and training of Fourth Class directors were lower than their Third Class counterparts. Members of the public who wished to enter the Third Class entrance examination required a minimum of three years further education after the *baccalaureate* (the equivalent to 'A' Levels) as opposed to two years for Fourth Class student directors. These differential entry requirements were reflected in the length of

training which lasted 12 months for Fourth Class student directors and 27 months for Third Class student directors.

**Table 3.3: The number of directors originating from the Fourth Class<sup>38</sup>**

Classes	Number	Percent of class
First	10	3
Second	74	6
Third	269	26
<i>Total</i>	<i>353</i>	<i>13</i>

The training of hospital directors for the Third and Fourth Classes took place in different geographical locations, although in principle the training of hospital directors was monopolised by the ENSP at Rennes. The ENSP opened its doors to directors in the first three classes in 1958, however, the School only took on responsibility for the training of Fourth Class directors in 1986. And even from 1986, the integration of Fourth Class student directors into the ENSP remained incomplete: for four of their five months in the classroom, Fourth Class student directors were taught at the *Institut International Supérieur de Formation des Cadres de la Santé de Lyon*, managed by the *Hospices Civils de Lyon* and supervised by the ENSP. Consequently, in 1991, only 16 percent of Fourth Class hospital directors had graduated from the ENSP and this was from the training course taking place for the most part at Lyon and not at Rennes.<sup>39</sup>

In practice, therefore, the Fourth class was a *corps* within a *corps*. Fourth Class hospital directors required lower entry qualifications than Third Class directors, undertook shorter training programmes and tended not to progress beyond the Second and Third Classes. Indeed, Third Class directors invoked their higher qualifications and lengthier training to oppose the promotion into the Third Class of Fourth Class directors whose

‘quite normal interests in promotion come up against, (...) even if it is not always openly said, (...) the *corps* interests of the Third Class directors. And there, there is an area of conflict, it's obvious. (...)... from time to time, there are things that are said that are not too pleasant.’<sup>40</sup>

These differing entrance requirements and training distanced the Fourth Class and

provided the foundations of a distinct collective identity for the top three classes. Over two thirds (68 percent) of directors in the first three classes, with a high of 74 percent in the Second Class, were graduates of the ENSP (See Table 3.5).<sup>41</sup> This common ENSP experience crosscut any cleavages born of function and responsibility: ‘the homogeneity of the *corps* of directors is true, especially from the Third to the First Class, because we all have this common training.’<sup>42</sup>

### ***The ENSP identity***

The ENSP began life in October 1945 as a government training department within the *Institut National d'Hygiène* in Paris. It opened its doors to public hospital directors in 1958; the same year that government increased the powers of hospital directors and transferred the formal nomination of hospital directors from the local Prefect to the Minister of Health (see Chapter Two). However, it was not until the early 1960s that the strong School-*Corps* bond was established. In 1960, the School took responsibility for the first national competitive entrance examination and training programme for hospital directors, and thereby gained its monopoly over the training of future hospital directors. Two years later, it moved to its own premises in Rennes, reinforcing the institutional and physical ties between the school and its graduates without which ‘the idea of the *corps* would be diluted, the dynamic School-Profession would disappear. The teaching [...] would no longer have a common physical base: a place, a school, specialised teachings.’<sup>43</sup>

The ENSP identity did not override competing allegiances from directors within the first three classes. The professional identity of the *corps*, as well as its external reputation, exploited the influence and responsibilities of head directors as managers of public hospitals. The representative organisations of the *corps* operated as a lobby for head directors. The whole package of reforms that developed in the 1980s not only focused upon the responsibilities of head directors, but equated head directors to heads of enterprise sitting at the top of the strategic apex of public hospitals (see Chapter Four). When asked in a 1991 internal SNCH survey to prioritise their personal career ambitions, hospital directors placed the desire to be recognised as a ‘true head of enterprise’ in second place behind the financial or other recognition of the ‘hands-on’ experience of hospital directors.<sup>44</sup>

However, the majority of hospital directors worked not *en plein exercice* as head directors, but as part of the wider management teams which developed in public hospitals after the June 1969 hospital management decree.<sup>45</sup> Only 37 percent of posts were *en plein exercice* as head directors, although there were significant differences between classes (see Table 3.4). Paradoxically, the proportion of head directors was largest in the lowest class where, given the size of the institutions managed by Fourth Class directors, the number of posts as head directors reached 69 percent of posts in the class. However, throughout the *corps* head directors distinguished their interests from those of assistant directors:

‘When one defends the profession of hospital director, you often feel quite strongly the split between the head directors and the non-head directors that is to say that the head directors (...) consider that they have very important responsibilities and that they have worries that perhaps some of their colleagues haven't got. And they demand, because of this, specific advantages that their colleagues don't have ... and quite rightly too!’<sup>46</sup>

**Table 3.4: Posts as head directors (1991).<sup>47</sup>**

Classes	Number	Percent of class
First	243	50
Second	320	30
Third	262	19
Fourth	1,154	69
<i>Total</i>	<i>1,979</i>	<i>43</i>

Second, the working environments of hospital directors in the smaller local and general hospitals had few common points of reference with the tasks of hospital directors working in regional hospitals or, for that matter, in the three hospital groups of the *Hospices Civils de Lyon*, the *Assistance Publique de Marseille* and the *Assistance Publique - Hôpitaux de Paris*:

‘Already the tasks and the responsibilities [...] are different, that is to say, that it is a lot more fragmented: the larger the structure, less one has the feeling of participating in the final decision or in the life of the institution.’<sup>48</sup>

The centralised management structures of regional hospitals and the larger hospital groups such as the *Assistance Publique* spawned competing conceptions of the role of directors

within the *corps*. Directors working within general hospitals in the provinces tended to claim that centralised management structures such as the *Assistance Publique* reduced the function of directors to that of ‘letter-boxes’<sup>49</sup> implementing directives from above or to that of specialist ‘orderer of string.’<sup>50</sup> And hospital directors working within Paris hospitals constituted a relatively closed sub-group within the *corps*: ‘the people who work there, do their whole career there.’<sup>51</sup> This insulation changed somewhat in the early 1990s when the *Assistance Publique* sought to ‘import’ hospital directors from outside its centralised structures to act as catalysts for a more entrepreneurial management culture within its hospitals.<sup>52</sup>

Within the first three classes, the ENSP created a multi-dimensional School-*Corps* dynamic which facilitated the forging of common professional networks. At its lowest common denominator, the School-*Corps* dynamic manifested itself as no more than the common experiences of teachers, classrooms and corridors. However, the ENSP monopoly over training gave an important institutional and physical focus for hospital directors. Success at the competitive entrance examination, the *concours* furnished a common reference for all directors; reinforced as it was by the selection of a nucleus of individuals with common backgrounds and educational standards.<sup>53</sup> In fact, graduation from the ENSP and success at its competitive entrance examination defined the parameters of group membership and came over time to symbolise common interests and values: ‘you have been to a *Grande École* [ENSP], therefore, you have come out of this *Grande École*, therefore, you have a sense of belonging which federates energies, which attenuates differences.’<sup>54</sup>

This experience provided hospital directors with a parallel process of recognising common interests which reinforced that derived from the shared occupational status of hospital director. Graduation from the ENSP automatically labelled hospital directors and communicated similarity and a common nucleus of values and attitudes:

‘We have all gone through the same training, we have all had the same discourse at the School about who we were, and what we should be in the profession.’<sup>55</sup>

The ENSP tag consequently enabled other hospital directors to short-cut information constraints and automatically fellow categorise directors. This process continued into their professional life because hospital directors identified themselves by the year of their ENSP

graduation or the names of the 'personalities' within the *corps* with whom they had graduated.

Of course, there remained differences between ENSP graduates. The ENSP experience did not produce shared outlooks which erased the influence of other opinion-forming variables such as family and social backgrounds. The School trained six other occupations alongside hospital directors and was marked by a culture closer to the conceptions of public health than to those of hospital management. Indeed, the history of the School was punctuated by a series of conflicts between the school's administrators and hospital directors who believed that:

'The School is not, in terms of the quality of training, at the required level of the ambitions that it should have. And, precisely because it is not this privileged place of reflection, of doctrinal construction, in relation to the occupation of director, it is more at the back of our evolutions than in the avant-garde of them.'<sup>56</sup>

Few hospital directors returned to the ENSP to teach and directors had no places by right on the Administrative Board of the School. Yet, the School furnished individual directors with the group identity with which to recognise their common subjective interests with others organised in the *corps*.<sup>57</sup> Its manner of doing so was the consequence of the gradual imposition of the *corps*-based organisation upon the function of hospital directors in France. However, the emergence of ENSP graduates within the *corps* did not occur overnight. The next section looks at the rise of ENSP graduates within the *corps* from the beginning of the 1960s, focusing on the top three classes.

### **3.2 TRAINING, MOBILISATION AND THE DEVELOPMENT OF THE *CORPS***

There was no immediate influx of ENSP graduates into the *corps* nor any overnight coup which seized its commanding heights. The training programmes introduced in 1960 lasted only one year, but the numbers of student directors accepted on these programmes were not sufficient to alter significantly the composition of the *corps*. Only 138 hospital directors graduated from the ENSP training programme in the first decade of its existence. Indeed, until 1969, the average number of student directors accepted on the programmes was only 20 a year; the lowest being 15 and the highest being 23.<sup>58</sup> In addition, these

ENSP graduates were only beginning to work their way through the ranks of the occupation, particularly since hospital directors were obliged to spend a minimum of six years in each class before entering the next. They were in no position to mount a dramatic push for the leadership of the *corps*.

The formalisation of the *corps* continued under successive French governments with the expansion of the ENSP training programme and the affirmation of the administrative hierarchy within public hospitals. In 1965, recognising the under-management of public hospitals, the Health Commission of the Fifth Plan put forward proposals to expand recruitment to the ENSP programme.<sup>59</sup> These proposals were in keeping with the late 1960s expansion of the civil service as a means of reversing the general post-war declines in recruitment.<sup>60</sup> Indeed, in July 1968, the government introduced a common fund financed by public hospitals for the teaching and payment of trainee directors.<sup>61</sup> More significantly, June 1969 circulars introduced the *interne* and *externe* entry paths to the ENSP as well as the *assistanat* training programme for hospital directors. The *assistanat* extended the training period of student hospital directors to three years, adding two years as trainee directors in public hospitals to the one year spent in the classroom at Rennes.<sup>62</sup>

At a stroke, the government increased the prestige of the *corps* within the universe of the civil service - for prestige tends to be based not only upon the entry requirements of the *corps*, but also upon the length of training undergone by its new recruits. In addition, the June circulars authorised the creation of management teams within public hospitals. At the same time, the circulars both improved promotion prospects for hospital directors and cemented the boundaries of the *corps* by reducing the number of civil servants transferring directly into the higher posts of the *corps* through the *Tour Extérieur*. These measures laid the ground for the 1970 Hospital Law which formally transferred responsibility for general management of public hospitals from boards of trustees to hospital directors (see Chapter Two).

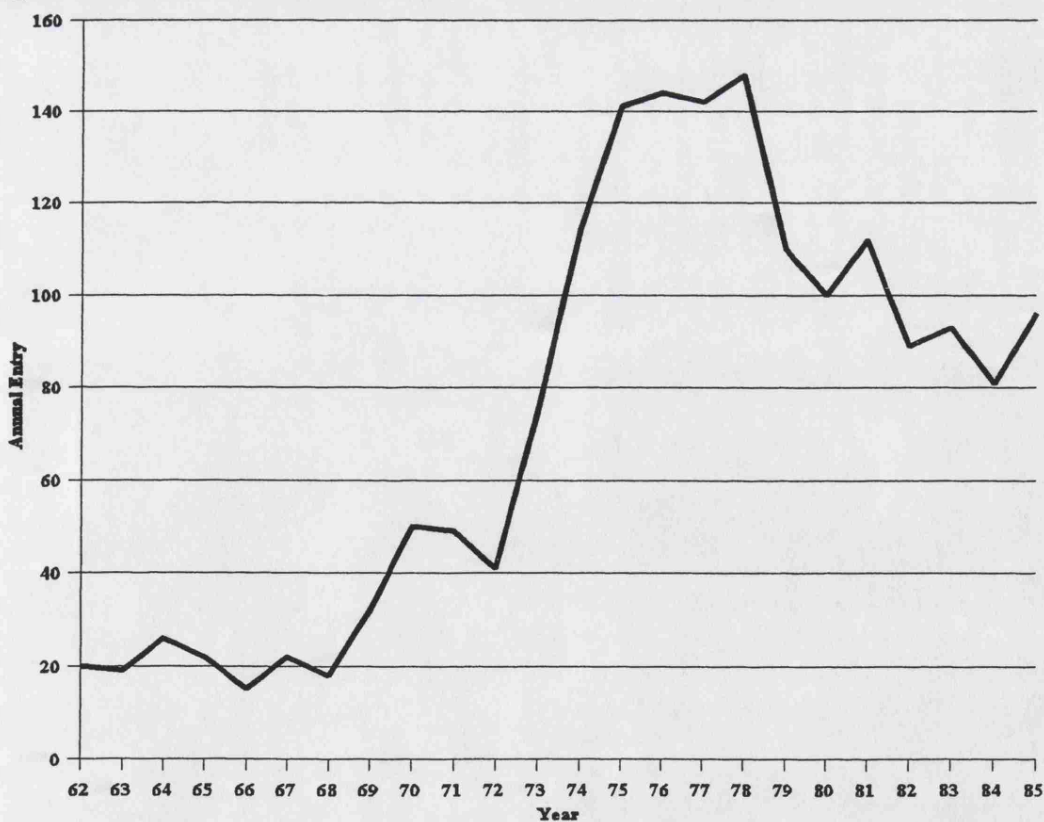
In 1972, the Health Commission of the French Plan, maintaining its calls for the expansion of the ENSP programme, sought a general increase in the prestige of the *corps* and advocated an opening of the *concours* to economists.<sup>63</sup> And following the switch to the *assistanat*, the number of student directors entering the ENSP increased. From



graduations of 20, the annual intake increased over seven-fold with a series of graduations of over 100 student directors between 1974 and 1981 (with a peak of 148 in 1978).<sup>64</sup> The first three classes of hospital directors more than doubled in size between 1972 and 1985, rising from 1152 directors in 1972 to 2347 directors in 1985 (see Figure 3.2).<sup>65</sup> Yet, of the 1796 ENSP graduates in the first three classes of hospital directors in 1991, 1698 graduated from the *assistanat* programme.<sup>66</sup> More importantly, between 1974 and 1981, graduates formed the bulk of these new entrants into the *corps*. Recruitment onto the training programme was itself declining from the mid-1980s as governments cut the number of students entering the ENSP to on average 40 a year (the same level as the early 1970s). The *assistanat* itself was replaced in 1987 by a twenty seven month training programme based on that followed by students at ENA; another attempt to increase its prestige.<sup>67</sup>

The rise of these graduates with common ENSP origins progressively homogenised the *corps* (see Table 3.5). By 1991, there remained less than one percent of directors in the first three classes who entered the *corps* under the 1943 statutes (see

**Figure 3.2: ENSP recruitment, 1962-1985**



Chapter Two). Few directors had been promoted either from the Fourth Class (13 percent) or, from the ranks of *chefs de bureaux*, the administrative staff below hospital directors within public hospitals (less than 5 percent). In addition, the number of hospital directors originating from the *Tour Extérieure* represented no more than 6.5 percent of the first three classes. The proportion rose to 20 percent in the First Class, although it fell to less than one percent in the Third Class (from 1969, integration into the *corps* of hospital directors from other civil service *corps* was limited to the First and Second Classes). Nevertheless, in the First and Second Classes, the number of hospital directors from the *Tour Extérieure* declined, from 21 percent in 1980 to 11 percent in 1991. Over the same period, the share of ENSP graduates in the First and Second Classes rose from 18 percent to 69 percent.<sup>68</sup>

**Table 3.5: The number of hospital directors in the first three classes by their method of entry (in 1991).<sup>69</sup>**

Method of entry	First class	Second class	Third class	All classes
1943 Statutes	11	8	4	23
ENSP (post 1960 courses)	72	21	5	98
ENSP (post 1969 courses)	152	730	816	16
<i>Tour Extérieure</i>	78	84	9	171
Promotion from Fourth Class	10	74	269	353
Promotion direct into Third Class	7	36	72	115
Diverse (N.Africa, 1969 integration)	56	73	45	174
<i>Total</i>	<i>386</i>	<i>1,026</i>	<i>1,220</i>	<i>2,632</i>

Between 1972 and 1991 both the First and Second Classes increased as a proportion of the *corps*, with the First Class almost doubling in size (see Table 3.6 and Figure 3.3).<sup>70</sup> Over the same period, the Third and Fourth Classes both declined, with the Fourth and Fifth classes increasing by only 185 hospital directors between 1972 and 1978. However, given the necessity to spend a minimum of six years in each class before entering the next, hospital directors originating from the *assistanat* programme did not

arrive *en masse* in the First Class until after 1985. In 1985, ENSP graduates represented 58 percent of First to Third Class directors (24 percent in the First Class, 46 percent in the Second and 68 percent in the Third). Only five of the *assistanat* graduates had achieved First Class status by 1985, but 42 of the pre-1969 graduates had achieved First Class status.<sup>71</sup> The large-scale new waves of graduates who entered the *corps* in the mid-1970s did not reach the First Class until over a decade later - 152 had done so by 1991.<sup>72</sup> Indeed, 'the School must have taken 20 years to produce a homogeneous body of managers amongst which the best took power almost everywhere.'<sup>73</sup> Many ENSP directors owed their promotion to the top classes of the *corps* to the general upgrading of the *corps* in 1988; one hospital director out of two in the First and Second Classes had less than three years seniority in 1991.<sup>74</sup>

However, the entry of the 1974-1981 *assistanat* generation into the *corps* enabled ENSP graduates to use 'the arrival in mass of these young graduates in health to overthrow, to effectively take, let's say, all the sectors in hospitals.'<sup>75</sup> The early ENSP graduates possessed different qualities from those hospital directors already in post. The previously weak selection procedures had produced a disparate recruitment into the *corps*, with appointments depending upon 'the fortune of their past history and the institutional history of the hospital.'<sup>76</sup> In contrast, ENSP graduates all had a higher level of formal education than existing members of the *corps*, with the national recruitment examinations bringing into the *corps* a nucleus of university and *Sciences Po* graduates from the pool of graduates preparing examinations for ENA and other civil service *corps*. In 1966, university graduates accounted for the first time for over 50 percent of the annual intake of the ENSP. In addition, from 1968, the intake began increasingly to comprise graduates of public administration and economics (5 out of 15 with university degrees in 1968, 11 out of 37 in 1970).<sup>77</sup> Although the intake remained dominated by law graduates (27 out of 39 graduates in 1971), there was thus an influx of graduates with:

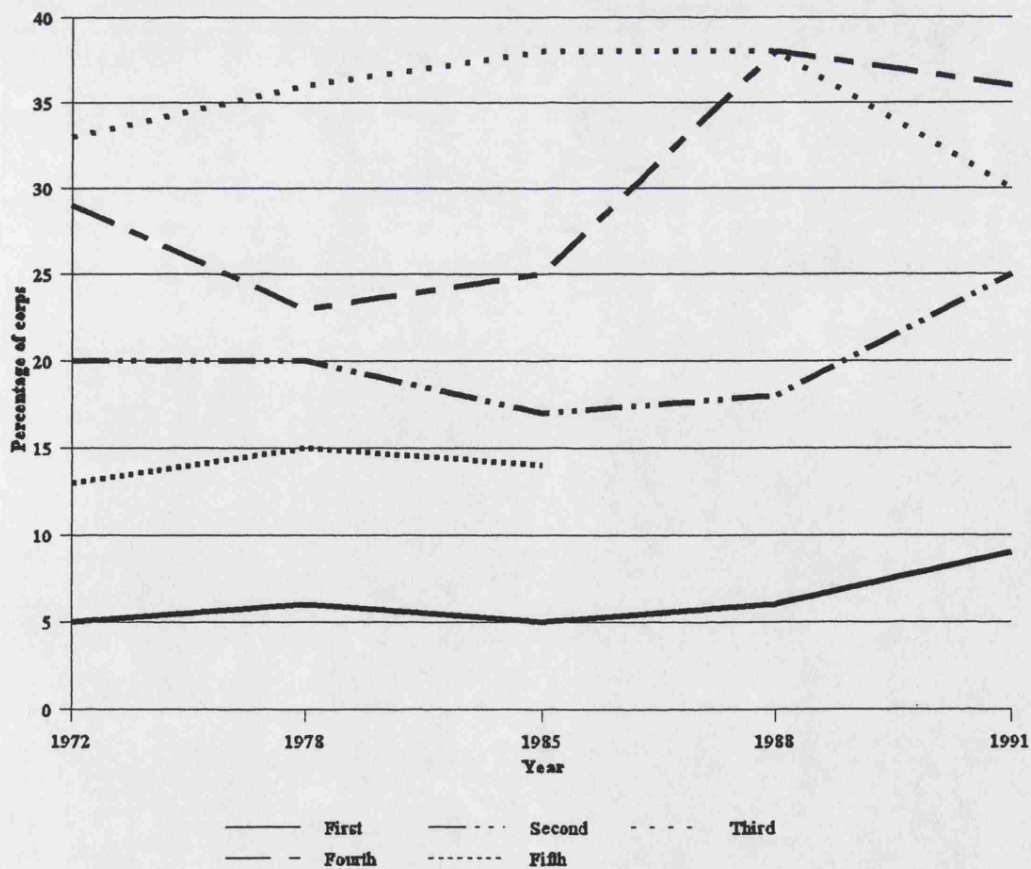
'a different basic training, people who had already been through further education, who had done *Sciences Po*, who had prepared the entrance exam for ENA, who had a higher education diploma.'<sup>78</sup>

**Table 3.6: The number of hospital directors in each class, 1972-1991<sup>79</sup>**

	1972	1978	1985	1988	1991
First class	100	151	194	252	386
Second class	401	548	663	739	1026
Third class	651	978	1490	1513	1220
Fourth class	576	603	967	1503	1474
Fifth class	256	414	565	-	-
<i>Total</i>	<i>1,984</i>	<i>2,694</i>	<i>3,879</i>	<i>4,007</i>	<i>4,106</i>

Notes: The Fourth and Fifth Classes merged in 1985.

**Figure 3.3: The corps of hospital directors, class by class, 1972-1991**



Upon entry into the *corps*, the first ENSP graduates began to organise as a distinct group of hospital directors with its own codes and conventions. Graduation from the ENSP and not simply the occupational status of hospital director, came to define group membership and the perception of common interests (see above). This divorced them from existing members of the *corps* and, in doing so, created an impetus towards change, towards the assertion of their own codes and conventions:

‘One put in the same saucepan [the ENSP], a community of people who integrated through the reality of professional *corps*, therefore, (...) the necessity to distinguish themselves from those who preceded them, to find working rules which were common to the *corps* and to lead a truly autonomous *corps* with its own internal rules, its culture and its methods of identification.’<sup>80</sup>

Such a perception of shared interests was evident as the early ENSP graduates took up posts in public hospitals. They faced competition for such posts from both non-ENSP hospital directors already in post and the *corps* of *chefs de bureaux*, the middle-ranking clerical staff within public hospitals. *Chefs de bureaux* had colonised hospital administrations with the aim of gaining access to management posts through internal promotion. It was not uncommon for head directors (often themselves *ex-chefs de bureaux*) to work directly with the *chefs de bureaux* and by-pass the ENSP directors within their management teams.<sup>81</sup> In this competition for posts, the recognition of ENSP group membership and common interests motivated decisions to appoint a candidate to vacant posts:

‘A director from the ENSP who found himself opposite candidates of whom certain were graduates of the ENSP, (...), he would favour, independently of the quality of the individual and of the quality of the training, he would favour those graduates, that is definite.’<sup>82</sup>

However, this recognition of a group identity was not based upon acceptance of a shared doctrine or programme of reforms emanating from their training at the ENSP. At best, the graduates who left the School did so with a code of practice and belief in management, with the common core values of a nascent advocacy coalition, but with few defined policy options. The ENSP remained wedded to a legalistic approach to management: ‘we had lessons on the regulations, how to read the regulations, how to apply the regulations, and what form to fill in to give your assessments.’<sup>83</sup> The firm policy commitments and management orientations to promote the interests of the *corps* had to

be pieced together outside the School in the representative organisations of hospital directors.

Overall, therefore, the rise of ENSP *assistantat* graduates progressively homogenised the *corps*, especially following the influx of ENSP graduates into the *corps* between 1974 and 1981. It was the arrival of this generation that allowed ENSP graduates to become the predominant group within the *corps*, although the rules governing promotion between classes precluded an overnight shift in the control of the *corps*' commanding heights. This generation, brought into the *corps* through the national recruitment examinations, was characterised by its nucleus of university graduates with legal and public administration backgrounds. This elevated the social and educational standing of the *corps*:

'It was with the training programme of the ENSP (that) the profession or the function of hospital director became well-regarded - obtained (...) in any case, respect from doctors on the one hand, and local politicians on the other hand.'<sup>84</sup>

Most importantly, through the socialisation of its training programme, the ENSP created a group identity based on the twin pillars of the occupation of hospital director and graduation from the ENSP. This group identity created a dynamic for change within the *corps* and its representative organisations. In the next section, I analyse the changing fortunes of hospital director trade unions in the 1970s and 1980s, and in particular, the entry of ENSP graduates into the SNCH.

### 3.3 UNIONISATION, THE SNCH AND THE *CORPS*' EXPANSION

The early ENSP graduates entered the *corps* when *Force Ouvrière* (FO) was ceasing to be the main union for hospital directors.<sup>85</sup> FO formed in 1948 when anti-communist trade unionists broke away from the then dominant *Confédération Générale du Travail* (CGT) amidst growing criticisms of French Communist Party influence within the CGT. The reformist FO subsequently replaced the CGT as the major hospital director trade union, drawing its support from hospitals in Paris, Lyon, Marseille, and North Africa, and from the psychiatric sector.<sup>86</sup>

However, by the end of the 1960s, FO was engaged in a (losing) struggle for pre-eminence amongst hospital directors with a new force, the SNCH, a small and specialist

union which aimed only to organize hospital directors. By 1966, at the elections to the *commissions paritaires*, an SNCH-led *Liste d'Union* won 62 percent of the vote.<sup>87</sup> The SNCH formed in 1947 when hospital directors in three regions (*Seine, Seine-et-Oise, and Seine-et-Marne*) themselves broke away from the CGT.<sup>88</sup> They did so in opposition to the decision of the CGT in December 1946 to integrate hospital directors into the same trade union branches as hospital personnel. This decision watered down the directors' specific identity, placing them in the same branches as the staff they were expected to manage: 'We could not decently be represented, trade union wise, by staff under our orders and whom we appoint, whereas they would not tolerate, quite rightly, to be represented by us.'<sup>89</sup> Refused permission by the CGT to continue to organise specific hospital director trade union branches, the directors formed the minority SNCH and sought to join the CGT as an independent trade union within the CGT confederation. When this request was denied, the SNCH directors broke away from the CGT altogether. Following the creation of FO, the CGT anyway lost its influence within the *corps* of hospital directors.

Unlike the CGT, both the SNCH and FO espoused a stance of political neutrality which prohibited formal links with any political parties. However, while FO and the CGT were general trade union federations, the SNCH adopted an occupation-specific trade unionism, stressing the distinct occupational problems facing hospital directors and refusing to affiliate to wider trade union movements. The SNCH argued that directors and administrators simply faced difficulties which could not be aggregated together with those of other hospital personnel and occupations. In contrast, FO maintained distinct hospital director trade union branches, but integrated them into the wider FO trade union confederation. It perceived the problems facing hospital directors as not distinctive, and capable of being handled within the policy framework defined by the confederation's national leadership with the interests of multiple occupations in mind.

From the outset, therefore, the competition between FO and the SNCH revolved around their rival conceptions of the position of hospital directors within the workforce. FO repeatedly condemned the SNCH for its occupation-based trade unionism. The FO leadership argued that FO's integration into a wider trade union movement meant that it was able to define a long-term global hospital policy whereas the occupation-based trade unionism of the SNCH was without:

'any support, neither technical nor moral. Inevitably, it is cut off from the totality of workers: it lives cut off from the rest of the world with all that this conception of trade unionism has that is disturbing and erroneous.'<sup>90</sup>

SNCH's single occupation approach also differed from that of the socialist *Confédération Française et Démocratique du Travail* and the Catholic *Confédération Française des Travailleurs Chrétiens* (CFTC). Like FO and the CGT, these two minor trade unions integrated hospital directors into a wider trade union confederation. So the structure of trade union competition presented ENSP graduates with two distinct identities when deciding which trade union to support: the politically neutral and occupation-based SNCH or the integrative stance of the dominant FO confederation (plus the minority variants offered by the CGT, CFDT and CFTC), which all espoused varying partisan positions.

The entry of ENSP *assistantat* graduates into the *corps* did not alter the emerging predominance of the SNCH at elections to the *commissions paritaires*. Despite its twin principles of non-affiliation and political neutrality, in 1972 the SNCH joined in the *liste d'entente*, an anti-FO electoral alliance with the CGT, the CFDT, and the CFTC. This electoral alliance prolonged its electoral strategy at the end of the 1960s.<sup>91</sup> Its joint list won 58 percent of the votes cast and took seven of the twelve seats on the commissions.<sup>92</sup> FO, with 42 percent of the vote remained the largest single trade union, but its dominance in the *commissions paritaires* was weakened. Indeed, FO argued that the SNCH represented only 41 percent of the vote, with the other 17 percent attributable to its partners in the *liste d'entente*.<sup>93</sup>

However, the decline of FO continued as ENSP graduates, particularly the post-1974 graduations of over 100, entered the first three classes. FO lost five percent of votes cast between 1972-1981 (see Table 3.7). Between 1972 and 1981, the SNCH confirmed its dominance at the expense of FO, and with the demise of the CFDT as an influence among hospital directors. At the elections in 1975, the broad anti-FO coalition disaggregated as the former partners presented two separate lists for the elections to the *commissions paritaires*. The SNCH presented a joint list with the minor CFTC which won 55 percent of the votes cast, commanding seven of the twelve seats on the *commissions paritaires*. At the subsequent elections of 1978 and 1981, the SNCH share of the vote, still in alliance with the CFTC, rose to 59 percent in 1978 and 60 percent in 1981. Although FO's vote remained relatively stable in 1975, its support fell to 37 percent in



1981. The support of the CFDT virtually disappeared as it failed to present a list at the elections to the *commissions paritaires* in 1978 and gained less than two percent of the votes cast in 1981. As for the CGT, it obtained less than two percent of the vote in 1978 and fell to less than one percent in 1981.

**Table 3.7: Trade union support at elections to the *commissions paritaires* from 1972 to 1991<sup>94</sup>**

Percent:	1972	1975	1978	1981	1984	1987	1991
Turnout	94.7	94.3	82.5	89.5	83.2	78.8	79.6
SNCH vote	57.7*	54.6	58.9	59.7	62.5	62.8	59.1
FO vote	42.3	40.9	39.5	37.3	31.6	29.4	25.2
CFDT vote	-	4.5*	-	1.7	4.9	6.8	15.6
CGT vote	-	-	1.6	1.3	0.9	1.0	-

Notes:\* In 1972, there was a joint SNCH/CFDT/CFTC/CGT list. In 1975, there was a joint CFDT/CGT list.

The decline in FO's vote share accelerated in the 1980s, dropping over 12 percentage points to reach 25 percent in 1991, with sharper declines in support occurring at the 1984 and 1991 elections. In contrast, SNCH support reached 62 percent in 1984 and 63 percent in 1987, although it fell back to 59 percent in 1991. This consolidation of SNCH support was achieved not only by its own performance, but also by the re-emergence of the CFDT at the expense of FO. The CFDT reversed its decline in the 1970s to progressively climb to 16 percent of votes in 1991. These trends meant that by 1991 the closest challenger to the SNCH at elections to the *commissions paritaires* was over 30 percent behind the dominant trade union.

However, only a minority of ENSP graduates joined the SNCH in the 1970s. By 1980, out of the 1163 ENSP graduates in the *corps*, only 388 (33 per cent) had joined the trade union.<sup>95</sup> This relative poor recruitment can be partly explained by the continued predominance of FO membership among the graduates of the *concours interne*. Promoted from within the ranks of the civil service, they often brought pre-established FO loyalties to the *corps*.<sup>96</sup> However, in its 1980 internal report on recruitment and membership, the SNCH leadership admitted that the expansion of the *corps* and the ENSP graduations in

the 1970s should have had 'a greater repercussion on the membership of the hospital director category. There was nothing of the sort and perhaps it is necessary to find out the reasons why.'<sup>97</sup> Indeed, set against the results obtained at elections to the *commission paritaires*, it became apparent that ENSP graduates were voting for the SNCH, but not taking the final steps to join the trade union. In 1978, whilst its membership accounted for 43 percent of the *corps* of hospital directors, the SNCH won almost 60 percent of votes at the elections for the *commissions paritaires*.<sup>98</sup> The difference between those voting for the SNCH and those actually joining the trade union suggests some important questions. Why did not the *corps* identity of the *corpsards* obviate large-scale collective action difficulties? And why did the minority of directors who mobilised within the SNCH do so against the majority behaviour of their colleagues? The next section shows that the minority of ENSP graduates who entered the SNCH possessed distinct motivations from those who remained outside the trade union.

### 3.4 THE ENSP GROUP IDENTITY

Group joining is commonly seen as determined by the extent of selective incentives which are only available to individuals who become group members.<sup>99</sup> In the case of trade unions, these private benefits encourage individuals to join trade unions by both minimising the net costs of membership, and reducing people's willingness to free-ride on the backs of other group members. In the case of ENSP graduates entering the *corps* in the 1970s, trade union leaderships made use of the private benefits that came through their defence of individuals and support for individuals' promotion dossiers on the *commissions paritaires* and *commissions de classements*, which came into operation in 1971 (see Chapter Two).<sup>100</sup> Trade unions leaderships were never slow to advertise these benefits. Even at the end of the 1960s, FO representatives made ENSP graduates fully aware of the alleged career advantages that would accrue to its members:

'When I was at the School in 1968, it was FO which dominated and they let it be known that if you took out a FO membership card, things would go better for you.'<sup>101</sup>

Trade union leaderships repeatedly defended their influence over the appointments of hospital directors. When Michèle Barzach, Junior Minister of Health in the 1986-1988

Chirac government, appointed 'her' candidate at Montpellier against the wishes of the Mayor, the SNCH publicly decried the ministerial intervention in the appointment of a director.<sup>102</sup> Their defence revealed the unstable influence of trade unions, but it also publicised the possible benefits of SNCH trade union membership in 'normal' circumstances. Indeed, over time, trade unions leaderships have delivered throughout the *corps* their message of selective benefits which has become widely accepted as motivation for membership:

'Except for the rare people who truly join for reasons concerning trade union philosophy, the majority join, in fact, simply because when you need the trade unions in the *commissions paritaires*, it is practical [to be a trade union member].'<sup>103</sup>

Most studies of the behaviour of elite civil servants fall back upon the selective benefits provided to the leaders of the *corps* through their management of individuals' careers. A common pattern is that of the maestro at the head of the *corps* who exercises control over the prospects of junior *corpsards* - for example, Chalandon at the head of the Mines. Collective action is made more likely because the *corps* advances the interests of individuals, which individual *corps* members cannot do on their own. Colonisation and maintenance of territorial gains moulds common and individual interests together. Even so, as Kessler argues, the balancing of individual and collective interests 'is sometimes a matter of acrobatics.'<sup>104</sup>

Amongst the cohort of the ENSP *assistanat* graduates, the mechanism of the *commissions paritaires* should have produced an inherent bias towards membership of the dominant trade union, the SNCH. Rational individuals, who were motivated by the prospect of support for their promotion dossiers, could have been expected to maximise these private benefits by joining the trade union capable of delivering the most votes in their favour. A rational choice account would predict that the dominant trade union will have remained so, with a 'snowball' drive toward membership once it was widely expected to rise to a predominant or a quasi-predominant position. Finally, as the trade union became dominant, the benefits derived from membership could have been expected to become increasingly haphazard as more candidates from the same trade union competed for its endorsement in the fight to gain posts. This change might be expected to promote greater involvement within the trade union, as individual members try to

secure the support of the trade union leadership. However, for some individuals, the same change might have caused them to drop out of trade union participation, or to join a minority trade union with more chance of securing support on the *commissions paritaires*, albeit minority support.

The SNCH's failure to mobilise ENSP graduates implies either that the majority of graduates who voted for the union but did not join it, acted irrationally; or, that the direct benefits to be gained from SNCH dominance on the *commissions paritaires* were minimal and that those ENSP graduates who joined the SNCH were maximising other benefits. Not wanting to label some 70 percent of ENSP graduates up to 1980 as irrational, I argue in favour of the latter assumption which finds support in the sequence of events in the 1970s. Some hospital directors in the SNCH criticised the lack of influence of trade union delegates on the *commissions paritaires*:

'If you think of the role of the trade union representatives on the *commissions paritaires*, where, for example, the grading of the directors is concerned, their role is reduced to nothing... The delegates on the *commissions paritaires* have absolutely no power to modify anything.'<sup>105</sup>

At its 1980 Grenoble conference, the SNCH bemoaned its lack of influence on the decisions taken in the *commissions paritaires*. It complained that the excessive influence of the Mayor in appointments meant that too often the choice of head director for vacant posts did not coincide with the professional standing of the candidate.<sup>106</sup> Indeed, it was in response to this criticism that Jacques Barrot, then overarching Minister of Health and Social Security, instructed the DH to allow hospital director trade unions to list their candidates in order of preference.<sup>107</sup> As a result, it was only in the 1980s that the selective benefits inherent in the mechanisms of the *commissions paritaires* became fully visible and formally open to trade union leaderships.

Downgrading our estimate of the private benefits delivered by trade union leaderships fails to explain why certain individuals did join the SNCH. The solution to this puzzle revolves around the concept of the group identity which was provided by the ENSP. Generally, people begin calculating the respective costs and benefits that membership of an interest group entails, and deciding whether or not to join the group, only after they have recognised that the group in question actually promotes their interests.<sup>108</sup> The maximisation of private benefits is the final stage of a process of group mobilisation. Individuals first situate themselves in relation to other individuals,

determining that the interest group's constituency exists, that they are members of that constituency and that the interest group defends their interests. It is the management of this process which is crucial in the choice of individuals to support one particular interest group. It seems plausible to assume that the ENSP identity and common background facilitated the entry of their graduates into the representative organisations of the *corps*. It seems reasonable to suppose that ENSP graduates who joined the SNCH, opted for the SNCH over other trade unions because they recognised themselves in the constituency defended by that trade union.

The constituency embraced by the SNCH was clearly that of public hospital directors. It adopted the dual organisational principles of an occupation-based trade unionism and political neutrality. These principles hinged upon the belief that hospital directors, like lower-ranking hospital administrators, faced occupational challenges which could not be bracketed together with those of other hospital personnel or, for that matter, with any other occupation. Although it opened its ranks to other hospital administrative staff, it remained none the less 'the' hospital director trade union, both in terms of their numerical weight within the SNCH (over half of its membership) and their control of its decision-making bodies. Hospital directors monopolised the presidency of the trade union and overwhelmingly dominated its national executive committee, the *Bureau National* (BN). From 1976 onwards, only one of the BN 12 members was not a hospital director.

This stance, more than votes on the *commissions paritaires*, explains the decision of those ENSP graduates who entered the trade union. They joined the SNCH because their ENSP-*corps* identity dictated that they recognised themselves within the SNCH constituency. It did so by laying down conditions of group membership which the internal structure and constituency of FO could not meet. First, as part of a wider trade union confederation, FO could not satisfy the focus of these ENSP graduates upon the occupation of hospital director:

'As a director, I think that there is, nevertheless, one difference between these two trade unions. It is that there is one which is, above all, a general trade union and the other is a *corps* trade union.'<sup>109</sup>

The SNCH was the only hospital director trade union which was capable of supporting the professionalisation of hospital directors. The institutional constraints of belonging to a wider confederation meant that FO could not develop such a project:

‘quite simply, because it belongs to the FO confederation. This means that in joining FO, you support the policies of the confederation, and as for any far reaching discussions, you are prevented from having them between directors.’<sup>110</sup>

Indeed, these distinct appeals were reinforced by the nature of the competition between FO and the SNCH which revolved around their distinct structures and constituencies.

Second, as the traditionally dominant trade union within the *corps* of hospital directors, FO was more clearly associated with pre-ENSP hospital directors than the SNCH. Its links with this constituency hampered its acceptance by ENSP graduates who saw themselves as members of a new constituency which was defined by generation and graduation from the ENSP. Even for one of its former general secretaries, the attractiveness of the FO for potential members suffered because it was perceived by ENSP graduates as ‘the trade union for grandfathers.’<sup>111</sup> The results of a 1991 survey of Third and Fourth class directors maintained that FO was typified by strictly controlled conservative policies.<sup>112</sup> The SNCH was able to distance itself from any association with such a constituency: ‘It is definite that the SNCH incarnated a certain modernist character.’<sup>113</sup>

The motivation of group identities within the *corps* is supported by the decline and subsequent re-emergence of the CFDT. Early ENSP graduates in the 1970s often entered the *corps* with a legacy of support for the CFDT, because as university students they had joined the CFDT whose support in universities rose after the protests of May 1968. Part of the anti-FO coalition in 1972, CFDT directors attacked the conservative FO discourse, endowing it with ‘the image of a trade union living in the past, fifty years behind.’<sup>114</sup> However, moves in the CFDT leadership towards *autogestion*, self-management in the workplace, led the confederation to merge its managerial branches with employee branches in the workplace. In March 1974, the CFDT put an end to its distinct hospital director trade union branches (the same decision as that taken by the CGT in 1947) and hastened its decline at elections to the *commissions paritaires*.<sup>115</sup> The CFDT’s organisational reform and attempted reconfiguration of its identity set, caused directors to leave for the SNCH:

‘Even for people who were *a priori* more attracted to the CFDT, [membership] became very difficult because we found ourselves (...) alongside the personnel who we were, outside trade union meetings, called upon to manage .... It was very difficult, which meant that there was a

important drop in CFDT members, and most of them joined the SNCH.<sup>'116</sup> The CFDT only recovered after 1986 when it re-established its hospital director branches following internal lobbying by directors such as Gérard Sacco, Director of Studies at the ENSP. Their pressure led to the creation in 1986 of a union of health and social managers, the *Union Fédérale des Cadres Santé-Sociaux*, which was affiliated to the CFDT. Returning to its traditional identity set within the hospital director constituency, the CFDT's revival was aided by the SNCH's ties with government and CFDT's appeal to assistant directors through decentralised management responsibilities. The new CFDT organization took votes from both FO and the SNCH (see Table 3.7).

However, in the 1970s, the *corps* identity outlined above was not determinant in directing all ENSP graduates to join the SNCH, even though it was the trade union most identified with the constituency of hospital directors. Since the benefits of SNCH support on the *commissions paritaires* were not decisively obvious, another motivation for entering the SNCH was the maximisation of the benefits inherent in the recognition of group identity.<sup>117</sup> Those ENSP graduates who did enter the SNCH seem to have been those graduates who had the most distinct hospital manager *corps* identity: 'Me, when I joined the SNCH, it was because it was a trade union of hospital directors.'<sup>118</sup> They 'felt better in a trade union of managers.'<sup>119</sup>

More importantly, this cohort of ENSP graduates possessed a higher level of formal education than existing members of the SNCH with a *corps*-oriented outlook to match. For them graduation from the ENSP (and not simply the occupational status of hospital director) defined their group membership and the perception of common interests. This allegiance was particularly true for those ENSP graduates who entered the SNCH, who had a distinct identity different from the SNCH's existing membership. This internal difference created an impetus towards change, towards the assertion of their own codes and conventions within the trade union:

'There was never a rejection of those who had not been to the School [ENSP]. But, in fact, it was those who had gone to the School who dragged the trade union along, who pushed the trade union towards the top.'<sup>120</sup>

## CONCLUSIONS

The gradual imposition of the *corps*-based organisation upon hospital directors triggered the development of an ENSP cadre of directors who wanted to become more like the *grands corps*. These graduates did not just sweep into the commanding posts of the *corps*. But, over time their entry into the ranks of hospital directors homogenised the *corps*, particularly with the influx of ENSP graduates from the 1974 to 1981 *assistanat*. The institution of an ENSP training programme with a national *concours* for entry into the first three classes nurtured a *corps* identity and attracted *Sciences Po* graduates, giving hospital directors many of the traits attached to civil service *corps*. The presence of *Sciences Po* graduates, particularly from Paris, elevated the *corps*' standing and brought it more into line with the middle- and higher-ranking civil service. (Graduates from the Institutes which were created as 'feeder institutions' for the higher civil service peopled all elite competitive entry examinations:<sup>121</sup> between 1945 and 1994, approximately half of students at ENA passed through the Paris Institute of Political Science).<sup>122</sup>

The ENSP structures and *corps* identity played a significant role in the mobilisation of hospital directors. First, the *corps* identity eased the formation of a group identity for hospital directors, particularly the acceptance of subjective interests and the existence of a defined identity set. The School acted as physical and institutional focus for hospital directors, providing common allegiances, personal networks and producing the primary cleavage with Fourth Class directors. Second, in the case of those ENSP graduates who entered the SNCH, the ENSP identity appears to have been the catalyst for collective action, rather than any great material benefits of group membership. The competition over identities structured most trade union conflict. Individual directors seemed to have most wanted to develop their group identity by joining SNCH during the entry of the most *corps*-oriented graduates in the mid-1970s. In addition, the ENSP identity of these graduates clashed with that of existing hospital directors, creating an impetus towards change both within the *corps* and the SNCH. However, the maximisation of group identity was very much tied to a particular generation of hospital directors. From the 1980s, the selective benefits of the *commissions paritaires* became fully operational.

The expansion of the *corps* cannot be dissociated from the attempts of central



government to improve the management of public hospitals. Successive French governments triggered the progressive imposition of the administrative organisation common to civil service *corps*. Once the ENSP took sole responsibility in 1960 for the hospital director training programme, a 'School-*Corps*'<sup>123</sup> dynamic was put in place. It in turn brought with it both the *Sciences Po* graduates and *esprit de corps* (drawn from success at a specialist national *concours* and passage through a *corps*-based school) which were common throughout the elite French civil service.<sup>124</sup> The significance of government intervention, therefore, lies not so much in the imposition of a *corps*-solution to hospital management, but in the timing of its expansion of the *corps*. This expansion was not a direct product of any shift to cost containment in the 1970s. It was the product of a package of measures designed to strengthen the line-management function in public hospitals, not least the 1970 Hospital Law and repeated Health Planning Commissions which recognised the need to expand the numbers entering the *corps* in the 1960s.

The dilemma for the French state was that it set up a *corps* of managers to strengthen the line-management function in public hospitals. Yet, it sparked off a series of events that laid the foundations of a rival lobby or influence constraining central government intervention and control. The institution of national examinations homogenised the entry of university graduates into the *corps*. The ENSP forged a collective group identity which embraced the *grands corps* model of the French civil service. These changes triggered the formation of an occupational group whose upward social mobility gave them increased autonomy from their nominal 'masters' in central government. However, at first, the ENSP did not provide hospital directors with any more than the *grands corps* model of professional mobility. The concrete platform of hospital management reforms was to be developed in the trade unions and professional associations of the *corps*, especially in the SNCH.

## ENDNOTES TO CHAPTER THREE

1. For a discussion of professions, see P. Wilding (1982), *Professional Power and Social Welfare*, London: Routledge and Kegan Paul; A. Abbot (1988), *The System of Professions*, Chicago: Chicago University Press; M. Burrage and R. Torstendahl (eds) (1990), *Professions in Theory and History*, London: Sage; R. Dingwall and P. Lewis (eds) (1983), *The Sociology of the Professions*, London: Macmillan; E. Freidson (1970), *Profession of Medicine*, New York: Harper Row; D. Rosenberg (1989), *Accounting for Public Policy*, Manchester: Manchester University Press.
2. Freidson (1970), *Profession of Medicine*, p. 23.
3. M.A. Elston (1991), 'The Politics of Professional Power: Medicine in a Changing Health Service', in J. Gabe, M. Calnan, M. Bury (eds), *The Sociology of the Health Service*, London: Routledge, p.58.
4. M. Larson, (1977), *The Rise of Professionalism*, Los Angeles: University of California, p.179.
5. Larson, *The Rise of Professionalism*, pp. 180-186.
6. J-L. Quermonne, (1991), *L'appareil administratif de l'État*, Paris: Éditions du Seuil, p.150.
7. A. Stevens, (1992), *The Government and Politics of France*, London: Macmillan, p.123.
8. The seven *grands corps* are the Council of State, the Court of Accounts, the General Finance Inspectorate, the *Corps* of Mines, the *Corps* of Bridges and Highways, the Prefectoral *Corps*, and the Diplomatic *Corps*.
9. M-C. Kessler (1986), *Les grands corps de l'état*, Paris: Presses de la FNSP.
10. B. Jobert and P. Muller (1987), *L'état en action*, Paris: Presses Universitaires de France, pp. 217-218.
11. See F. Dupuy and J-C. Thoenig (1985), *L'administration en miettes*, Paris: Fayard; A. Stevens (1978), 'Politicisation and cohesion in the French administration', *West European Politics*, vol. 1, no. 3, pp. 69-80; E. N. Suleiman (1974), *Politics, Power and Bureaucracy in France*, Princeton: Princeton University Press; E. N. Suleiman (1978), *Elites in French Society*, Princeton: Princeton University Press; J-C. Thoenig (1987), 'Pour une approche analytique de la modernisation administrative', *Revue française de science politique*, vol. 37, no. 4, pp. 526-538; V. Wright (1989), *The Government and Politics of France*, London: Unwin Hyman.
12. J. Chevallier, cited in Quermonne, *L'appareil administratif de l'État*, pp151-152.
13. J-C. Thoenig, (1973), *L'ère des technocrates*, Paris: Les Éditions d'Organisation.
14. V.A. Schmidt, (1996), *From State to Market? The Transformation of French Business and Government*, Cambridge: Cambridge University Press, p.424
15. Schmidt, *From State to Market?*, p. 335.
16. Kessler, *Les Grands Corps de l'État*, p.167
17. Wright, *The Government and Politics of France*, pp. 120-125; V. Wright (1974), 'Politics and Administration under the French Fifth Republic', *Political Studies*, vol.22, no. 4, p. 54; Suleiman, *Elites in French Society*, p.245.
18. There are four categories of *corps* which are broadly concerned with executive management and decision-making (the top-ranking category 'A' *corps*), implementation (category 'B'), and routine administrative and clerical tasks (categories 'C' and 'D'). Entrants require degree-level qualifications for category 'A' *corps* as opposed to

- baccalaureate (equivalent to A-level) qualifications for category 'B' corps. See Quermonne, *L'appareil administratif de l'État*, pp.149-151; Stevens, *The Government and Politics of France*, pp.122-133.
19. M. Tirel, interview, 06 March 1992.
  20. Quermonne, *L'appareil administratif de l'État*, p.150.
  21. P. Rayroles, interview, 27 February 1992.
  22. SNCH internal survey, 1991.
  23. M. Kesselman, (1996), 'Does the French Labour Movement have a future?', in J.T.S. Keeler and M.A. Schain (eds), *Chirac's Challenge. Liberalisation, Europeanisation and Malaise in France*, London: Macmillan, p.149.
  24. Figures on 01 January 1991 excluding student directors. J-P. Gusching, 'Les personnels de direction', internal report for the National Executive of the SNCH, March 1992.
  25. Stevens, *The Government and Politics of France*, 2nd edition, p. 140.
  26. Figures on 01 January 1991 excluding student directors. Gusching, 'Les personnels de direction', p.1.
  27. *Le Quotidien du Médecin*, 09 October 1987.
  28. Civil servants with at least two years experience since gaining tenure or four years in post without tenure.
  29. Individuals under the age of forty and with degree-level qualifications.
  30. Candidates to the *concours externe* between 1985 and 1991 (figures not available before 1985). Source: *Direction des Hôpitaux*, Ministry of Health.
  31. Candidates to the *concours interne* between 1985 and 1991 (figures not available before 1985). Source: *Direction des Hôpitaux*, Ministry of Health.
  32. Source: *Direction des Hôpitaux*, Ministry of Health.
  33. 'Note d'orientation relative à la réforme de la 4e classe', *Le nouvel hospitalier* (1990), no.2, pp. 18-21.
  34. Gusching, 'Les personnels de direction', p. 2.
  35. One-third of new posts in the Third Class went to candidates from the Fourth Class whilst the remaining two-thirds were allocated to Third Class student directors. See, *Le nouvel hospitalier* (1990), no.2, pp. 18-21.
  36. Gusching, 'Les personnels de direction', p. 6
  37. *Le Quotidien du Médecin*, 09 October 1987.
  38. Gusching, 'Les personnels de direction', p. 6 and p. 9.
  39. Gusching, 'Les personnels de direction', p. 9.
  40. R. Le Berre, interview, 13 March 1992.
  41. Source: *Direction des Hôpitaux*, Ministry of Health, October 1992.
  42. Le Berre, interview, 13 March 1992.
  43. P. Jahan, (1992), 'Quo vadis ENSP?', *Le directeur d'hôpital*, no.5, p.11.
  44. 'Etude d'Image auprès des Directeurs D'Hôpitaux : Phase Qualitative', report by *Sacchi Conseil* for the SNCH, 26 March 1991, p.38.
  45. *Revue Française des Affaires Sociales* (1971), special edition on hospitals, no. 3, p. 77.
  46. J-P. Gusching, interview, 16 March 1992.
  47. Figures on 01 January 1991 excluding student directors. Gusching, 'Les personnels de direction', p. 6.
  48. Gusching, interview, 16 March 1992.

49. P. Domy, interview, 03 July 1992.
50. Gusching, interview, 16 March 1992.
51. M-F. Gonner, interview, 21 February 1992.
52. For example, Philippe Domy and Loius Omnès, two directors reputed as 'entrepreneurs' within the *corps*, both entered the *Assistance Publique* in the early 1990s.
53. P. Birnbaum, (1982), *The Heights of Power*, Chicago: University of Chicago Press.
54. C. Anastasy, interview, 03 February 1992.
55. Gonner, interview, 21 February 1992.
56. R. Le Berre, interview, 13 March 1992.
57. P. Dunleavy (1991), *Democracy, Bureaucracy and Public Choice*, London: Harvester Wheatsheaf, pp. 56-58.
58. *L'Hospitalier* (1986), no. 390, p. 71.
59. *L'Hospitalier* (1972), no. 281, p. 26.
60. See, J-L. Bodiguel and L. Rouban (1991), *Le fonctionnaire détrône? L'Etat au risque de la modernisation*, Paris: Presses de la FNSP, pp. 93-95.
61. Law 31 July 1968. *L'Hospitalier* (1972), no. 281, p. 30.
62. *L'Hospitalier* (1972), no. 281, p. 30.
63. *L'Hospitalier* (1972), no. 281, p. 31.
64. *L'Hospitalier* (1986), no. 390, p. 71.
65. *L'Hospitalier* (1986), no. 390, p. 71; *Direction des Hôpitaux*, Health Ministry, October 1992.
66. Gusching, 'Les personnels de direction', p.6.
67. J-Y. Jacob (1989), '20 ans après... Une nouvelle formation à l'ENSP', *Revue Hospitalière de France*, no. 418, pp. 117-120.
68. Gusching, 'Les personnels de direction', p. 6-8.
69. Gusching, 'Les personnels de direction', p. 6.
70. Source: *Direction des Hôpitaux*, Health Ministry, October 1992.
71. *L'Hospitalier* (1986), no. 390, p. 71.
72. Gusching, 'Les personnels de direction', p. 6.
73. C. Anastasy, interview, 03 February 1992.
74. Gusching, 'Les personnels de direction', p. 2.
75. J. Le Behec, interview with author, 28 February 1992.
76. Domy, interview, 03 July 1992.
77. *L' Hospitalier* (1971), no. 275, pp. 20-24.
78. M. Buisson, interview, 23 March 1992.
79. Figures exclude hospital directors, source: *Direction des Hôpitaux*, Health Ministry, October 1992.
80. Domy, interview, 03 July 1992.
81. M-C Burmier, interview, 25 March 1992.
82. Le Behec, interview, 28 February 1992.
83. L. Omnes, interview, 26 February 1992.
84. Le Behec, interview, 28 February 1992.
85. To avoid confusion between the *Syndicat National des Cadres Hospitaliers* (SNCH) and the *Syndicat National des Cadres Hospitaliers-Force Ouvrière* (SNCH-FO), I refer to the SNCH-FO as FO.
86. *L'Hospitalier*, no. 284, May 1972, p. 13.
87. *Résultats du scrutin du 21 décembre 1966*, SNCH archives.

88. *Bulletin Officiel du Syndicat National des Cadres Hospitaliers*, no.1, March 1947, p.1.
89. *Bulletin Officiel du Syndicat National des Cadres Hospitaliers*, no.1, March 1947, p.1.
90. 'L'Action Hospitalière', no.230, Jan-Feb 1976, cited in *L'Hospitalier* (1976), no.323, p.23.
91. G. Sacco, interview, 06 March 1992.
92. *Cadres-Plus*, UFCASS-CFDT, February 1992, p.1
93. *L'Hospitalier*, no.284, May 1972, p.13.
94. *Cadres Plus*, p. 1
95. G. Poisson, *L'Hospitalier*, no. 361, Sept 1980, p.29.
96. Sacco, interview, 06 March 1992.
97. Poisson, *L'Hospitalier* (1980), no. 361, p.29.
98. Poisson, *L'Hospitalier*, p.29.
99. M. Olson, (1965), *The Logic of Collective Action*, Cambridge: Havard University Press.
100. *Libération*, 14-15 June 1986.
101. Omnès, interview, 26 February 1992.
102. *Libération*, 14-15 June 1986.
103. Gonner, interview, 21 February, 1992.
104. Kessler, *Les Grands Corps de l'État*, p.175.
105. R. Dubois, *L'Hospitalier*, no. 326, August-September 1976, p.55.
106. C-G. Charlotte, *L'Hospitalier*, no. 359, May 1980, p. 23.
107. *L'Hospitalier* (1980), no. 359, p. 28.
108. Dunleavy, *Democracy, Bureaucracy and Public Choice*, p. 54-71.
109. Burmier, interview, 25 March 1992.
110. A. Lepère, interview, 16 June 1992.
111. Lepère, interview, 16 June 1992.
112. 'Etude d'Image auprès des Directeurs des 3ème et des 4ème classes', report by *Sacchi Conseil* for the SNCH, 26 March 1991, p. 8.
113. Gusching, interview, 16 March 1992.
114. Lepère, interview, 16 June 1992.
115. Decision taken at a extraordinary general assembly of the *Syndicat National des Cadres Hospitaliers et Sociaux CFDT*, held 09 March 1974. Sacco, interview, 06 March 1992.
116. Le Berre, interview, 13 March 1992.
117. For work on the role of expressive benefits in group joining, see D. Chong (1991), *Collective Action and the Civil Rights Movement*, Chicago: University of Chicago Press; G. Jordan and W. Maloney (1997), *The Protest Business?*, Manchester: Manchester University Press; K-D Opp, P. Voss, and C. Gern (1995), *Origins of a Spontaneous Revolution: East Germany, 1989*, Ann Arbor: University of Michigan.
118. Gusching, interview, 16 March 1992.
119. Le Behec, interview, 28 February 1992.
120. G. Vincent, interview, 17 May 1993.
121. S. Maheshwari, (1991), *The Higher Civil Service in France*, Bombay: Allied Publishers Ltd, p.45.
122. J-F. Kesler, (1997), 'L'Énarchie n'existe pas', *Pouvoirs*, no. 80, p. 32.

123. Jahan, 'Quo vadis ENSP?', p.11.

124. Stevens, *The Government and Politics of France*, pp.122-127.

## CHAPTER FOUR

### PROFESSIONAL ORGANISATION: THE DEVELOPMENT OF THE SNCH

The organisational dynamics of the SNCH in the early 1970s were firmly tied to the established practices of a trade union negotiating pay and conditions for its membership. However, these established practices were progressively undermined in the late 1970s by *assistanat* graduates who employed the SNCH as a vehicle for their collective social mobility, and progressively integrated its established practices into the organisational dynamics of a lobby and learned society. This transition hinged upon increasing the ties between hospital management reform, improved pay and conditions and the professionalisation of the *corps*. ENSP graduates entering into the leadership of the SNCH juggled three organisational dynamics: a professional dynamic, dedicated to raising the knowledge base of the *corps* and acquiring the traits of 'core' professions; a lobby dynamic, seeking to deliver legislative change; and a trade union dynamic, aiming to improve pay and conditions for the SNCH membership.<sup>1</sup>

This chapter analyses the changes in the leadership of the trade union, detailing how *assistanat* graduates fused multiple organisational dynamics into one competitive strategy from the beginnings of cost containment in 1976 through to the rewriting of hospital legislation in 1991. This transition imposed a significant change in the accepted practices of the SNCH, marking it out as the main vehicle for the professionalisation of the *corps* of hospital directors - a task more often attributed to learned societies, lobbies and certifying organisations. It was marked by changing goals and pressures on the SNCH leadership as the different organisational dynamics waxed and waned for distinct periods (see Table 4.1). The opening section examines the SNCH's first steps towards the development of a package of health policy reforms where the trade union dynamic entered into crisis. The second plots the takeover of SNCH leadership roles by ENSP graduates in the early 1980s, which triggered the union's shift towards becoming a powerful health policy lobby. The third analyses the emergence of the discourse of hospital planning which cemented the SNCH's new lobby role and moved it towards a professionalisation strategy.

The final section plots the emergence of *hôpital-entreprise* in the late 1980s, which translated into a concrete policy programme the aspirations of the ENSP graduates to upgrade their occupation.

**Table 4.1: The Changing Organisational Dynamics of the SNCH, 1976-1991**

<b>Period</b>	<b>Main Organisational Dynamic</b>
1976-1979	Lobby orientation contests established trade union orientation
1980-1982	Lobby orientation allies with emerging professional orientation
1983-1986	Lobby and professional orientations reinforced under compromise merger with trade union orientation
1987-1991	Professional orientation comes to the forefront of SNCH strategy

#### **4.1 FROM TRADE UNION TO HEALTH POLICY LOBBY**

The SNCH leadership went into its annual trade union conference at Strasbourg in April 1976 under pressure to redefine its practice of collective bargaining. Its established pattern of consensual ‘behind closed doors’ negotiations with the Health Ministry had failed to deliver sufficient improvements in pay and conditions to satisfy the growing demands of its rank-and-file membership. Claude-Guy Charlotte, the trade union's president, voiced concerns that the model of trade unionism adopted by the SNCH was at a crossroads, if not at the end of its life span, informing delegates that ‘it is absolutely crucial that we find another path along which to centre our demands.’<sup>2</sup>

In the months leading up to Strasbourg, the SNCH toyed with a strategy of overt confrontation in its negotiations with the Health Ministry. Twelve months earlier at La Baule, delegates had voted for strike action for the first time in the union’s history.<sup>3</sup> As a result, on 17 October 1975, the SNCH held its first national day of action with approximately 1500 hospital directors demonstrating on the streets of Paris.<sup>4</sup> However, this policy of overt confrontation clashed with the SNCH president's brand of ‘responsible’ trade unionism and placed unsustainable demands upon the organisational resources at the union’s disposal. The national executive, the *Bureau National* (BN) did not initiate the radicalisation of the SNCH stance in negotiations with the Health Ministry,



but was forced by the rank-and-file into overt confrontation:

'The willingness to abandon a certain passive attitude - indeed, a fatalistic attitude - in favour of attacking stances, going as far as to take to the streets, proves that the times have changed and the BN can no longer today modify the speed of change except under threat of being accused of backtracking.'<sup>5</sup>

In an effort to minimise attacks on the leadership's strategy of collective bargaining, the Strasbourg conference debated the findings of an internal working group which questioned the future of hospital directors as civil servants.<sup>6</sup> Its report argued that the inclusion of hospital directors within one of the general categories of French civil servants hampered the *corps* in its pursuit of improved pay and conditions. It made it difficult to award improved pay and conditions to hospital directors without attributing them to all other civil servants. The report thus proposed that, whilst remaining civil servants, hospital directors should seek to opt out of the general civil service categories (as had hospital doctors). This change would not only divorce their pay demands from other civil servants, but also have the advantage of simultaneously increasing the prestige of the *corps*. Much like Charlotte, the working group concluded that the SNCH had exhausted all its possible means of action within the existing civil service structures:

'Let's recognise, that having tried everything in its midst and used all the means at our disposal, including striking, we have nothing more to expect from our status as civil servants. It has within itself its own constraints and condemns us to never bring out the originality of our functions without straightaway unleashing chain reactions right through the whole civil service.'<sup>7</sup>

However, the people outside the leadership calling for radical strike action explained the SNCH's relative failure as caused by its lack both of a developed lobby role and of a coherent doctrinal base upon which to found its demands and collective action. Jean-Paul Fischer, a leading spokesperson for this view, socialist member of the BN and ENSP graduate (1974-1976 *assistanat*), agreed with (if he did not lead) the demands for more radical action by the SNCH. He had been instrumental in the first ever strike of assistant directors which took place on 17 June 1975. At Strasbourg, he linked the union's perceived lack of progress in furthering its demands not only to its consensus-led and 'behind closed doors' pattern of negotiations, but also to its lack of a distinct

programmatic base. For Fischer, the SNCH leadership could not continue 'to veer from left to right according to circumstances, events and [external] pressures.'<sup>8</sup> On the contrary, if the SNCH was to defend adequately the interests of hospital directors, it was obliged to anchor its demands within its own platform of health policy reforms and values. He consequently moved from the conference floor at Strasbourg that the BN or, conference delegates, establish an internal working party to study health policy issues - the SNCH's first step towards developing its own platform of health policy reforms.

The choice of strategy open to the Charlotte leadership was increasingly that of continued impotence, waiting for unlikely statutory change, or making moves towards the SNCH becoming a health policy lobby. However, although the development of a lobby orientation was far from a closed option for the SNCH, there was little immediate public support from the leadership or those close to Charlotte for the development of this orientation. In the debate on general policy, Charlotte at first ignored Fischer's request. Instead, he chose to raise the fear that the development of a health policy platform ran the risk of impinging upon the declared political neutrality of the SNCH and identifying it with a particular political party:

'Our SNCH includes a whole range of members who go from the extreme right to the extreme left and one of the essential principles of our organisation is to be perfectly apolitical.'<sup>9</sup>

However, Guy Vallet, a colleague of Fischer and a member of the same ENSP graduation, subsequently returned the debate to the question of an internal health policy working party. At the second time of asking, Charlotte conceded to their demand. The first meeting of the BN after the conference put in place the health working group demanded by Fischer.<sup>10</sup>

This appeasement of Fischer and Vallet brought the development of a platform of health policy reforms onto the SNCH's agenda, reflecting the alleged exhaustion of the SNCH's traditional model of collective bargaining. Charlotte publicly admitted the need for a new direction. However, Fischer and Vallet, both ENSP *assistantat* graduates, had a rival conception of the trade unionism to that of the Charlotte leadership. They coupled its role as trade union negotiating improved pay and conditions to that of learned society expanding the knowledge base of the *corps* and that of lobby delivering legislative change. For the moment, however, this challenge remained discreet, dependent upon frail

interventions from the floor of conference.

In fact, the orientations of the SNCH continued to follow the preferences of its President and his close associates. The national executive, the BN, whose 12 members were elected at the annual conference,<sup>11</sup> functioned as a presidential regime - with two-thirds of its members being no more than 'extras' on the sidelines of any decision-making.<sup>12</sup> Legitimised both by the election from within its ranks of the president and empowered by the organisational constraints impeding wider consultation, the BN had usurped the sovereign policy-making role of the annual conference. The BN also bypassed the union's *Conseil National* (CN) of regional and departmental delegates, which met only a handful of times a year.<sup>13</sup> This pattern of control meant that the SNCH functions rested chiefly upon the shoulders of the presidential 'messiah': 'As it's not a class-based trade union, it's not the CGT [the French communist trade union confederation], it always works on [the back of] a providential man.'<sup>14</sup> In this case, the president was Charlotte, elected in 1974. He was an ENSP graduate from 1964, but he was not part of the *assistanat* generation of hospital directors entering the *corps* in the 1970s.

### *Discussions without decisions*

Charlotte's acquiescence to Fischer demands did not commit the BN to anything more than the setting up of one working party. Yet, following Strasbourg, the SNCH leadership actually constituted five working parties on health policy. The working parties reported back to the following conference at Pau in 1977 with their proposals for reforms in the areas of planning and financing of the health care system, the organisation and missions of public hospitals, and the future role of the Social Security funds in health care management. The constitution of these five working groups marked the beginning of a process of internal health policy debate within the SNCH. This process was enshrined by Charlotte before the 1977 Pau conference when he publicly came out in favour of the development of an SNCH health policy platform:

'The time has come when it [SNCH] must owe its originality, in addition to its character as a free and independent trade union of managers, [...] to its doctrine in health policy.'<sup>15</sup>

Duly debated at Pau, the reports produced by the working groups subsequently provided

the core argument of *Objectifs Santé*, the internal health policy document debated at the Rouen conference in 1978.<sup>16</sup> Rouen was followed by the creation of a further SNCH working group which produced *Vers une évaluation du système de santé*, the health policy document debated at the Metz conference in 1979.<sup>17</sup>

The rapid conversion of Charlotte to the Fischer philosophy went well beyond the initial proposals of Strasbourg. Fischer and his growing band of supporters continued to attack the conciliatory approach adopted by Charlotte, particularly as the Barre government began from 1976 to impose progressive top-down controls on hospital spending (see Chapter Five). Echoing the criticisms of some rank-and-file members at the failure of the leadership to win improved pay and conditions, Fischer maintained that the SNCH needed to undertake radical strike action.<sup>18</sup> However, in the short-term, Fischer and his colleagues posed no threat to the continued predominance of the Charlotte leadership. The initiative of Vallet and Fischer was not backed by the formal support of an organised faction within the SNCH. Fischer and his supporters remained an informal grouping operating through a lone representative within the BN.

Nevertheless, the Fischer thesis won support from the gradual development of a further informal school of thought within the SNCH, that of the 'modernisers.' The 'modernisers' were primarily hospital directors who had graduated from the ENSP - such as Gérard Vincent, vice-president from 1976, Louis Rolland who entered the BN in 1978, Bernard Grandjean who entered the BN in 1979, and Alain Grenon who led the Metz working group. They came to support the shift towards the development of a health policy platform because of their common desire to modernise public hospital management through the introduction of private management techniques in public hospitals.<sup>19</sup> Such calls for modernisation betrayed a common objective to enhance the standing of the *corps*, because the modernisation of management implied giving an expanded role to administrative hierarchies within hospitals. As with Fischer and his supporters, the modernisers backed the promotion of health policy debates within the SNCH because it promoted management reform, increased the profession's standing and presented the SNCH with the opportunity to lead public debate on health care reform.

Both the 'modernisers' and Fischer were pushing at a half-open door as the government's imposition of top-down controls on hospitals led Charlotte to accept the

shift towards health policy debate as a necessary pre-requisite of the continued defence of the *corps*. Along with Jean Hue and others such as Alain Halbout (president of the SNCH from 1970 to 1974) Charlotte argued that it was impossible to ignore the threats of top-down spending controls on the function of hospital director and the environment of public hospitals. The SNCH had thus to react, to enter into the fray, not to launch a programme of managerial reform but to counter the cost containment agenda of the Barre government:

‘We talk now of widening the debate [...] we are orientating ourselves towards proper political-economic problems [...] I would say that, in fact, we have only reacted, that in these circumstances, the initiative comes from the Ministry.’<sup>20</sup>

So, for Charlotte, the health policy commitment was a defensive reaction to perceived external threats best characterised as an ‘externalist’ strategy which engaged the SNCH in the on-going public debate to defend the existing status and working conditions of hospital directors. There was no desire to transform the SNCH into a lobby for hospital management reform. Rather, the union confined debate to a defensive counterattack on the policies implemented by the Barre government. From the Pau conference onwards, it was this ‘externalist’ strategy led by Charlotte which dominated the SNCH; a strategy which welcomed health policy working groups, but took no concrete steps to formulate a programme of managerial reform.

Under Charlotte’s leadership, there was a status quo of discussions without decisions. A shift towards the development of health policy in order to defend the *corps* of hospital directors was endorsed, but the leadership did not actively create the conditions for it to take place. Indeed, the SNCH leadership retained its reservations about the possible politicisation of the SNCH if it was to engage in wider health policy debates outlined by Charlotte at Strasbourg. They were publicly shared by Jean Hue, one of the three vice-presidents of the SNCH from Strasbourg through to Metz, and Roger Alliaud, BN member at Strasbourg and Pau. At Pau, Hue attacked the prospect of specific policy commitments, arguing that it was a question of creating ‘not a doctrine, as one [i.e. opponents] too often demands without measuring the dangers that that represents, but [creating] guiding principles.’<sup>21</sup>

The BN took no action on the outcomes of debates at conference. It made no attempt to use these motions to define an SNCH official position or draw up a concrete

policy document. First, the motions adopted were little more than diverse and somewhat vague references to general principles concerning the structure and organisation of the French health care system (see Table 4.2). Second, the BN did not accept that the documents produced by the working groups were anything more than discussion documents. As a result, the working party debates languished for the twelve months between conferences:

‘These measures [conference reports] were never followed up. It remained at the level of conference speeches [...] Everyone expressed themselves, we were going to revolutionise the world, and then, at the end of the third day of the conference, it's over. Everyone goes home, and then, forgets what they heard for a year, what was said at conference.’<sup>22</sup>

Even this minimal continuity was broken when an entirely new working group was created for Metz, a move which abruptly stalled the small progress towards policy formulation with the production of reports for Pau followed by their integration into a single document at Rouen.

Thus, by the end of the 1970s, there was a three-way split within the SNCH, although the boundaries between each school of thought were blurred because each had no formal organisational structures. The leading spokesmen of all schools of thought co-habited within the leadership of the BN. Fischer and his supporters were united with Charlotte and the ‘externalists’ in condemning government policy, although they were split over which strategy the SNCH should pursue in defence of its interests and their support of a health policy doctrine. The Fischer group’s support for the development of a union health policy position lined them up with the ‘modernisers’ who were gaining in influence within the BN. Yet, the two groups remained divided over their respective attitudes towards the reform process engaged by the Barre government, with Fischer’s group emphasizing a lobby focus and politicisation as distinct from the professionalisation orientation of the modernisers. However, the ties between the modernisers and Fischer’s supporters were strengthened by the common ENSP background of Fischer, Vallet, Vincent and the majority of graduates who dominated the working parties at annual conferences.

**Table 4.2: SNCH Working Parties 1977-1979 - an array of diverse initiatives**

Recognition of the relationship between the general health of a society, its economic system and its health care system. Development of preventative medicine with improved indicators of health status.
Call for improved co-ordination of health care services. Regional planning to provide overarching framework within which hospitals would have their autonomy.
General director and management team of regional hospitals should replace departmental health boards as the external <i>tutelle</i> of public hospitals. <i>Corps</i> of hospitals directors to expand its tasks to include the regulation of hospitals, forming a single self-regulating administrative corps within public hospitals.
Renewal of management practices within public hospitals, with wider use of computerisation and analytical accounting.
Parliament to decide the objectives of the health care system with reduced involvement for Social Security funds. Reform of hospital financing, but no endorsement of the global budget.
Hospital directors to gain authority over all hospital staff including doctors. Increased participation of all hospital staff within hospital management, with the introduction of devolved budgets. Doctors as technicians to be increasingly regulated with the introduction of medical audit.

Indeed, the rise of the *assistanat* generation marked the beginning of a process of renewal within the composition of the formal decision-making bodies of the SNCH. In 1976, ENSP graduates occupied approximately half of the seats in the BN. Graduates of the *assistanat* accounted for three of these posts. Their number subsequently rose to four in 1978 and six in 1980. Parallel to their progressive rise in the BN, ENSP graduates entered the national working groups that the SNCH established on an *ad hoc* basis to report on the chosen themes for debate at annual conferences. At Strasbourg in 1976, ENSP graduates, all from the *assistanat* programme, provided five out of eight hospital directors in the working group on the future of hospital directors in the civil service. At Pau in 1977, ENSP graduates provided 17 of the 30 hospital directors involved in health policy working groups, including 12 graduates of the *assistanat*.<sup>23</sup> Their predominance was temporarily lost at the following conference in Rouen in 1978. However, at Metz in 1979, they represented seven out of ten directors in the health policy working group<sup>24</sup>, including six graduates of the *assistanat*. However, the SNCH did not differentiate itself from its rival unions for some time, maintaining with FO and the CGT an alliance against the measures undertaken by the Barre government (see Chapter Five).

The 'externalist' strategy permitted the proliferation of working groups, but only as a reaction to the progressive top-down controls imposed on public hospitals. It produced a status quo of discussions without decisions. Yet, these changes within the SNCH also began the construction of a substantive knowledge base fuelled by its annual working groups. The trade union benefitted from the entry of ENSP graduates whose common identity helped to overcome the collective action difficulties inherent in such undertakings. The challenge to this status quo came once again from Fischer and his supporters of a rival conception of trade unionism. On this occasion, however, it was a formal challenge as Fischer led an internal faction against Charlotte at his re-election to the BN in 1980. The elections took place at the Grenoble conference in May 1980, hence the name of the Fischer-led faction, *Grenoble 80*. It provided the foundation for what was to be a key transition period in the SNCH's development of a series of health policy measures.

#### 4.2 THE KEY TRANSITION PERIOD

The challenge of *Grenoble 80* marked the beginning of the takeover of the SNCH by ENSP graduates. However, its campaign against Charlotte also tapped the rival constituencies to hospital directors within the SNCH. Its electoral list for the vacant seats on the BN paraded Fischer with Jacques-Yves Coz, a fellow hospital director. But, it also included both Jean-Claude Fréhou, a *chef de bureau*, and Jean-Paul Lemaire, a trainee director, and former outspoken critic of Charlotte on the SNCH's National Commission for Hospital Administrative Personnel.<sup>25</sup> However, the driving force behind the faction came from an ENSP network of graduates revolving around Vallet and Fischer, 'the one who brought in [to *Grenoble 80*] the whole current of thought.'<sup>26</sup> The backbone of this network was forged by personal contacts at the ENSP between the years of 1974 and 1976: Fischer, Vallet, Ravelo de Tovar, Dandel, Hillariet, and Gaussens.<sup>27</sup> However, they were later joined by fellow hospital directors such as Coz and Roland Ollivier. Coz joined the cause of Fischer and Vallet at the 1979 Metz conference.<sup>28</sup> Ollivier, who presented one of the additional reports at the Grenoble conference, was a member of the next graduation after Vallet and Fischer, that from 1977 to 1979.



As if to meet the challenge of Fischer and his supporters at Grenoble, conference debated the report of a working group on the internal organisation of the SNCH and its future strategy in the 1980s.<sup>29</sup> The findings were even presented by Vallet and another supporter of *Grenoble 80*, Alice Rozié. The *Grenoble 80* challenge perpetuated Fischer's attacks on the alleged conciliatory approach of Charlotte to the increasing constraints placed on hospital spending by the Barre government.<sup>30</sup> Indeed, it presumed that such conciliation had not only failed to deliver the necessary improvements in the working conditions of trade union members, but had also led the SNCH, through its absence, to endorse the introduction of cost containment measures, making it:

'the only trade union which did not react to the [government] circulars blocking investments, limiting the growth of hospital technology. We thus gave our backing to the package of measures which really put in doubt hospital services. We should have been at the forefront of the protests, but we were not there.'<sup>31</sup>

In fact, *Grenoble 80* accused the Charlotte leadership of making sporadic and ideologically inconsistent interventions in the quest for short-term gains:

'The governing majority of the trade union has nothing to offer in way of a line of action: it's not a question of embracing the twists and turns of current affairs without an analytical framework.'<sup>32</sup>

To counter these deficiencies, *Grenoble 80* proposed a twin-pronged remedy. First, it advocated internal organisational reform to widen trade union democracy and participation.<sup>33</sup> These reforms would tackle what it saw as the weak accountability of the BN, which not only informally co-opted individuals into its decision-making processes, but also worked too often with no mandate or distribution of information to the grassroots membership.<sup>34</sup> Second, it argued that the SNCH had to act as 'social mediators' defending the interests of its members in the arena of political parties through the promotion of wider social transformations. This role, it argued, could only be achieved through the development of a health policy platform which would enable the trade union to propose reforms rather than suffer from projects inspired by others.<sup>35</sup> *Grenoble 80* was thus the first organised grouping to go beyond the declarations of enlightened individuals and formally promote the development of a health policy doctrine by the SNCH:

'the first to say that if the SNCH did not have a doctrine, that if we did not propose a project, we would not be ... the SNCH was going to die a beautiful death.'<sup>36</sup>

The polarisation between the *Grenoble 80* leadership and the SNCH's governing majority was heightened by the fundamental political opposition between the two camps. The leadership of *Grenoble 80* was primarily composed of left-wing activists and supporters of the *Parti Socialiste*, the PS. Its left-leaning health policy commitments employed a socialising discourse advocating, for example, 'the adaptation of man to his environment and not simply the repairing of his productive force.'<sup>37</sup> Mirroring the policy shifts within the PS in opposition in the 1970s, it gave prominence to preventative medicine, improved patient rights, decentralised planning and increased staff participation in the running of hospitals to

'make the hospital a more democratic hospital, a place of autonomy where decisions could be made in favour of the user up against a statist system which did not appear to take the interests of the hospital into account.'<sup>38</sup>

The PS-label which attached to Fischer and his colleagues amplified their criticisms of the conciliatory stance of the Charlotte leadership to the Barre right-wing government. It further divorced *Grenoble 80* from the governing majority behind Charlotte which was dominated by a right-wing and to a lesser extent, centrist bloc of support. Ironically, Charlotte, although not a card-carrying member, was a known socialist supporter who from 1977 to 1981 sat as a local councillor within the PS group on the Pau town council.<sup>39</sup>

The challenge to Charlotte ended with Fischer losing his place on the BN. And *Grenoble 80* with 29 per cent of the vote was nonetheless shut out by the majority system of elections, securing no representatives in the election of vacant seats on the national executive. The list headed by Charlotte won 61 per cent support, with three 'independent' candidates getting the remaining seven percent of votes cast.<sup>40</sup> Charlotte won a personal vote of confidence, gaining the highest number of votes of any candidate as his list took all four vacant seats on the BN. Fischer only managed to come sixth, beaten into fifth place by his colleague, Coz. This demise of Fischer relegated *Grenoble 80* to the ranks of opposing minority within the trade union; the launch of a formal opposition to Charlotte having brought out in the open the polarisation between the competing factions.

However, support for the aims of *Grenoble 80* came from a group of hospital directors gathered around the vice-president and leading 'moderniser', Vincent. For the rising generation of ENSP graduates, Vincent was very much 'the identikit profile of the

ideal hospital director.<sup>41</sup> Upon graduation from the ENSP, he entered the *Assistance Publique de Paris* where, in 1977, at the age of 28, he was appointed head director of *Hôtel-Dieu*, one of the oldest and most symbolically important hospitals in France.<sup>42</sup> At the end of the 1970s, he mobilised within Paris an informal health policy think-tank which was encouraged by the internal debate over strategic planning within the *Assistance Publique*.<sup>43</sup> The common bond running through its membership was that of generation. Those hospital directors alongside Vincent, such as Christian Anastasy, Patrice Barberousse and Christian Paire, were all aged roughly between 27 and 35 years old and graduates of the *assistanat* programme. Indeed, Vincent was ‘through his age and his charisma, [...] the animator, in effect, of a group, you could say, which was of young Parisian intellectuals.’<sup>44</sup>

The Vincent network had no formal organisation or policy commitments in the mould of *Grenoble 80*. At best, it drew upon the organisational culture of the *Assistance Publique* and demonstrated a more pronounced openness than other directors to the integration of doctors into multidisciplinary management teams.<sup>45</sup> It retained a marked *ad hoc* character when compared to the collective ranks of *Grenoble 80*:

‘The team of Gérard Vincent was more a team of men, you could say of quite brilliant individuals, but who were all promoters of individual projects. Whereas I think that *Grenoble 80*, (with, however, the phenomena of charisma as well, in particular, Jean-Paul Fischer who was an important character at the time,) was, even so, in my opinion, [...] more a team effort, that is to say, that somewhere, it had a collective discipline of reflection.’<sup>46</sup>

However, emerging from their socialisation within the *corps* was the collective ambition to professionalise the *corps* through the assertion of the autonomy of hospital directors as fully-fledged managers:

‘If we chose this occupation, it was not by chance. We wanted to work in the civil service, but we did not want to be civil servants [...]. In fact, we wanted to be managers.’<sup>47</sup>

The means to this common goal was perceived to be the transformation of the SNCH from a traditional trade union defending pay and conditions into the champion of managerial reform:

‘At that time, what struck me was more the lobby aspect of the SNCH: we wanted to make it a lobby. And I believe that we were aware that lobbying needed the constitution, the creation, the affirmation of a collective discourse.’<sup>48</sup>

These organisational principles, inspired by the modernising discourse of Vincent, lent themselves to an alliance with *Grenoble 80*. Held together by their common critique of the 'externalist' leadership, both groups argued that the development of a platform of health policy reforms would increase the SNCH's unity, improve its credibility in the eyes of other actors and encourage managerial change within public hospitals.<sup>49</sup> More importantly, the alliance was facilitated by the *effet de génération* which bound together the leading members of *Grenoble 80* and the Vincent group. They were all ENSP graduates imbued with the same ENSP identity.

In fact, whilst failing to defeat Charlotte, the challenge of *Grenoble 80* ended the cohabitation of informal schools of thought within the BN. It formalised the fuzzy boundaries between rival schools, publicly designating the alliance between ENSP graduates in Vincent's group and *Grenoble 80* as the governing majority elect in the SNCH. However, the alliance between Vincent and *Grenoble 80* had to be cemented and depended upon Vincent's further rise within the BN. Indeed, rather than the challenge of *Grenoble 80*, it was the emergence of Vincent within the governing majority which posed the more serious threat to Charlotte's continued leadership.

After Grenoble, Vincent mobilised increasing support. Christian Paire, one of his lieutenants, entered the BN on the back of the presidential majority at Grenoble. 'Modernisers' in the national executive such as Rolland and Grandjean equally threw their support behind the leader of the Paris modernisers. The polarisation between the Charlotte and *Grenoble 80* factions cast Vincent as a bridgebuilder between the rival camps. Unlike Charlotte, he alone could mobilise the support of both the leading cliques of *Grenoble 80* and the Charlotte leadership. Indeed, Vincent, as vice-president, had one foot in the Charlotte camp as it was. However, his reputation within the SNCH as a 'moderniser' also gave him links to *Grenoble 80*. Equally, his embracing of pragmatic and centrist positions within the BN made him acceptable to the Charlotte camp: 'Vincent very quickly gave the impression of someone who was serious, obviously competent and moderate [...] He, thus, avoided all excesses.'<sup>50</sup> Progressively, therefore, Charlotte's hold over the presidency waned as Vincent, already vice-president, was increasingly accepted within the BN as his natural successor: 'He was institutionally more than a Number Two, he was almost a co-President.'<sup>51</sup>

Charlotte's position as the incumbent president became untenable as delegates at Monaco in 1981 voted to introduce proportional representation for elections to the BN. Charlotte reinforced his hold over the SNCH at Grenoble partly because of the vagaries of the electoral system which shut *Grenoble 80* out of the BN despite its substantial minority vote. After Grenoble, the demands of this official opposition persisted. The decision at Monaco to introduce proportional representation paved the way for *Grenoble 80* candidates to continue their attacks from within the BN. It reinforced the impression that Charlotte was no longer in control of the changing agenda both within and outside the trade union. Having given ground on this issue at the conference, and then been progressively sidelined within the BN, he formally resigned from the presidency of the SNCH. At Mâcon, the BN elected Vincent as President, who was also the chosen successor of Charlotte. At the same conference, Coz became the first director to enter the BN on the *Grenoble 80* ticket.

Thus, by 1982, the key transition of the SNCH to a health policy lobby had been cemented by the ENSP graduates of the *assistanat* programme. The first step in this transition was the challenge of *Grenoble 80*, launched as it was by a generation of ENSP *assistanat* graduates. However, it was its alliance with Vincent and the Paris modernisers, also facilitated by their common ENSP origins, which was the catalyst for change. The lobbyist orientation of Fischer was allied to the professional orientation of the modernisers who sought the increasing autonomy of the *corps*. From these foundations, the SNCH was able to enter into the fray of health policy debates, distinguishing itself from its rivals by adopting a progressive stance on hospital management reform. However, the SNCH leadership had still to settle the demands of the rank-and-file for improved pay and working conditions. The collective action difficulties emerging from these traditional trade union demands had to be minimised by integrating them into the professionalisation strategy of the modernisers.

### 4.3 MODERNISATION AS CENTRAL PLANNING

With the election of Vincent, a clique of a dozen ENSP *assistantat* graduates seized control of the leadership of the SNCH. The backbone of the group was formed by the leading members of the Paris modernisers and *Grenoble 80* as Vincent took his circle of directors into an informal alliance with the former opponents of Charlotte. Symbolically, *Grenoble 80* continued to abstain at conference when it came to voting the annual report of the president.<sup>52</sup> However, Vincent integrated Coz fully into the workings of the BN. Indeed, as Vincent progressively cemented the alliance, his own circle of supporters accused him of being too accommodating of *Grenoble 80's* positions:

‘The president is elected by the majority and is governing with the minority. There is something here that seems to me to be a bit contradictory.’<sup>53</sup>

However, the SNCH’s organisational reliance upon an *homme providentiel*, rapidly biased decision-making towards the views of the newly-elected president and his team of confidantes. At Mâcon, Vincent broke with the indecision of the ‘externalist’ strategy and swung the SNCH’s support behind the global budget and the introduction of departments in public hospitals; the twin pillars of the health policy formulated by the Mauroy government (see Chapter Five and Chapter Six).

This break with the ‘externalist’ strategy imposed new constraints upon the Vincent leadership. The new leadership group sought to tie the SNCH into a wider modernising coalition within the health policy arena and to transform their trade union into a health policy lobby. Yet, the administrative divisions within the relevant ministries were captured by *énarques* (graduates of the elite National School of Administration) and the rival *corps* of *Inspecteurs des Finances*. As far as the Vincent leadership was concerned, this situation dictated both the expansion of the SNCH’s media profile, particularly within the specialised medical press, and the co-ordination of networks of contacts with political parties.<sup>54</sup> Consequently, from Mâcon onwards, the SNCH leadership matched its endorsement of health policy reform with a call to its members to exploit both their pivotal positions within local political and economic networks and their organisational contacts with mayors:<sup>55</sup>

‘Not only to “make them alive to” [our policies], but to make their mandate dependent upon our support so we can obtain a good statute. We

must be strong and, therefore, it suits us to be in league with one of the institutional and political powers of the country.<sup>56</sup>

Leading trade unionists undertook a series of local and fragmented initiatives which ranged from the organisation of regional conferences to the invitation of local politicians to dine with the SNCH president and national delegates.<sup>57</sup> Coz and Vallet were members of the PS. Likewise, Edouard Couty, ENSP graduate, although not a leading militant of the SNCH, was active in the PS Health Commissions. Jean-Xavier Trazzini and Christian Anastasy, a hospital director close to Vincent, were members of the RPR. Indeed, Anastasy was part of a small group of hospital directors who,

‘were very friendly with one another [and] decided to share themselves out into the different political parties [...] Well I [Anastasy] said “Well, you, you go into the PS... You, especially given your beliefs, you go in the UDF. And you, where do you want to go?”’<sup>58</sup>

The end result was that hospital directors started from the mid-1980s to participate in the health commissions of all mainstream political parties: ‘There was a certain number of hospital directors who found themselves within political parties, in the health commissions of these political parties with the will to get their ideas accepted.’<sup>59</sup>

Within the narrow clique surrounding Vincent, the task of engineering a favourable climate of opinion towards hospital directors was allotted to Dominique Paillé who Vincent delegated ‘to create openings within political parties.’<sup>60</sup> Paillé was not an elected member of the BN, but was appointed in 1981 as the first full-time national delegate of the SNCH after the repeated procrastinations of conferences at the end of the 1970s.<sup>61</sup> A graduate of both the Paris Institute of Political Studies and the ENSP, he was widely seen within the trade union as a ‘political animal,’ with little experience of management in public hospitals.<sup>62</sup> He brought with him to the SNCH informal contacts with the christian democratic, *Centre des Démocrates Sociaux* (CDS). Like Vincent, he was identified with the pragmatic centre. Supported by Vincent, he duly exploited the contacts of leading directors who were either well-established or on the fringes of political parties. The two men forged a ‘modernist’ tandem at the head of the SNCH whose close working relationship progressively undercut the influence of the BN on the strategy of the trade union:

‘During the time that Paillé was the full-time national officer, I believe that you could say that almost half of the public discourse of the SNCH was

done by Paillé.<sup>63</sup>

Despite these advances, the SNCH continued to lack its own formal programme of objectives and management reforms. Beyond the endorsement of the global budget and departments at Mâcon, annual conferences hesitated to grant official union-backing to hospital management policy reforms, as they had under Charlotte.<sup>64</sup> However, in preparation for the 1986 legislative election campaign, Vincent moved the SNCH towards the formulation of its own manifesto of hospital management reform.<sup>65</sup> The manifesto, known as the *200 Propositions*, was published in June 1985 and constituted the first formal programme of health care reform voiced by the SNCH.<sup>66</sup> Its formulation engaged a process of consultation to incorporate the views of a committee of experts and regional branches; views which for the most part had already emerged within the working groups at conferences. Nevertheless, the manifesto ultimately bore the imprint of Vincent and Paillé, who argued that the need to synthesize a large number of proposals meant that responsibility should be legitimately concentrated in the hands of the President and the national delegate<sup>67</sup>:

‘These propositions were done in a very simple way and that was that Dominique Paillé, [and] Gérard Vincent called people up [...] like me, for example, and people decided and provided their contribution individually.’<sup>68</sup>

In fact, the *200 Propositions* bore witness to the ascendancy behind Vincent of the managerial culture of the *Assistance Publique* (see Table 4.3).<sup>69</sup> In keeping with the centralised structures he had experienced throughout his career, the manifesto called for increased managerial autonomy of hospitals, but maintained an overarching framework of top-down regional planning to regulate the development of services in both the public and private sectors. After consultation, regional health boards would formulate development plans within which the medium term plans of public hospitals were obliged to fit. Individual contracts agreeing service developments and guaranteeing the necessary finance would then be signed between hospitals and health boards. However, hospitals would have increased managerial freedom to reach their contractual objectives, albeit within the framework of the global budget. Control of hospitals by health boards would move from being *a priori* to becoming an *a posteriori* evaluation.<sup>70</sup> Hospital directors



would have complete freedom to move funds across budgets and to place funds on the financial markets. In addition, the internal organisation of hospitals would move towards increased deconcentration and participation of staff within management, with the introduction of human resource management and incentive schemes. Multiple cost centres would be set up, with each centre signing contracts with the management within the framework of the hospital's general policy.<sup>71</sup>

**Table 4.3: The 200 Propositions - Modernisation As Central Planning**

Regional health boards to formulate decentralised regional plans. Hospitals define own medium-term plans setting out medical objectives and future development plans.
Regional health boards approve hospital plans against the background of regional plan; approval cemented by hospital-health board contracts with guaranteed financial backing for investment plans.
Move to a <i>posteriori</i> evaluation. The departmental health boards, the DDASS, to ensure no more than coherence decisions taken with medium term plans and approve the budget. Hospitals free to meet objectives of contracts as seen fit and within limits of global budget.
Directors free to move funds within hospital budgets with access to the financial market for loans and the placement of funds.
Introduction of human resource management and incentive schemes. Internal contracts between cost centres and hospital management.

These moves towards the development of the SNCH as a health policy lobby satisfied one of the primary objectives of the *Grenoble 80* manifesto. However, the union did not break entirely with the strategy of collective bargaining endorsed by Charlotte. Like his predecessor, Vincent sought to exploit the legitimacy gained for the SNCH from its 'sensible' actions and its development of 'insider' networks. Indeed, his strategy rested upon his capacity to convince government that the union's leadership could guarantee its members' discipline. He refused to condone strike action which not only jeopardised his strategy but also placed untenable demands upon the organisational resources of the SNCH:

'We do not have the right to behave like rank-and-file trade unionists. Our trade union is strong because it has come of age and it knows not to go beyond certain limits.'<sup>72</sup>

However, the discipline required for the modernist strategy could only survive if the Vincent leadership delivered the pecuniary rewards desired by the rank-and-file. At the annual conference at Angers in 1984, *Grenoble 80* was quick to renew its calls for strike action, although it did no more than refuse to vote the president's annual report.<sup>73</sup> The

conversion to the modernising strategy affected primarily the leadership group surrounding Vincent. Rank-and-file members remained more concerned with pay and conditions, producing a schizophrenic trade union with

‘its modernist leadership labouriously seeking to provoke the birth of a new race of ‘hospital manager’, but dragging behind itself a rank-and-file which is not always in its own image.’<sup>74</sup>

In the short-term, Vincent bargained that support for hospital management reform would deliver improved pay and conditions for hospital directors. In the long-term, he wagered that the modernisation of public hospital management would reinforce the line-management function and the ‘strategic apex’ within public hospitals. So Vincent tied the SNCH to a discourse which integrated the demands for improved pay and conditions with managerial change within public hospitals:

‘To conceive of the role of hospital director, but in a renovated hospital, and to never dissociate this from the individual stature of hospital directors themselves... I believe that Vincent was a visionary for that. ... He knew how to provoke in his entourage and in the profession an understanding that... ‘We keep that which is good for me but what is also good for the hospital.’ I believe that that was truly an innovative discourse and a cultural revolution.’<sup>75</sup>

The increasing financial constraints placed upon public hospitals helped the Vincent leadership accomplish its task of redefining accepted ‘best practice’ within the *corps*. The imposition of the global budget in 1983 put an end to the pump-primer that was the patient-day rate and reinforced the top-down financial controls on public hospitals. This changing environment sparked a grassroots cultural revolution within the *corps* as the ‘director-builder’ aiming to expand the number of beds in her hospital gave way to the ‘director-manager’ searching for efficiency gains.<sup>76</sup> The director-manager elevated the language of private sector management, obliged by financial constraints

‘to invest in programmes for better management, for the better use of resources [...] and that’s how we [hospital directors] were led to take decisions as managers and no longer like administrators...decisions as managers which have effectively certain similarities with decisions in firms, directors of firms.’<sup>77</sup>

The popularisation of private management techniques spread through the *corps* by means as diverse as participation in training programmes and managerial conferences, daily contacts with private sector suppliers, professional journals such as *Gestions*

*hospitalières*, and SNCH documents. The *Association des Anciens Élèves de l'ENSP* held its own conference days.<sup>78</sup> 'Pathfinders' such as Louis Omnès at Lorient publicised management improvements within their own hospitals, spreading them through the diverse professional networks of the *corps*. Trazzini and Paillé formed the *Association pour le développement des innovations hospitalières*.<sup>79</sup> Other directors attended courses only to then popularise the themes through interpersonal networks:

'I, like a lot of others, followed, for example, training courses of the type "projet d'entreprise". And I think that these courses aroused among the majority of us an obvious interest and as we meet up even so quite a lot in the profession, we keep ourselves more or less up to date with the actions that each other are carrying out in their establishments. And, finally,... there was a mutual enrichment of each others' diverse experiences.'<sup>80</sup>

At the forefront of much of this evolution in 'best practice' were those directors who were sent by the Health Ministry on the advanced managerial courses at the prestigious business school, the *École des Hautes Études Commerciales* (see Chapter Five).<sup>81</sup>

Thus, by end of 1985, the SNCH had assembled many of the attributes associated with lobbies and learned societies. Once elected, Vincent renounced the 'externalist' strategy of Charlotte and tied improved working conditions for hospital directors to the reform of public hospital management itself. Working with Paillé, he led the development of a distinct platform of policy commitments, endorsing the global budget and the introduction of departments. These commitments went hand in hand with the creation of SNCH networks within traditional political parties. The reformist discourse propagated through these networks was characterised by a belief in planning as the means of achieving increased managerial discretion for hospital directors. The *200 Propositions* which proposed a system of regional planning reflected the dominance within the Vincent leadership of the managerial culture of the *Assistance Publique*. However, Vincent did not discard the responsible trade unionism advocated by Charlotte which placed increasing pressures on his Mâcon strategy. Rank-and-file discipline remained contingent on the Vincent strategy reaping the promised rewards of improved pay and conditions. More importantly, rival market-led conceptions of the function of hospital directors came to challenge the planning vision advocated by Vincent. These conceptions, fuelled by grassroots changes in 'best practice', emerged in the late 1980s under the banner of *hôpital-entreprise*.

#### 4.4 QUASI-MARKETS AND *HÔPITAL-ENTREPRISE*

*Hôpital-entreprise* was inextricably bound up with the advancement of the statutory interests of the *corps*. In its most rudimentary expression, it encapsulated no more than the introduction of private management techniques into public hospitals. In a sense it broke with the progressive public administration of the past to borrow from the 'new public management' discourse, which argued that the public sector could be managed using methods employed in the private sector.<sup>82</sup> However, its likening of public hospitals to private enterprises and its recognition of the risks and organisational culture of the private sector also provided a vehicle for the collective aspirations of hospital directors to professionalise the *corps*. Once again, it borrowed from the new public management agenda which argued for the increased discretion of managers at the grassroots. Like their counterparts in private enterprise, directors were to be free to manage, with the assumption that this would lead to greater efficiency and control of resources. Indeed, Vincent and Paillé argued that if public hospitals were enterprises, albeit particular forms of enterprises, then as in private sector firms management was crucial to their success.<sup>83</sup> Hospital directors were not administrators, but managers who should be paid accordingly:

'Because a business is the opposite of an administration, it is necessary that the director of a firm does not have the status of a civil servant, that he is paid as a salaried manager of a firm.'<sup>84</sup>

The espousal of *hôpital-entreprise* by the SNCH leadership exploited the evolution towards private sector ideologies within political parties. The slogan was raised without substance from conference to conference in the 1970s and early 1980s as a leitmotif for modernisation.<sup>85</sup> However, in the mid-1980s, its new public management connotations mirrored the entrepreneurial discourse voiced across the political spectrum from the PS through to the RPR. Following the 1983 economic policy reversal of the Mauroy government, the PS government reconciled itself with the private sector and the values of free enterprise and the market.<sup>86</sup> Equally, at the 1986 legislative elections, the gaullist RPR with its interventionist traditions endorsed a free market economic platform inspired by the policies of Thatcher and Reagan.<sup>87</sup> Its manifesto for hospital management reform embraced the language of *hôpital-entreprise*, advocating increased managerial

responsibilities for directors.<sup>88</sup>

Within the SNCH, *hôpital-entreprise* was primarily popularised by an emerging right-wing tendency orbiting around the RPR directors, Alain Grenon and Jean-Xavier Trazzini. These two directors came from the clique of directors surrounding the Vincent leadership. Grenon hailed from the 'modernising' wing of the SNCH. Trazzini even stood on the Vincent list for election to the BN in 1985. However, in 1986, Grenon led his own list against Vincent at elections to the BN at the annual conference at Bordeaux. Its programme called for a recognition of the entrepreneurial nature of hospital directors' tasks. And exploiting the resentment felt at the influence exerted upon Vincent by leaders of *Grenoble 80*, it alleged that the Vincent leadership was too compliant in its dealings with the socialist governments of Mauroy and Fabius (the mirror image of *Grenoble 80*'s previous attacks on Charlotte).<sup>89</sup> At the elections, the Grenon list won approximately 21 percent of votes cast, while *Grenoble 80* achieved 26 percent. The pro-Vincent list won 43 percent of votes and two of the four seats being contested to ensure its majority on the BN.<sup>90</sup> However, from Bordeaux onwards the Vincent leadership was outflanked on its left and its right, and although Grenon did not possess the necessary status of being one of the union leaders, Vincent did face a competing project of hospital management reform.<sup>91</sup>

Following this first right-wing challenge, the Vincent leadership dedicated its 1987 Lyon conference to an evaluation of the concept of *hôpital-entreprise*. In the run-up to conference, Trazzini led an internal working group in the formulation of the principal conference report, '*Hôpital-entreprise, mythe ou réalité?*'.<sup>92</sup> In parallel, from the end of 1986 and through the first half of 1987, he worked with Grenon and Michel Le Guennec, a member of FO, but fellow RPR supporter, on a manifesto for hospital management reform commissioned in November 1986 by Michèle Barzach, the gaullist Junior Minister for Health in the Chirac government.<sup>93</sup> Barzach asked the three RPR directors to produce a series of draft managerial reforms to ease the straitjacket of the global budget. The ensuing government report, known commonly as the Trazzini report, was published in June 1987, after the SNCH's annual conference in May.<sup>94</sup> Consequently, throughout late 1986 and 1987, although far from a threat to Vincent on the BN, the emerging 'RPR wing' of the SNCH dominated debates over professional practice; the SNCH rode with the tide of the changing political environment and the demands of Barzach.

However, the Trazzini-inspired reports were not entirely divorced from the official policy stance of the SNCH. The skeleton of the *200 Propositions* resurfaced in both the Lyon conference document and the Trazzini report (see Table 4.4). Running through the different programmes was the common framework of decentralised planning, contractualisation and increased ‘zones of freedom’ for directors. Indeed, the Trazzini report recognised the need to lay down safeguards about the dangers of total deregulation of public hospitals. It accepted the demands of public service, common staffing policies and funding constraints which worked against the adoption of either the statute of private companies or the aim of profit maximisation. However, whereas the *200 Propositions* made great store of its decentralised but somewhat top-down system of planning, the Trazzini report devoted more time to the benefits of less administrative control over public hospitals.<sup>95</sup>

**Table 4.4: The Trazzini Report - A step on from the 200 Propositions**

Zones of freedom for public hospitals, with moves towards <i>a posteriori</i> monitoring and evaluation by health boards.
Contractualisation of objectives, with strategic targets between hospitals and health authorities in a negotiated <i>projet d'entreprise</i> . Hospitals free to reach agreed targets as seen fit.
A bottom-up budgetary process, with annual contracts defining objectives between personnel and management.
Equality of treatment for hospitals and private clinics, with more collaboration between hospitals and private clinics.
Loosening of financial management enabling directors to place funds and have free access to the financial markets.
Encouragement of improved methods of human resource management.

In fact, the managerial culture or view of the world which accompanied the two sets of reports was markedly different. Vincent exploited the concept of *hôpital-entreprise* very much as a modernising slogan for a package of managerial reforms formulated in past conferences in the 1970s and early 1980s. In keeping with his renowned pragmatism, he justified his use of *hôpital-entreprise* because it created an echo in the media.<sup>96</sup> He did no more than pay lip-service to the concept of *hôpital-entreprise*, leaving it to Paillé to adopt an overt ‘entrepreneurial’ discourse.<sup>97</sup> Socialised within the centralised management of the

*Assistance Publique*, Vincent had ‘absolutely no comprehension of the entrepreneurial dimension of public hospitals. For him, the hospital hadn't got a strong identity, hadn't got an autonomous strategy.’<sup>98</sup> From the conference platform at Lyon, he recognised hospital directors as *chefs d'entreprise*, but was quick to rebuff the liberalisation of the market for health care services:

‘This theme is fashionable and allows certain [individuals], notably outside the hospital profession to think that by managing hospitals like enterprises [they] will finally solve, as if by miracle, the haunting problem of the Social Security deficit. [...] Hospital managers in the SNCH are not dreamers who would think that hospitals are enterprises, that it is necessary to abolish the *tutelle* [the DDASS] and let them do what they want - the fantasy of a few reckless individuals who confuse freedom and irresponsibility liberalism and corporatism. Because they live through the money of the French, the public hospital must lay down in front of the principles and schemes defined by those who govern.’<sup>99</sup>

In contrast, the Lyon conference report advocated the heightening of managerial freedom and competition between hospitals to usher in a market for new activities which would ‘reward the better, let’s say, health [projects]’.<sup>100</sup> For the zealots, public hospitals would compete openly in the marketplace under the stewardship of hospital directors who as the ‘true bosses’ would stand or fall by the success of their strategies in the market:

‘push[ing] the system right to the end of its logic that is to say that the hospital effectively no longer has a budget, [...] if private clinics are better they should take the share of the market, it's up to hospitals to be good.’<sup>101</sup>

This rupture with civil service culture demanded an end to the principle of seniority and the introduction of strict performance evaluation and sanctions for failure to reach objectives (as with all managing directors in the private sector).<sup>102</sup> Of course, hospital directors would receive improved pay and working conditions in exchange for this increased risk.

The emergence of *hôpital-entreprise* highlighted the cleavage within the SNCH leadership between ‘statists’ who placed hospitals within a top-down planning system and ‘autonomists’ who stressed the freedom of hospitals within a competitive market for health care services. Members of *Grenoble 80* such as Vallet tended to voice their disapproval of the underlying values of the concept of *hôpital-entreprise*. However, the cleavage crosscut the left-right axis within the SNCH; not all members of *Grenoble 80* voiced disapproval (see below). It reflected more accurately the distinct managerial

cultures separating directors within the *Assistance Publique* and larger organisational structures from those in the provinces (see Chapter Three). Directors outside the large teaching hospitals demonstrated more support for the autonomist line than those who worked inside centralised managerial hierarchies. Indeed, statist, typified by Vincent, replicated the centralised planning prevalent within regional teaching hospitals and the three hospital groups in Paris, Lyon and Marseille.

This maturing division within the leadership did not threaten the Mâcon strategy. Vincent's hold over the SNCH somewhat masked the cleavage between statist and autonomists. His espousal of modernisation and pragmatic use of the language of *hôpital-entreprise* was sufficient to offset challenges to his leadership. Indeed, the formal Grénon challenge began to falter even after Bordeaux. However, Vincent's refusal to endorse the *hôpital-entreprise* programme weakened the claims to professionalisation which were at the heart of the modernising discourse. *Hôpital-entreprise* ensured the autonomy of hospital directors and pushed the *corps* to throw off the shackles of state regulation. Vincent, who endorsed a renovation of hospital management through regional planning, began to defend the trade union and lobby orientations of the SNCH against those who elevated the professional dynamic of the SNCH. Yet, challenges to his leadership persisted as the SNCH failed to deliver improvements in the working conditions of hospital directors.

### *Challenges to the Vincent majority*

The change of government in 1986 with the RPR-UDF coalition replacing the PS brought little immediate reward for the *corps* of hospital directors. Indeed, Vincent was obliged to hold a special conference in Paris on 10 March 1987 to discuss the union's tactics, faced with the continued failure of the Chirac government to grant improvements in the statute of hospital directors.<sup>103</sup> This conference sent a message to the Chirac government, but also reflected the discontent of grassroots activists. In the aftermath of the March conference, the Vincent coalition fragmented as Christian Paire, one of the stalwarts of the 'modernisers' and vice-president of the SNCH, created with Flourent, Van Costenoble and Barberousse, an opposing tendency, *Agir et Renover*.<sup>104</sup> Its threat to Vincent manifested itself in further demands for statutory advances and criticisms of the



union's internal running. Harping back to similar criticisms to those of *Grenoble 80*, *Agir et Rénover* attacked the media-dominated strategy followed by the Vincent leadership as well as the centralisation of control within the SNCH and the lack of representation for its different occupations. This said, it did not contest the moves under Vincent towards SNCH involvement in health policy debate:

'We would like to underline again how much we appreciate the evolution of the SNCH over the last five years, notably under the drive of its president, in terms of the major debates relating to public hospitals and across the media.'<sup>105</sup>

However, it proposed that the SNCH should return to its policy of political neutrality, adopt more assertive traditional forms of action, not excluding strikes, and undertake 'less political behaviour and more trade union behaviour.'<sup>106</sup> *Agir et Rénover* raised the spectre of the traditional trade union function which the lobby/profession orientation of the Vincent leadership had sublimated.

At elections to the BN in Lyon in 1987, *Agir et Rénover* presented its own list of candidates, winning a single seat on the BN with 18 percent of votes cast.<sup>107</sup> However, it represented little threat to the Vincent presidency as the ailing *Grenoble 80* assured the BN of its total loyalty to Vincent in June 1987.<sup>108</sup> Indeed, support for Vincent within the SNCH was contingent upon his success in the statutory negotiations with the Chirac government. *Agir et Rénover* were riding upon a wave of discontent with had relatively weak foundations within the trade union. Both opposing tendencies, *Agir et Rénover* and *Grenoble 80* tried to tap cross-occupation support in their attacks on the Vincent leadership, placing non-directors in key positions in their electoral lists.

However, once the Chirac government delivered the promised statutory improvements to directors in spring 1988, the Vincent leadership reinforced its hold over the SNCH (see Chapter Six). The Reims 1988 conference was at times no more than a self-congratulatory celebration of the gains made by Vincent for hospital directors.<sup>109</sup> The Vincent list won an overwhelming majority at the elections to the national executive, winning all the vacant seats on the BN.<sup>110</sup> This shift sparked off an internal resettlement/renegotiation of the existing cleavages within the SNCH. The clean slate of the Vincent majority meant that *Grenoble 80* lost the voice of Coz on the BN, winning only 17 percent of the vote: having scored its lowest vote ever at elections to the BN, the tendency entered into terminal decline. Shortly afterwards in March 1989, Vallet and Coz

publicly wound up *Grenoble 80*, citing the adoption by the Vincent leadership of most of the *Grenoble 80* platform as the reason for its demise.<sup>111</sup> Grenon's autonomist challenge also petered out at Reims in the absence of any independent candidates to the BN. Indeed, after Reims, Trazzini left the BN to concentrate upon his work in the *Conférence des Directeurs des Hôpitaux Généraux*.<sup>112</sup>

Against the background of these events in the spring of 1989, the ruling group of hospital directors surrounding Vincent refashioned the settlement which underpinned his leadership of the trade union. First, the leadership of the defunct *Grenoble 80* was formally integrated into the union's governing majority of the SNCH - a change publicly cemented by the constitution of 'joint' lists for the elections to the BN at the annual conference in Orléans in 1989. Under the banner of 'With the President', Coz, led the majority Vincent list with the official support of Vallet, Grandjean and Rolland.<sup>113</sup> Second, the emerging fissure between statist and autonomists within the SNCH was welded together at a special seminar at Corbiers in February 1989, which involved the BN and a few invited guests including Coz. It thrashed out the formula of hospitals as public health enterprises, *entreprises publique de santé* which gained cross-union support.<sup>114</sup> The Eight Point SNCH Charter defined at Corbiers stated as its fourth aim that 'the SNCH wants to promote the Hospital as an effective enterprise which responds to the health and social needs of its clientele.'<sup>115</sup>

However, less than two months after Corbiers, as the SNCH prepared its Orléans conference, Vincent left the presidency of the trade union. On 19 April 1989, Claude Évin, Minister of Solidarity, Health and Social Protection in the Rocard government, appointed Vincent to the post of *Directeur des Hôpitaux*. Vincent was the first hospital director ever to accede to this post. His departure, when it was generally believed that he was to move to the *Saint-Antoine* hospital in Paris, came one week after the launch of the rewriting of the 1970 Hospital Law by the Rocard government (see Chapter Seven).<sup>116</sup> It immediately broke the Vincent-Paillé tandem which had defined the strategy of the trade union since the 1982 Mâcon conference. With Vincent gone, Paillé, although remaining in the BN, subsequently resigned as national delegate to work as general secretary for the centrist parliamentary group, the *Union du Centre* (UDC). Rolland then became interim president until the election by the BN of a new president at the Orléans conference.

In the run-up to Orléans, Rolland failed to assert his claims to the presidency. Despite his tenure of the interim presidency, the BN elected Coz over Rolland in what Coz himself described as a 'big surprise... a clap of thunder.'<sup>117</sup> Although he was outside the BN at the time of Vincent's departure, the former stalwart of *Grenoble 80* emerged as a compromise candidate, who was acceptable to the members of both the former Vincent majority and its opponents such as Paire. His leadership of the Vincent list returned him to the BN in time for the election of president. In addition, he could call upon the support of Paire<sup>118</sup> whose criticisms of the Vincent leadership matched those previously voiced by *Grenoble 80*. Both factions decried the absence of internal organisational reform and called for firmer action, particularly in favour of non-hospital directors within the SNCH.<sup>119</sup>

Vincent's departure did not reverse the strategy pursued by the SNCH since Mâcon. As expected, Coz continued to push for hospital management reorganisation as a vehicle for improved pay and conditions for hospital directors. In response to the Évin initiative, the SNCH formed an internal working party to formulate its reply to the legislative proposals of the Rocard government. Composed of roughly ten individuals, it was led by another stalwart of *Grenoble 80*, Ollivier. However, as work progressed, the working party revealed the new core of decision-makers orbiting around Coz: 'Very, very quickly, it was reduced to three or four people, people like Rolland Ollivier, Christian Paire, Michel Pallot [who replaced Paillé as national delegate].'<sup>120</sup> With Coz and Paire sharing common criticisms of the Vincent leadership, Ollivier proved to be closest within the ranks of *ex-Grenoble 80* stalwarts to the positions endorsed by Paire.<sup>121</sup> Indeed, he progressively endorsed moves towards an autonomist managerial line:

'For the first time, a path was open which implied that the mission of public service could very easily be achieved with private sector methods. I admit that people like me, as well as others noticed that. There was an important conceptual turning point.'<sup>122</sup>

In fact, Coz, working outside the *Assistance Publique* and large regional hospitals was typical of those directors who, like Trazzini (in the RPR), were more or less seduced by the autonomist line. *Grenoble 80* had always endorsed a programme 'more aimed at the idea of autonomy, of responsibility.'<sup>123</sup> However, his transition as president, although remaining identified with the Left, was facilitated by the general swing towards modernisation and the withdrawal of the state in national politics.

Assured within the presidency, the leadership alliance under Coz, progressively exposed its autonomist credentials, borrowing from the discourse of *hôpital-entreprise*. If little else, it offered Coz the opportunity to distinguish his tenure from that Vincent and assert his fledgling presidency. However, this emergence of the autonomists was marked by the acceptance of the legal framework of an *Établissement Public Industriel et Commercial* (EPIC) to govern the managerial attributions of public hospitals. Frequent conference debates in the 1970s had rejected the concept of EPIC because of its commercial connotations.<sup>124</sup> However, inspired by the EPIC framework granted to *France-Télécom* in 1990, a transition towards EPIC status was accepted by the Coz leadership because it would lessen the external managerial controls on public hospitals.<sup>125</sup> For Coz, it was central to the status of the corps of hospital directors that directors be granted managerial autonomy:

‘Let everyone understand that your social status will and will only be what is the degree of freedom of the hospital in relation to its present status of a hospital-administration.’<sup>126</sup>

EPIC status permitted diverse co-operation with the private sector and freed up the management of hospital personnel, because all but the directors and public accountants lost their civil service standing and gained that of the private sector. However, more importantly, the SNCH attached itself to a legal framework which carried a significant message: hospitals were equated to commercial and industrial public organisations such as *France-Télécom*. It brought the professional orientation of the SNCH to the fore, privileging the increased managerial autonomy of hospital directors and aligning them to entrepreneurial leaders of the strategic apex of public hospitals.

Thus, in the early 1990s, with the departure of Vincent, the policies of the SNCH moved closer to the spirit of *hôpital-entreprise* as the autonomist line within the trade union cemented a new consensus. The emergence of *hôpital-entreprise* was driven by the right of the SNCH although autonomists eventually mobilised behind Coz, the *Grenoble 80* stalwart. Indeed, with the election of Coz, the opposition to Charlotte and the centrist leadership of the SNCH took control of the trade union. Coz allied with Paire and Ollivier and, although on the Left, ended the statist orientation pursued by Vincent. However, Vincent’s departure did not threaten the pursuit of the Mâcon strategy. The strategy had borne its fruits at Reims. The evolution within the SNCH from trade union to lobby and

to learned society was accepted within the union's elite and survived the departure of its main advocate. Vincent handed over to one of his generation.

## CONCLUSIONS

The internal development of the SNCH was driven by the urge of ENSP graduates to piece together a professionalising discourse at the head of the trade union. That the SNCH was the main vehicle chosen by ENSP graduates to carry their collective aspirations demanded in itself an unlikely redefinition of its established practices. Despite its group identity, the union was tied to the delivery of pecuniary benefits for its membership which included not simply hospital directors, but also general hospital administrative personnel. Trade unions, fraught with the collective mobilisation difficulties surrounding the delivery of pecuniary benefits, sit uneasily with the organisational dynamic of professions. Professions, whilst not ignoring material benefits, elevate the definition and creation of expertise, originating knowledge and making technological improvements. These traits justify their autonomy and self-regulation in the workplace.

However, the discourse of ENSP graduates promoted organisational change within the SNCH as a means of delivering pecuniary benefits for the rank-and-file membership. It advocated the development of the SNCH as a health policy lobby whilst tethering the future status of the *corps* to hospital management reform. Indeed, Vincent and Coz both maintained to conference that pecuniary benefits would accompany the continued evolution of hospital directors at the forefront of the strategic apex of public hospitals. They coupled the organisational dynamics of trade unions to that of learned society, expanding the knowledge base of the *corps* and that of lobby delivering legislative change. However, this approach did not fully resolve the tensions between the relatively autonomous leadership, focused on the presidential 'messiah' somewhat above the rank-and-file. The merger of organisational dynamics sidestepped the demands of rank-and-file in the short-term, but ultimately the Vincent strategy depended upon the delivery of improved wages and conditions. This imposed a constraint upon the leadership, since the BN was obliged to refuse calls for strike action not only because of the resources demanded by such action, but also because strikes undermined the professional orientation

sought by ENSP graduates.

The catalyst for a challenge to existing practices within the SNCH was the failure of the collective bargaining endorsed by the Charlotte leadership. However, the ensuing shift, sparked by Fischer and his colleagues, towards health policy debate at SNCH conferences was neutralised by the 'externalists' who minimised the moves towards health policy debate to nothing more than a necessary response to the imposition of top-down controls on hospital financing. The key transition was the emergence of both *Grenoble 80* around Fischer and the 'modernisers' around Vincent who were driven by their own agendas: a rival model of trade unionism and the promotion of the *corps*. Vincent, acting as a bridgebuilder between the Charlotte leadership and the supporters of Fischer, subsequently brought the two camps together under a modernising strategy at Mâcon. The alliance was facilitated by the common presence of a generation of ENSP graduates within *Grenoble 80* and the modernising clan surrounding Vincent in Paris. As Thoenig illustrates in the case of Bridges and Highways, change passed through a generation of 'young turcs.'<sup>127</sup> Indeed, when Vincent left the presidency of the SNCH in April 1990, the torch simply passed on to a fellow *assistanat* graduate, Coz. With the appointment of Coz, a long standing supporter of *Grenoble 80*, the changes in the leadership of the SNCH came full circle: the original opposition to the centrist leadership of Charlotte took control of the SNCH.

The integration of Coz into the Vincent camp reflected the ENSP background of the dozen or so directors orienting around Vincent and Paillé, the national delegate. However, Vincent's discourse, which interpreted the modernisation of hospital management within an overarching framework of regional planning, was challenged by the *hôpital-entreprise* and market orientation endorsed by Coz. Indeed, in the 1980s, the primary cleavage within the SNCH was that between statist and autonomists. This cleavage progressively became entwined with the professional dynamics within the trade union. *Hôpital-entreprise* was the vehicle for the professionalisation of the *corps*, since it implied the autonomy of hospital directors and state withdrawal from the management of public hospitals. This elevation of the professional dynamic was confirmed rather ironically when Vincent, the moderniser more in tune with the professionalisation of the *corps*, left the SNCH and Coz, in contrast more tied to the clan of lobbyists in *Grenoble*

80, took over the presidency.

Finally, the transition within the SNCH to health policy lobby increased the resources at the disposal of its leadership. First, it upgraded the substantive knowledge at the disposal of the *corps*. The working groups within conference produced an array of diverse measures, first formalised in the *200 Propositions*. Although in no way exercising a monopoly over such knowledge, the SNCH stole a march over the *Fédération Hospitalière de France* and *Force Ouvrière* which converted rather belatedly to the positions endorsed by the SNCH. Second, the establishment of a national delegate in the form of Paillé transformed the lobbying capacity of the SNCH. This lobbying was supported by the entry of directors into the networks and working groups of political parties; a movement orchestrated by Paillé and Vincent. Third, the linkage between the different organisational dynamics running through the SNCH lessened the collective mobilisation difficulties facing its leadership. However, the internal changes within the SNCH cannot be divorced from changes in the public sector and its environment. The cost containment of the 1980s produced a grassroots evolution of management and conceptions of 'best practice' within the *corps* which was exploited by the SNCH leadership. Indeed, the transitions within the SNCH mirrored the changing balance of the political parties and ideologies within the French political system. The emergence of the left-leaning *Grenoble 80* and the adoption by Vincent of a planned solution to hospital management corresponded with the rise of the French Socialists. The transition towards *hôpital-entreprise*, driven initially by right-wing directors, shadowed both the warming of the French Socialists towards the private sector and the arrival in office of a Gaullist-Giscardian government committed to the market. The next part of the thesis examines how these evolutions within the SNCH interacted with successive French governments and enabled it to gain both pecuniary benefits and influence within the policy-making process.

## ENDNOTES TO CHAPTER FOUR

1. M. Burrage, K. Jarausch, H. Siegrist (1990), 'An actor-based framework for the study of the professions' in M. Burrage and R. Torstendahl, (eds), *Professions in Theory and History. Rethinking the Study of the Professions*, London: Sage, p.208.
2. *L'Hospitalier* (1976), no. 326, p.48.
3. *L'Hospitalier* (1976), no. 326, p.55.
4. L. Giralde, *L'Hospitalier* (1976), no. 327, p. 5.
5. G. Poisson, *L'Hospitalier* (1976), no.323, p.9.
6. *L'Hospitalier* (1976), 'Pour un statut des directeurs d'hôpitaux', no. 326, pp. 82-89.
7. *L'Hospitalier* (1976), 'Pour un statut des directeurs d'hôpitaux,' no. 326, p.89.
8. *L'Hospitalier* (1976), no. 326, p. 51.
9. *L'Hospitalier* (1976), no.326, p.52.
10. *L'Hospitalier* (1976), no.326, p.56.
11. A third of BN members were elected at each annual conference.
12. L. Giralde, 'Pourquoi je ne me représente pas...', *L'Hospitalier* (1978), no.341, pp.23-25.
13. C-G. Charlotte, *L'Hospitalier* (1978), no. 353, p.26.
14. G. Chodorge, interview, 19 February 1992.
15. C-G. Charlotte, 'Pau 1977, un tournant?', *L'Hospitalier* (1977), no. 333, p. 9.
16. *L' Hospitalier* (1977), no. 336; *L'Hospitalier* (1978), no. 341.
17. *L'Hospitalier* (1979), no. 350.
18. See, for example, his speech at the Rouen conference, *L'Hospitalier*, no. 341, April 1978, p. 42.
19. B. Grandjean, speech to the Metz conference, *L'Hospitalier* (1979), no. 353, p. 35.
20. G. Barsacq, *L'Hospitalier* (1979), no. 353, p.25.
21. J. Hue, *L'Hospitalier* (1977), no.336, p.70.
22. L. Rolland, interview, 01 July 1992.
23. There were in total 36 trade unionists involved in working groups at Pau.
24. There were in total 12 trade unionists involved in the working group.
25. *L'Hospitalier* (1980), no. 358, p.20.
26. R. Ollivier, interview, 30 June 1992.
27. A. Halbout, interview, 17 March 1992. Based on names occurring in *Grenoble 80* documents published in *L'Hospitalier*.
28. J-Y. Coz, interview, 11 May 1993.
29. See conference proceedings, *L'Hospitalier* (1980), no. 361.
30. For summary of the positions adopted by *Grenoble 80*, see 'Projet de Charte: Grenoble 80', *L'Hospitalier* (1980), no. 362, pp. XX; 'Grenoble 80: qui sommes-nous?', *L'Hospitalier* (1981), no. 367, pp. 15-16; 'Forum sur la Charte de Grenoble 80', *L'Hospitalier* (1982), no. 369, pp. 8-11.
31. J-P. Fischer, *L'Hospitalier* (1980), no.361, p.25.
32. 'Projet de Charte: Grenoble 80', *L'Hospitalier* (1980), no.362, p.34.
33. *Grenoble 80* proposed the wider distribution of information, the reinforcement of regional trade union structures, the attribution of a concrete rôle to the *Conseil National*, the appointment of a full-time national delegate and, the attendance (with voting rights) at meetings of the BN of the national representatives of all the occupations within the SNCH. 'Projet de Charte: Grenoble 80', *L'Hospitalier* (1980), no.362, p.33.



34. 'Projet de Charte: Grenoble 80', *L'Hospitalier* (1980), no.362, p.33.
35. 'Projet de Charte: Grenoble 80', *L'Hospitalier* (1980), no.362, p.33.
36. Coz, interview, 11 May 1993.
37. *Grenoble 80* also advocated the introduction of health service funding by taxation and the redistribution of funding responsibilities between the government and social security funds. See 'Grenoble 80: Qui sommes-nous ?', *L'Hospitalier* (1981), no.367, p.15.
38. Ollivier, interview, 30 June 1992.
39. *Le Figaro*, 05 December 1994; L. Rolland, interview, 01 July 1992.
40. *L'Hospitalier* (1980), no. 361, p. 45.
41. C. Anastasy, interview, 03 February 1993.
42. *Le Monde*, 20 December 1983,
43. C. Paire, interview, 06 July 1992.
44. Paire, interview, 06 July 1992.
45. Paire, interview, 06 July 1992.
46. Paire, interview, 06 July 1992.
47. G. Vincent, interview, 17 May 1993.
48. Paire, interview, 06 July 1992.
49. Vincent, interview, 17 May 1993.
50. J. Le Behec, interview, 28 February 1992.
51. Paire, interview, 06 July 1992.
52. Ollivier, interview, 30 June 1992; Paire, interview, 06 July 1992; Rolland, interview, 01 July 1992.
53. C. Anastasy, *L'Hospitalier* (1984), no.382, p.32.
54. D. Paillé, interview, 18 March 1992.
55. For example, see the call-to-arms of J-L. Romanens, *Hospitalier-Actualités* (1986), no.45, p.7.
56. Romanens, *L'Hospitalier-Actualités*, p.7.
57. For example, Christian Anastasy, organised all-party debates in the region of Poitou-Charente. Jean-Pierre Gusching, when director of the general hospital of Amboise, invited Gérard Vincent and Dominique Paillé to dine with Michel Debré, former Prime minister and chair of the hospital Board of Trustees, and his son, Bernard Debré, leader of *Solidarité Médicale* and advisor to Jacques Chirac. C. Anastasy, interview, 03 February 1992; M. Buisson, interview, 23 March 1992; J-P. Gusching, interview, 16 March 1992.
58. Anastasy, interview, 03 February 1992; although P. Rayroles argues these initiatives were not overly co-ordinated, interview, 27 February 1992.
59. Anastasy, interview, 03 February 1992.
60. Vincent, interview, 17 May 1993.
61. Delegates at Metz voted unanimously in favour of full-time officials upon the report of a working party created at Rouen in 1978. However, Charlotte, fearing financial difficulties, delayed the appointment of a national delegate, arguing at one point that the BN had temporarily resolved the issue through the creation of a monthly information bulletin and the computerisation of the membership list. See, for example, *L'Hospitalier* (1979), no.353, pp.54-56.
62. G. Chodorge, interview, 19 June 1992.
63. Paire, interview, 06 July 1992
64. See, for example, proceedings of Angers (1984) and Caen (1985) in *L'Hospitalier* (1984), no. 382 and *L'Hospitalier* (1985), no. 386.

65. D. Paillé, *Hospitalier-Actualités* (1985), no.39.
66. SNCH, '200 Propositions', supplement to *L'Hospitalier* (1985), no. 385; *Le Monde*, 14 June 1985, p.12.
67. Paillé, interview, 18 March 1992; Vincent, interview, 17 May 1993.
68. R. Ollivier, interview, 30 June 1992.
69. SNCH, '200 Propositions', supplement to *L'Hospitalier* (1985), no. 385.
70. SNCH, '200 Propositions', pp. 9-26.
71. SNCH, '200 Propositions', pp. 61-92.
72. *L'Hospitalier* (1984), no.382, p.35.
73. *L'Hospitalier* (1984), no. 382, pp.31-32.
74. *Libération*, 14 September 1983.
75. Rayroles, interview, 27 February 1992.
76. G. Bédex (1990), 'Qui sont les directeurs?', *Vie Sociale et Traitements*, no. 18, pp.20-21.
77. Le Behec, interview, 28 February 1992.
78. Rayroles, interview, 27 February 1992.
79. *Le Quotidien du Médecin*, 03 August 1984.
80. Le Behec, interview, 28 February 1992.
81. Rayroles, interview, 27 February 1992; J. de Kervasdoué, interview, 18 February 1992.
82. C. Hood (1991), 'A public management for all seasons?', *Public Administration*, vol. 69, no. 1, pp. 3-19.
83. *Le Monde*, 18 December 1985.
84. Chodorge, interview, 19 June 1992.
85. See the conference proceedings in *L'Hospitalier* (1977), no. 336, p. 70; (1979), no. 350, p. 18 and no. 353, p.33.
86. For the changing economic policy of François Mitterrand, see *Le Monde*, 11 March 1995, supplement, 'François Mitterrand, Artisan de son destin', p.xiv; P. Bauchard (1986), *La guerre des deux roses*, Paris: Grasset.
87. P. Fysh (1991), *Gaullism and the Liberal Challenge -How parties change their programmes: the case of the RPR, 1978-1986*, Ph.D., London: London School of Economics.
88. *Le Quotidien du Médecin*, 03 March 1985.
89. *L'Hospitalier* (1986), no.392, p.69.
90. The remaining ten percent of votes were won by a list representing the specific interests of the administrative personnel and categories within the SNCH. *Hospitalier-Actualités* (1986), no. 46, p. 6.
91. Paire, interview, 06 July 1992.
92. *L'Hospitalier* (1987), no. 395, pp 16-20; *Le Quotidien du Médecin*, 20 May 1987.
93. *Le Quotidien du Médecin*, 29 June 1987.
94. *Le Quotidien du Médecin*, 29 June 1987; *L'Hospitalier* (1987), no. 397, pp. 9-22.
95. *L'Hospitalier* (1987), no. 397, pp. 9-22; *200 Propositions*, p.10
96. *L'Hospitalier* (1986), no.390, p.28.
97. Paire, interview, 06 July 1992.
98. P. Domy, interview, 03 July 1992.
99. *L'Hospitalier* (1987), no.395.p.7.
100. *L'Hospitalier* (1987), no.395, p.17.

101. Ollivier, interview, 30 June 1992.
102. *L'Hospitalier* (1987), no. 395, pp.12-13.
103. *Hospitalier-Actualités* (1987), no. 52, p. 7.
104. For a summary of the positions of *Agir et Rénover*, see *L'Hospitalier* (1988), no. 397, pp. 27-28.
105. *L'Hospitalier* (1988), no. 397, p. 28.
106. *L'Hospitalier* (1988), no.397, p.28.
107. *Hospitalier-Actualités* (1987), no.53, p. 5.
108. *Hospitalier-Actualités* (1987), no. 53, p.3.
109. *Hospitalier-Actualités* (1988), no. 59, pp. 6-11.
110. *Hospitalier-Actualités* (1988), no. 59, p. 26.
111. *Hospitalier-Actualités* (1989), no. 63, p.2.
112. *Hospitalier-Actualités* (1988), no.59, p.1.
113. *Hospitalier-Actualités* (1989), no. 64, p. 8.
114. Rolland, interview, 01 July 1992.
115. *Hospitalier-Actualités* (1989), no.65, p.6.
116. *Le Quotidien du Médecin*, 21 April 1989.
117. Coz, interview, 11 May 1993.
118. G. Chodorge, interview, 19 June 1992.
119. *Hospitalier-Actualités* (1988), no.58, p.3.
120. M. Buisson, interview, 23 March 1992.
121. Paire, interview, 06 July 1992; *Hospitalier-Actualités* (1988), no.58, p. 3.
122. Ollivier, interview, 30 June 1992.
123. A. Halbout, interview, 17 March 1992.
124. See, conference debates in *L'Hospitalier* (1976), no. 326, p. 45 and (1977), no. 336, pp. 45-54; *Le Quotidien du Médecin*, 23 May 1977.
125. Coz was influenced by the example of France-Télécom, interview, 11 May 1993; see E. Cohen (1992), *Le colbertisme 'high tech': économie des télécom et du grand projet*, Paris: Hachette.
126. *Le nouvel hospitalier* (1990), no.6 p. 20.
127. J-C. Thoening (1973), *L'ère des technocrates*, Paris: Editions de l'Organisation, p. 89.

**PART II**

**HOSPITAL DIRECTORS AND KEY POLICY CHANGES**

## CHAPTER FIVE

### REORGANISING HOSPITAL FINANCING: THE INTRODUCTION OF THE GLOBAL BUDGET

The system of hospital financing based on patient-day rates helped to sustain the state-medical profession compromise in France by devolving ultimate control of hospital spending to doctors. This allocation of roles aided and abetted hospital directors in the management of annual budgets, although the patient-day rate was only one of a range of accounting rules which bolstered local control of spending (see Chapter 2). However, faced by mounting financial pressures for cost containment in the 1970s, the Barre government began in earnest to claw back control of financial aggregates from local actors from 1976 onwards. This centralisation through top-down controls on financial aggregates led to the replacement of the patient-day rate system by the global budget in 1983, and forms the focus of attention here. At this point, I broaden out attention from the previous narrow individual-group perspective to look at the SNCH's interactions with other actors and government in the policy networks shaping hospital management policy.

The introduction of the global budget was the first managerial reform that Vincent's modernist SNCH leadership openly supported as it strived to push the hospital directors' union towards the role of health policy lobby. Its early support for the global budget signalled the SNCH's evolving strategy, reversing the union's previous opposition to financial reform. The change tied future improvements in the terms and conditions of hospital directors to hospital management reform. The opening section of the chapter examines the first moves to cost containment under the Barre government from 1976 to 1981. The second analyses the arrival of the Left in office in 1981 and its reversal of the controls on hospital spending. The third details the Mauroy government's policy reversal in June 1982 and its return to top-down controls on financial aggregates. The final section provides an account of the formulation of the global budget under the Mauroy government in 1983.

## 5.1 EARLY MOVES TO TOP-DOWN CONTROLS

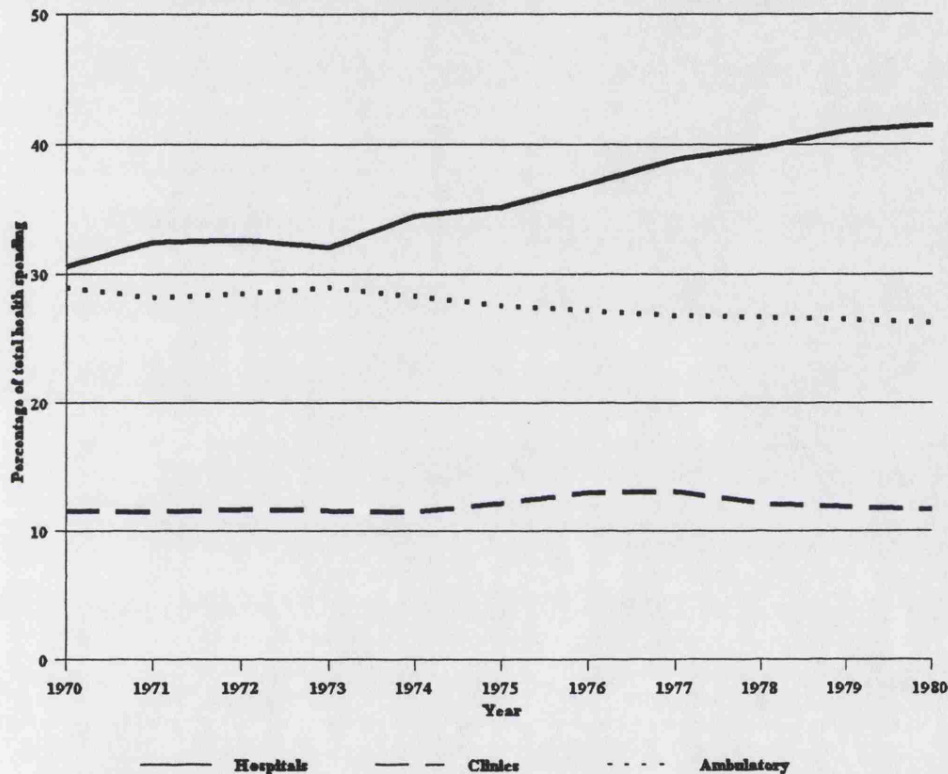
By 1980, spending on hospital services, both public and private, reached over half of all health care spending in France. The motor behind this rise was spending on public hospitals which increased throughout the 1970s at a rate which outstripped spending on both private clinics and ambulatory care (see Figure 5.1). The patient-day rate, with its in-built capacity for hospitals to manipulate funding by massaging the length of patient stays, largely explains this growth (see Chapter One). By 1980, public hospital spending accounted for over 40 per cent of total health spending (as opposed to 30 per cent in 1970).<sup>1</sup> This rise in hospital spending occurred at the same time as the stagflation of the French economy, following the 1973 oil crisis, which placed increased pressure upon the funding of the health sickness funds, the CNAMTS. With each subsequent decline in economic growth and rise in unemployment, the CNAMTS received fewer contributions with which to finance the bill for its comprehensive insurance coverage, let alone match growth in demands fuelled by rising technological costs, demographic changes and inflation.<sup>2</sup> From 1975 onwards, the French government began to experience its first serious financial difficulties with the CNAMTS. One participant recalled:

‘financial problems, we started to get them uniquely from 1975 onwards... I was occupied with all that, 1971, 1972, 1973, 1974, 1975. I saw the Hospital Law [in 1970] and its implementation problems and, then, we had no financial problems with the Social Security... The first time that we had them, serious ones, it was 1975.’<sup>3</sup>

In response to the failed reflationary programme undertaken by the Chirac government, Raymond Barre, a market liberal and faithful Prime Minister of the president Giscard d'Estaing, swung from September 1976 towards a monetarist economic policy. He aimed to control inflation, reduce the public spending and foreign account deficits and improve the monetary position of firms.<sup>4</sup> In line with the squeeze on public spending, the Barre government introduced from 1976 a series of top-down controls on hospital investment and development programmes (see Table 5.1).<sup>5</sup> Simone Veil, Health Minister, argued that the control of spending would not be achieved through the reform of hospital financing, but rather through ‘the mastering of [health service] structures.’<sup>6</sup> This stance assumed that the absence of a finite demand for health care created the conditions for

supply to produce its own demand. Controls on the health care infrastructure would thus ultimately quell rising costs within public health care systems. These controls reached their logical conclusion at the end of 1979 when the Barre government endowed the Health Minister with the right to close hospital wards even against the wishes of public hospitals.<sup>7</sup>

**Figure 5.1: The rise of public hospital spending 1970-1980**



**Table 5.1: Top-down controls on investment and development 1977-1979<sup>8</sup>**

<b>August 1977:</b> Prefects forbidden to grant hospitals permission for any projects which would increase the number of beds. Limits subsequently placed on increases in hospital personnel (not to go beyond 1.5 percent of the existing total).
<b>March 1978:</b> The proportion of hospital investment programmes able to be financed by recourse to external loans limited to 60 percent of the total outlay. In practical terms, this meant that projects had either to be either self-financing or supported by government subsidies.
<b>September 1979:</b> Hospitals obliged to include within investments programmes the measures which would enable them to finance any increased costs through efficiency savings. Approval for projects over 10 billion French Francs transferred from the Prefect to the Health Ministry. Increases in hospital personnel ended.
<b>December 1979:</b> Health Minister could unilaterally close hospital beds and wards if requests to do so were ignored

However, controls on the supply of hospital services were undermined by the declining length of patient-stays, driven by improved medical technology, which permitted a greater throughput of patients in existing beds.<sup>9</sup> Indeed, whilst controls on the supply of hospital services were prioritized, Veil also announced, in May 1975, the launch of trials of the global budget and a more sophisticated variation of the patient-day rate, the *prix de journée éclaté* (see Table 5.2).<sup>10</sup> The Finance Ministry delayed the start of the trials because it considered that the two proposed reforms did not provide a sufficiently radical alternative to the patient-day rate.<sup>11</sup> The reform was initially announced for October 1976, but it was not until May 1977 that the Barre government eventually announced the development of simulations of the two replacements for the patient-day rate before their introduction in selected hospitals in 1978.<sup>12</sup> The practical trials began in January 1978 and were scheduled to last for two years.<sup>13</sup> Six hospitals were to participate in the trials with three hospitals testing the global budget and three hospitals testing the *prix de journée éclaté*.<sup>14</sup>

**Table 5.2: Alternative funding mechanisms**

<i>Prix de journée éclaté</i>
Broke the patient-day rate down into its various components (a patient-day rate for hotel costs according to types of hospitalisation and for different types of medical specialisms or discipline, and a charge for expensive prostheses <sup>15</sup> ).
<i>Global budget</i>
Ended individual billing of patients. Annual budget in twelve monthly instalments determined through internal negotiations with medical services.

Introducing the trials, Veil argued that the replacement for the patient-day rate should provide government with more information about the true nature of costs, breaking the patient-day rate into its various components (in keeping with the 1970 Hospital Law).<sup>16</sup> However, by the time the trials began, the priorities of the Barre government were no longer the clarification of hospital costs, but rather the termination of the inflationary nature of the patient-day rate. Even before the lessons of the trials had been learnt, the



government was quick to push for the introduction of the global budget. Only twelve months into the trials, on 31 January 1979, the Council of Ministers endorsed the introduction of the global budget with plans to put the global budget legislation through the National Assembly in the following autumn session. The Prime Minister Raymond Barre announced his support for the global budget in early 1978.<sup>17</sup>

The case in favour of the changeover was twofold. First, the implementation costs of the *prix de journée éclaté* were higher than those of the global budget. It necessitated a high-level investment in analytical accounting, increasing the burden on management teams particularly in smaller hospitals without adequate computer systems. In contrast, the global budget was somewhat of a known quantity which had passed its trials throughout the French administration and was known to have been introduced successfully in Quebec: 'Everyone knew that a budget, it works, I mean there was no need for a great deal of thought.'<sup>18</sup> Second, the global budget offered the possibility of controlling hospital spending whereas the *prix de journée éclaté* was full of loopholes. In the first year of the trials of the *prix de journée éclaté*, the Antoine-Beclère hospital spent more than it would have done if its budget had been calculated using the old system of the patient-day rate.<sup>19</sup>

Yet, despite this support for the global budget, the trials were extended for an indeterminate period at the end of December 1979.<sup>20</sup> The Barre government was hampered by divisions within its parliamentary majority. It had no desire to mobilise opposition by the implementation of unpopular hospital management reforms during the run-up to the 1981 presidential elections, particularly as doctors had already opposed the government's reorganisation of ambulatory care.<sup>21</sup> Indeed, the December 1979 legislation which enabled the Health Minister to unilaterally close hospital beds was never applied. Such conflict-avoidance motivated the Barre government's acceptance of a second version of the *prix de journée éclaté* as five hospitals began further trials in January 1981 (see below).<sup>22</sup> The global budget trials were simultaneously extended to four additional hospitals (one hospital already having been added in January 1980) including regional hospitals which were not previously involved in these trials.<sup>23</sup>

However, the Barre government did move towards a practical globalisation of hospital budgets. The top-down control of investments was progressively supported by

matching controls on the mechanism of the patient-day rate. In 1975, the Chirac government introduced a national guideline on the desired increases in the patient-day rate, the *taux directeur* (TD). In 1977, the Barre government created the National Interministerial Commission for the Rationalisation of Hospital Management. These measures still did not signal any significant controls on the patient-day rate. In 1978, the Interministerial Commission awarded half of the supplementary budgets requested. However, from September 1979, the base calculations for the patient-day rate were significantly altered (see Table 5.3). Progressively, the percentage increases in spending determined by national guidelines no longer applied to the patient-day rate, but to total hospital spending for the previous financial year.<sup>24</sup> These measures were 'of a purely budgetary nature, brutal, so as to limit the infernal game of the patient-day rate.'<sup>25</sup> In practice, such top-down measures as with the shift towards statutory increases in the mass of budgets rather than the patient-day rate, gave the Barre government the global budget in all but name.

**Table 5.3: Steps towards the globalisation of hospital budgets, 1979-1980<sup>26</sup>**

<p><b>September 1979:</b> Increases in patient-day rate no longer calculated according to actual spending for the previous financial year, but according to the prospective budgets drawn up at the beginning of the year. Deficits no longer carried over into the following financial year. Supplementary budgets withdrawn. The TD transformed into statutory ceiling rather than a guideline. Increases above national guidelines required the approval of the Minister.</p>
<p><b>October 1980:</b> the increases in total spending had to be aligned on the predicted increases in the gross domestic product for the forthcoming year.</p>

In fact, the progressive implementation of the global budget did not fit within the timetable imposed upon the Barre government by the 1981 presidential elections. The President, Giscard d'Estaing, appointed Jean Farge as Junior Minister for Social Security in July 1979 and gave him a free hand to balance the books of the CNAMTS in the remaining twenty months before the 1981 presidential elections. Farge and his team saw their task as so urgent that they had to impose top-down controls on hospital budgets rather than move towards the global budget. Top-down controls on the patient-day rate gave the prospect of immediate results, whilst the global budget only offered the prospect of cuts in the future.<sup>27</sup> Indeed, despite previous announcements, there was no proponent

of the immediate implementation of the reform within the Barre government: 'It's necessary to understand quite clearly that as long as we remained within the period of trials, nobody could care less.'<sup>28</sup> Rather, the measures taken by the Barre government shifted aggregate budgetary decisions upwards from local health boards to Farge and his team who demonstrated allegedly more resistance to budgetary increases than local actors:

'Choussat [the Director of Hospitals] arrived with the budgets of the largest hospitals in France ... And I [Farge] would say: "Listen, there it's less 10 percent, there it's less 15 percent and if they make a fuss, they make a fuss and that's that."' <sup>29</sup>

Nevertheless, hospital budgets spiralled above the accepted constraints of the national guidelines encompassed in the *taux directeurs* (TD): 17.2 percent for a TD of 9.8 in 1979 and 17.5 percent for a TD of 11.8 percent in 1980.<sup>30</sup>

### *The SNCH in opposition*

Under the externalist strategy pursued by Charlotte, the SNCH remained in limbo, declaring its opposition to all the possible changes - the global budget, the *prix de journée éclaté* and the patient-day rate. The working groups at conference acknowledged the inflationary nature of the patient-day rate, but shied away from endorsing the global budget. At Pau, the hospital finance working group condemned the implementation of the global budget in Quebec, which it saw as having reduced the managerial freedom of hospital directors.<sup>31</sup> At Metz, it accepted the principle of the global budget, but raised the twin fears that its implementation would not apply to private clinics and that it would be exploited by government to produce a centralised administrative process, setting hospital budgets according to the funding capacities of the Social Security funds.<sup>32</sup>

However, the minority of hospital directors involved in trials did voice their support for the global budget. These hospital directors latched on to the increased managerial responsibilities for directors as they negotiated objectives and internal budgets with doctors. Marc Buisson, involved in the trials at *St. Germain-en-Laye*, argued at Rouen in 1978 that the introduction of devolved budgets increased participation within the management process and eased dialogue with doctors through their involvement in budgetary negotiations.<sup>33</sup> At his hospital, the size of the global budget allocation rested upon the outcome of bottom-up negotiations led by directors with individual services. More importantly, Vincent, himself involved in the trials at *Hôtel-Dieu*, argued that

administrative simplifications and improvements in the cash-flow of hospitals would derive from the monthly payments and the end to individual billing which accompanied the global budget.<sup>34</sup> Vincent and his *Assistance Publique* modernisers had embraced the global budget, although the role of director was to allocate between services a top-down budget set externally. However, this support for the global budget was never an organised opposition to the SNCH's official stance. As long as the trials persisted, Vincent shied away from publicly identifying himself with the reform. He offered a series of non-committal statements both at Rouen and Metz endorsing concerns over the increased involvement of the Social Security funds in the management of public hospitals and the use that government might eventually make of the global budget.<sup>35</sup>

In fact, the dominance of the externalist leadership radicalised the stance of the SNCH towards the Barre government as the union made increasing forays into the health policy arena to defend the *corps* of public hospital directors. At Rouen, the SNCH condemned (with only three abstentions) both the global budget and the *prix de journée éclaté*.<sup>36</sup> Members of the Bureau National interpreted the global budget as a tool to reduce hospital spending whilst blaming hospital directors for budgetary cutbacks: 'a trap that has been set for us... To want to enclose us in these structures [the global budget] is to make us carry the can.'<sup>37</sup> The leadership even intensified its attacks on the Barre government at the Metz conference in 1979 where SNCH delegates 'that some would have easily imagined to be more "moderate" and preoccupied with advancing their claims for improved pay and conditions said all the ill that they think of government policy.'<sup>38</sup> In his opening speech to conference, Charlotte called on delegates to reject the global budget and, attacking the moves towards cost containment, declared that the SNCH refused 'to be the accomplices of a undertaking to demolish the public hospital service.'<sup>39</sup>

Following Metz, the SNCH joined with *Force Ouvrière* and the *Confédération Générale du Travail* (CGT) to castigate in particular both the bill enabling the unilateral closure of hospital beds and the introduction of the global budget. Joint trade union meetings were organised under the banner of a *Tour de France* of grassroots consultation with hospital directors.<sup>40</sup> The trade unions derided claims that public hospitals were the 'gravediggers' responsible for the rising debt of the Social Security funds. They attacked the global budget as a reversal of the long-established policy of hospital modernisation

which threatened to place hospitals within an arbitrary straitjacket of budgetary controls calculated not on the basis of need, but according to the budgetary deficit of the Social Security funds. The change would unnecessarily complicate hospital management (a reference to the negotiation of budgets by each service). Appealing to their 'natural' supporters, they argued that the reform threatened the safety of patients, favoured private clinics who would continue with the patient-day rate and impinged upon the rights of hospital boards of trustees - or, in other words, local Mayors.<sup>41</sup>

However, opposition to the global budget was more pertinently driven by the leadership of the *Fédération Hospitalière de France* (FHF). It reluctantly recognised the inflationary nature of the patient-day rate, but argued that its maintenance was a necessary 'safeguard for the financial autonomy of hospitals' as were adjustments to budgets during the financial year.<sup>42</sup> It lobbied in favour of a simplified version of the *prix de journée éclaté* which provided a standard patient-day rate by medical discipline, but reduced earlier complications by providing no detailed breakdown of costs except for expensive prosthesis and hotel costs.<sup>43</sup> The FHF exploited its ties with politicians, but it was further able to make use of its ties with the *Direction des Hôpitaux* (DH) to hinder any concrete validation of the global budget within the health commissions of the National Plan.<sup>44</sup> Indeed, the DH was 'very much in the hands of the FHF'<sup>45</sup> and, in alliance with the FHF, it manoeuvred the health planning commission to call for the globalisation of hospital spending, but only when conditions were right. As a result of such rearguard lobbying, the trials of the second *prix de journée éclaté* began in the spring of 1980.<sup>46</sup>

Equally, the FHF neutralised the moves by the technical services of the CNAMTS to increase their involvement in hospital budgeting. Led by Patrice Legrand, a graduate of ENA, the national school of administration, the CNAMTS technical services believed the *prix de journée éclaté* to be unworkable and supported the global budget as a superior, but flawed alternative destined to freeze the existing distribution of resources between hospitals.<sup>47</sup> However, the FHF made use of its connections with FO (the head of Social Affairs within the CNAMTS was a hospital director, member of the FHF riding on an FO ticket) to prevent any encroachment of the CNAMTS within hospital budgeting:

'The FHF managed to get itself heard, and I want to say, widely. And, in the spirit of the FHF, the CNAMTS only had two functions: the first was to pay up for the patient-day rate an open till, and the second was to

intervene as a complement to the state in the financing of infrastructure'.<sup>48</sup> In fact, the FHF pushed on an open door because at the end of the 1970s, the philosophy of the CNPF delegates in the health sickness funds readily accepted the defence of the health 'industry' and its funding (see Chapter One).

However, as the Barre government imposed top-down controls on financial aggregates, a coalition of civil servants primarily from the *Inspection des Finances* swept into the health and social divisions of the central administration. Farge, the Junior Minister appointed to resolve the funding crisis facing the Social Security funds, was himself an *Inspecteur des Finances* with ten years experience at the head of the Division of Public Accounts (DCP). He took with him to Social Affairs, Pierre Laturelle, fellow *Inspecteur des Finances* and his former deputy at the DCP. Jean Choussat, another *Inspecteur des Finances* from the *Direction du Budget* (DB) took over at the head of the DH and the general direction of health, the *Direction Générale de la Santé* which were fused for the first time in their history (see Chapter Two). In addition, Jean Marmot, from the Court of Accounts became director of the *Direction de la Sécurité Sociale* (DSS) thereby ending the monopoly of 'lawyers' from the Council of State over the leadership of the DSS. Finally, Dominique Coudreau, health policy advisor to Raymond Barre and also *Inspecteur des Finances*, was appointed director of the CNAMTS in 1979. Within its technical services, Legrand had already assembled a team of economists rather than the traditional legal experts.

Giscard and Barre's assembling of this group signalled a significant change in the regulation of the health policy sub-system as the network of finance personnel increasingly internalised decision-making over financial aggregates. Farge kept a close team of four advisors, sharing a technical advisor on hospital affairs with the centrist Jacques Barrot, who had replaced Veil at Social Affairs. The newly appointed people shared common perceptions of the inadequacies of health care management and the necessary solutions to rising health care spending. Farge said of Coudreau and the other 'financiers' that 'as we were from the same ministry, we already had a certain communality of thinking.'<sup>49</sup> Integral to these shared perceptions was the acceptance that hospital directors lacked the requisite resources to enter into any strategic posts within central government. In the words of Barre, '[we] didn't have opposite us at that time, a *corps* of hospital directors that have the maturity that they have now [in 1992].'<sup>50</sup> At this time, access to the central

administrative divisions was still barred to the *corps* and the 'outsider' SNCH.

Thus, in the initial stages of cost containment, there were neither any structural or organisational reforms nor promotion of hospital managers into the decision-making process. The coalition of 'financiers' assembled by Giscard and Barre did not push towards the implementation of the global budget. The imposition of top-down controls on financial aggregates and the appointment of Choussat weakened the established relationships with the FHF and internalised policy-making. The SNCH under the guidance of the externalists remained wedded to the alliance of anti-modernisers led by FO and the FHF which fought the introduction of the global budget. However, within the SNCH, hospital directors, particularly those involved in its trials, were offering their cautious support to the global budget. Vincent was growing in influence within the national executive, the *Bureau National* (BN) and the modernisation coalition of *Grenoble 80* and the Paris modernisers was beginning to take shape. In fact, the victory of Mitterrand at the 1981 presidential elections and the subsequent election of a PS government under the premiership of Pierre Mauroy in a Union of the Left with the communists, signalled a new stage in the formulation of the global budget; at a time when Vincent was to take control of the SNCH.

## 5.2 THE PHASE OF SOCIALIST EXPANSION

After the 1981 elections, the negotiations between Mauroy and the communist PCF settled upon Health as one of four ministries to be awarded to communist ministers.<sup>51</sup> On 24 June 1981, Jack Ralite, PCF deputy and mayor of Aubervilliers, took office as Health Minister in the second Mauroy government, although he had previously expressed his personal preference for Culture.<sup>52</sup> Ralite was joined at Social Affairs by Nicole Questiaux, supporter of the leftwing CERES faction within the PS, who was appointed as Minister for National Solidarity. However, unlike his immediate predecessors, Ralite was a full minister and Questiaux was unable to exercise any hierarchical authority over his actions.

Ralite packed his *cabinet* with the 'principal actors of the health care commission of the PCF.'<sup>53</sup> He appointed five communist advisors including the former PCF deputy, Gilbert Millet, who acted as a quasi-spokesperson for the PCF health commission within

his *cabinet*.<sup>54</sup> However, Mauroy took the opportunity to remove the DH from PCF influence, ending the joint tenure of Choussat in November 1981. In a compromise agreement, the communist candidate, Professor Guy Roux, was attributed the DGS whilst a known socialist, Jean de Kervasdoué, was imposed at the head of the DH.<sup>55</sup> Kervasdoué, who worked previously within the Planning Office of the *Assistance Publique* as well as the *Centre de Recherche en Gestion de l'Ecole Polytechnique*, was a former advisor to Mauroy as well as a member of the socialist health policy lobby, *Santé et Socialisme*. His forced appointment instilled from the outset a deep-seated cleavage within the Health Ministry between Kervasdoué, the DH and the Ralite *cabinet*.<sup>56</sup>

The Mauroy government embarked upon an economic programme best defined as 'redistributive Keynesianism'.<sup>57</sup> This macro-economic dash for growth relaxed the top-down financial controls imposed upon public hospitals under Barre. At Health and Social Affairs, Ralite and Questiaux repeatedly upped the spending commitments of the Mauroy government as they engaged in a game of ministerial oneupmanship:

'It's her who said that she would not be the Minister of Health Accounts ... She almost added more on top of what we [the Ralite *cabinet*] could have demanded. If there was a competition with Ralite it was in this domain: 'I'm going to do more .... She perhaps had the mission to brake the spending by Ralite, but she didn't do it'.<sup>58</sup>

In the first few months of the Mauroy government, Ralite trumpeted not only the suspension of the National Commission for the Rationalisation of Hospital Management, but also the repeal of five circulars and the December 1979 law which accounted for much of the framework of top-down controls imposed under Barre.<sup>59</sup> He tied his colours firmly to the mast of expansion on 22 July 1981, reinstating supplementary budgets and proclaiming the creation of 2000 personnel posts in hospitals, 1500 further posts as doctors and 1000 new posts in psychiatric hospitals.<sup>60</sup>

In September, Ralite set out on a tour of health care institutions throughout France to prepare the *Chartre de la Santé*, the health charter which was to embody the overarching health care philosophy of the Mauroy government.<sup>61</sup> The global budget was not discarded. It remained one of three interdependent managerial reforms which, along with the introduction of departments in public hospitals and a single statute for hospital doctors, were signalled by Mitterrand in his ten campaign measures dedicated to health.<sup>62</sup> However, the justification for the implementation of the global budget lay no longer in its



capacity to constrain rising spending, but in its concurrent modernisation of hospital management. Underlining the new found relaxation of controls, Ralite gave advance warning in October 1981 of a 'major reform of management and hospital billing' referring to a global financial envelope which could be updated during the course of the financial year.<sup>63</sup>

However, the introduction of the global budget was pushed down the political agenda by the Mauroy government. Initial moves towards more formal consultation continued in October after the end of Ralite's personal tour with a series of four Round Table discussions between Ralite, Questiaux and hospital trade unions and associations. The Round Tables kicked off on 24 November 1981 and ended on 25 March 1982.<sup>64</sup> The November Round Table led to the creation of two working parties for hospital reform which met twice in early January 1982 and were managed by the *cabinets* and the DH (see Chapter Six).<sup>65</sup> However, through the end of 1981 to the spring of 1982, the Ralite *cabinet* was preoccupied with the publication of the Health Charter. The report on the trials of the global budget remained unpublished and the Mauroy government had still to make an overt commitment to the exact nature of the global budget reform. The Health Charter, finally discussed at the Council of Ministers on 12 May 1982, was a vague statement which was more concerned with general principles than concrete policy proposals. Although it committed the Mauroy government to the replacement of the patient-day rate, it made no mention of the global budget.<sup>66</sup>

In practice, the global budget was struck from the agenda as Ralite and his *cabinet* threw established relations with hospital doctors into crisis over Ralite's moves to abolish private pay beds in public hospitals, negotiate a single set of terms and conditions for hospital doctors and widen the entry qualifications for specialists.<sup>67</sup> Such measures undermined the state-profession compromise, particularly the proposal to rid public hospitals of private pay beds. For many hospital doctors this measure broke the 'moral contract' established by the 1958 ordinances.<sup>68</sup> More importantly, the panoply of measures eroded the divisions hampering the collective mobilisation of hospital doctors, and thus prompted umbrella demonstrations.<sup>69</sup> From the end of March through to mid-April 1982, public hospitals were hit by strikes, with demonstrating doctors at one stage even storming Ralite's office.<sup>70</sup>

The Ralite ministry acted as a catalyst for the creation and mobilisation of hospital doctor unions outside the established avenues of the consultative *conférences* for regional and general hospitals. The most vehement opponent to the Ralite ministry, *Solidarité Médicale*, only formed in November 1981 as a common front for health care professionals to defend liberal practice against the impending incursions.<sup>71</sup> Its overriding aim was to do no more than create disorder in public hospitals. The union attended the first consultation meeting on private sector reform in November 1981 only to boycott the rest.<sup>72</sup> Launched by Bernard Debré, grandson of Michel Debré, the organization was progressively dominated by the gaullist RPR *mandarins*, particularly Debré and Canlorbe.<sup>73</sup> Indeed, the RPR officially gave its support to the defence of private sector rights which it designated as an ‘apolitical’ struggle.<sup>74</sup>

However, the policies adopted by Ralite only provide a partial explanation for the breakdown of relations between the Mauroy government and hospital doctors. His agenda reflected the propositions voiced by Mitterrand who stood by his PCF minister, although the President was concerned over the speed of Ralite's proposed abolition of private sector rights.<sup>75</sup> The abolition of private pay beds had been considered by the Court of Accounts and Barrot under Giscard (although ultimately discarded). However, Ralite who already suffered from his communist party affiliation broke the rules of the game regulating consultations between the *mandarins* and the government. First, his communist affiliations were like a ‘red flag to a bull’, tapping into the right-wing hostility of the medical leadership and revealing the paucity of the Left's ties with hospital doctors<sup>76</sup>: ‘I am not saying that [opposition] was only political but a little nevertheless. It is obvious.... Do not forget that we had at first a communist minister.’<sup>77</sup> Second, in his first meeting with hospital doctor trade unions, Ralite invited non-medical trade unions, most notably the communist CGT, to the negotiating table. This change broke with tradition and the acknowledged place of the medical profession. Convinced of the futility of consultation, several unions left the last Round Table in protest at Ralite's methods.<sup>78</sup> The near-total breakdown in the state-medical profession relationship created an opening for the SNCH to acquire influence, which had relatively little to do with the global budget, which lay forgotten in the ministry as the wider battles unfolded.

### *The SNCH and Vincent's arrival*

In the first expansionist months of the Mauroy government, the leadership of the SNCH did little to end its externalist strategy or to depart from the stances endorsed by its rivals. Although at its 1981 Monaco conference, it reasserted its opposition to the private pay beds within public hospitals, it maintained its opposition to the global budget.<sup>79</sup> Indeed, like the FHF and FO, it opposed the August 1981 circulars on trade union rights in public hospitals.<sup>80</sup> These measures played to the clientelistic relationship between Ralite and the CGT, proffering improved rights and conditions of representation upon trade unions in public hospitals, much to the annoyance of directors. At the 'mass' consultation meetings held by Ralite, dedicated as they were to rhetoric rather than specific policy proposals, the SNCH was no more than a face within the crowd of over 50 hospital doctor trade unions.<sup>81</sup>

However, in the spring of 1982, Vincent and his modernising coalition in alliance with *Grenoble 80* took over the leadership of the SNCH (see Chapter 4). No longer president-elect, Vincent put an end to his diplomatic non-committal utterances at conference and adopted promotion of the global budget as the core policy to guide his actions throughout his presidency. Despite its relegation down the policy agenda of the Mauroy government, he regarded the implementation of global budgets as inevitable, calculating that rising hospital expenditure and shorter patient stays would produce politically untenable increases in the patient-day rate.<sup>82</sup> He consequently argued that the global budget was a means of actually staving off severe clampdowns on hospital spending, contrary to popular opinion.<sup>83</sup> More importantly, in the short-term, he bargained that an endorsement of the global budget would set the SNCH apart from the FO and the FHF and alert the Mauroy government to its newly-established modernising discourse:

'My argument was the following. In any event, we will not escape ... the global budget, and it's either one or the other. Either we are its promoters and we come out of the reform with an increased reputation or, we oppose [the reforms] and we will be considered to be reactionaries who have no sense of the general interest'.<sup>84</sup>

Vincent's modernising thesis was buttressed by the fact that hospital directors involved in the trials argued that the global budget fostered new managerial methods, decentralised budgets, medical information and computing systems (see above).<sup>85</sup> Whether bottom-up or top-down in its implementation, the global budget appeared to assert the authority of

hospital directors, reinforcing the line-management and the strategic apex within public hospitals.

Opposition to the Vincent thesis within the union's national executive, the BN, was mute. Charlotte and his supporters were quickly sidelined by the clique of ENSP directors surrounding Vincent. Louis Rolland, who led what little organised opposition there was to the global budget, could only count upon the support of one other member of the BN, Jean-Louis Romanens. Their opposition was subsequently undermined by both their repeated insistence that the patient-day rate had no inflationary tendencies, and their inability to agree upon an alternative to the global budget. Whilst Romanens opposed the global budget regardless of the conditions governing its implementation, Rolland directed his attacks not at the principle of the global budget *per se*, but at the fears surrounding its implementation. He claimed that the global budget trials were falsely managed by the Health Ministry so that directors such as Vincent and his team worked within an artificially flexible global budget which would not be generalised throughout France:

'The government did all it could so it went well. If they [Vincent and his team] had a variation in the level of their activity, immediately, this variation was taken into consideration and the global envelope was readjusted.'<sup>86</sup>

In practice, however, the government, according to Rolland, would discard bottom-up negotiated budgets in favour of an externally-imposed top-down global budget.

However, Vincent neutralised this opposition at conference by ensuring Rolland's appointment as reporter at Mâcon on the conditions for the successful implementation of the global budget. Underpinning Rolland's attacks on the global budget was an acceptance that it could be perfected if certain conditions were attached to its implementation. With Bernard Grandjean, Rolland drew up a list of eight conditions for the successful implementation of the global budget.<sup>87</sup> The two primary conditions were bottom-up budgetary negotiations and the possibility to update the budget during the financial year according to changes in the level of hospital activity and the wider economic situation, particularly changes in inflation. These concessions, voiced at earlier conferences, made the global budget palatable to its opponents, but maintained the SNCH's public signal of support for the global budget, which the FHF and the FO had not sent.

The choice of conference as the forum for the endorsement of the global budget further brushed aside debate within the BN and gave more legitimacy and increased media

attention to the reversal of the SNCH policy. Directors involved within the trials, as well as the Vincent group, had already professed their support for the financial reform. However, the personal engagement of Vincent, allied with the compromise report of Rolland and Grandjean and the lack of counter proposals, swung conference behind the SNCH endorsing the global budget:

‘The membership as a whole would certainly not have followed it [global budget], but the people who were at the conference, I would say that, in the crowd of the conference and with the weight of the president [Vincent] and then, his election, it went through. Gérard took a position for it’.<sup>88</sup>

Conference voted in favour of the global budget as presented by Rolland with only one abstention, that of Romanens.<sup>89</sup>

Following Mâcon, the SNCH leadership duly sought a meeting in June 1982 between a delegation led by Vincent and Ralite to push home the change in leadership and strategy of the trade union. However, Ralite’s appointment negated any possible opportunities for the SNCH to exploit the contacts, despite the informal contacts between *Grenoble 80* and *Santé et Socialisme* whose members were expected to capture the Ministry. There was no SNCH lobby within the diverse networks of the PCF. The trade union’s informal channels of influence born of ‘personal friendships’ with ministers which it had employed in the past simply did not exist now.<sup>90</sup> Georges Merhle, the only hospital director within Ralite’s *cabinet* was on its fringes, viewed suspiciously by his colleagues. Merhle was a graduate of the ENSP and a rank-and-file member of the SNCH. However, he owed his appointment to his work in the PS Health Commission which automatically ‘isolated’ him from his colleagues within the *cabinet* who saw him as the ‘obligatory’ socialist keeping tabs on PCF management of public hospitals.<sup>91</sup>

Nevertheless, Ralite greeted the SNCH’s support for the global budget favourably, interpreting its shift towards the reform as an ‘important step-forward’.<sup>92</sup> He assured the SNCH that it would be involved in the formulation of any global budget reform (as it would be for the hospital reform planned by Ralite for the 1983 spring session of Parliament). For certain members of the BN, the meeting consequently symbolised an acknowledgement by Ralite of the pivotal role to be played by the SNCH in the reform of hospital financing:

‘At the first meeting with the Minister which took place [after Mâcon], Gérard Vincent made known the position of the SNCH and straightaway

the Ministry took in this information and considered it to be [of] fundamental [importance]'.<sup>93</sup>

For Rolland, the Mauroy government was simply waiting for the SNCH endorsement to launch the global budget reorganisation.

Thus, the SNCH's conversion to the global budget, coming after Vincent's election, appeared to members of the BN to have catapulted the trade union into the networks surrounding decision-making. Forcing through the acceptance of the global budget, Vincent led the SNCH to break ranks from rival organisations, particularly FO, delivering a salient message of change to the Mauroy government at a time when it lacked supports to deliver its policies within public hospitals. However, even at Mâcon, the acceptance of the global budget by the rank-and-file floundered upon conditions which the SNCH leadership would find difficult to impose upon any government. Vincent could paper over the cracks at Mâcon simply because Ralite, buoyed by the expansionist policy of the Mauroy government and pre-occupied by the unrest among hospital doctors, failed to advance the global budget dossier.

However, as the Mauroy government mistakenly wagered on international expansion granting France an export-led emergence from recession, pressure increasingly came to bear on public spending in 1982.<sup>94</sup> The deteriorating macro-economic performance of the French economy provided a catalyst for the reorientation of health policy, symbolised by the removal of Questiaux. Calls were made by Mauroy, Jacques Delors, the Finance Minister, and Laurent Fabius, the Budget Minister for the removal of Questiaux who publicly announced that she would not play the role of 'Minister of Accounts'.<sup>95</sup> Marmot at the DSS even complained directly to Mauroy about the behaviour of his minister, pointing out that 'it was useless to go and see Nicole Questiaux to talk to her about hospitals, as if you would go and see Saint Peter in heaven to talk about poker.'<sup>96</sup> Her position became untenable after the Mauroy government agreed the June 1982 deflationary economic programme.<sup>97</sup> On 29 June 1982, Mauroy wrote to Mitterrand arguing that Questiaux 'must go. It's urgent now.'<sup>98</sup> The next day, Pierre Bérégovoy, Mitterrand's General Secretary at the Elysée, replaced Questiaux as Minister of Social Affairs and National Solidarity.

### 5.3 POLICY REVERSAL AND CUTBACK MANAGEMENT

The government reshuffle made Bérégovoy one of the leading ministers within the Mauroy government.<sup>99</sup> Like Farge in 1979, his immediate agenda was dictated by the burgeoning deficit of the Social Security funds. The swing towards economic austerity acknowledged implicitly that private firms could no longer bear the weight of rising social security contributions, privileging the control of rising costs rather than the 'traditional' response of raising receipts to cover welfare deficits.<sup>100</sup> Indeed, Bérégovoy supported rigid public spending guidelines for the Social Security funds, viewing cost containment as the sole means of ensuring the survival of the welfare system.<sup>101</sup> His infamous announcement to waiting journalists upon entering the Ministry of Social Affairs was that, unlike Questiaux, he knew how to count.<sup>102</sup>

The appointment of Bérégovoy ushered in a new division of labour between Health and Social Affairs. Bérégovoy first dispossessed Ralite of his remaining responsibilities for the management of hospital spending and the global budget. He then assembled a ministerial *cabinet* which was suited to the needs of financial management. Grafted on to the remnants of Questiaux's *cabinet* were specialist financial management experts such as Claude Rubiniwicz to improve cash-flows within public hospitals, Marie-Laurence Pitois to work on pension funds and the economists Guy Worms and André Gauron.<sup>103</sup> As his *directeur de cabinet*, Bérégovoy appointed Jean-Charles Naouri, another *Inspecteur des Finances* and author with Simon Nora of a well-known 1978 report on the financing of the Social Security funds.<sup>104</sup> Naouri dominated the team assembled behind Bérégovoy, with Marmot at the DSS readily accepting that intellectually Naouri 'was in Formula One.'<sup>105</sup> In fact, his work with Bérégovoy gave birth to a new strategic axis of decision-making within the Ministry of Social Affairs, as one commentator noted:

'Jean-Charles Naouri [was] the computer who allowed him [Bérégovoy] to put into practice what he had within his head. Rarely has a more perfect symbiosis between politician and technician given such efficient results'.<sup>106</sup>

Through the summer of 1982, Bérégovoy and Naouri formulated a time-honoured mix of income-generating measures and reduced levels of reimbursement to cap the

Social Security budgetary deficit. The first concerted measures came with the 29 July 1982 government circular and the Bérégovoy Social Security Plan on 30 September 1982.<sup>107</sup> These measures included a one percent social security contribution on individual incomes, modified social insurance contributions for the self-employed, a tax on tobacco and alcohol and pharmaceutical advertising, and reduced reimbursement for various treatments. Bérégovoy and Naouri targeted health care spending and, in particular, public hospital spending which continued to increase at a faster rate than spending on general practitioners or private clinics.<sup>108</sup> The Plan abolished supplementary budgets, placed constraints on hospital funding and ordered the CNAMTS to claim back its advance payments from public hospitals (advances paid in order to offset the delay between the billing of the Social Security funds and the payment of hospitals)(see Table 5.4). However, it provoked widespread opposition with its proposal to introduce a daily hotel charge for hospital patients. And opposition to the wider Bérégovoy Plan, let pass its significant announcement that the global budget would come into being from 1984. This first formal announcement of a date for its introduction came less than two months after Bérégovoy's arrival in office.

**Table 5.4: Bérégovoy's moves towards cost containment, July-September 1982<sup>109</sup>**

Abolition of supplementary budgets for 1982.
Social Security funds instructed to claim back part of the monthly advances given to hospitals
Daily patient indemnities after a period of three months were to be refused.
Introduction of a daily hospital charge, <i>le forfait hospitalier</i> .
Limits placed on increases in hospital staff.
Target of 14.5 per cent growth for hospital spending in 1983 (compared with 22 per cent in 1982).
Introduction of the global budget from 1 January 1984.

The swift endorsement of the global budget under Bérégovoy and Naouri was not matched by the DH report on its trials in public hospitals. Finally published in September 1982, it gave the global budget a far from complete endorsement.<sup>110</sup> The authors, none of whom were hospital directors, argued that the trials revealed the limited returns of both variations of the *prix de journée éclaté*, stressing both their complexity (particularly of



decisions surrounding their various components) and the necessary improvements in computer and statistical systems in public hospitals.<sup>111</sup> However, they identified two primary obstacles to the introduction of the global budget.<sup>112</sup> First, the global budget developed for the trials was incomplete: it did not apply to all areas of hospital spending, omitting, in particular, the treatment of outpatients and long-stay patients. Second, its successful implementation required the reorganisation of the Social Security funds. The multiplicity of funds and the individual reimbursement of patients necessitated, even under the global budget, the maintenance of a fictitious system of patient-day rates. Without it, the funds would have no knowledge of the financial contribution of individual funds to the global budgets awarded to hospitals. Indeed, the funds risked losing knowledge of questions surrounding individual reimbursement; the data which generated their statistical system and the information exploited by their own *médecins-contrôleurs*.<sup>113</sup>

In fact, the report concluded that the reform of hospital financing was not as pressing as the need to introduce new managerial systems inside hospitals.<sup>114</sup> It advocated the development of management by objectives, with hospital budgets resulting from bottom-up negotiations between doctors and directors. In this process, doctors, enshrined as heads of cost centres, *centres de responsabilité*, would set future objectives for patient care and receive budgets that would be directly assessed in relation to pre-determined objectives. Hospital budgets would then be discussed with departmental health boards, the DDASS, on the basis of the objectives decided within the hospital. The whole process would rest upon the shift towards the contractualisation of hospital management, both within public hospitals and between public hospitals and the DDASS.<sup>115</sup>

However, Naouri believed that the existing national guidelines of the *taux directeur* (TD) enabled public hospital spending to increase out of control, like 'a ship without a captain drifting with the winds.'<sup>116</sup> He argued that the TD was not a budget since it did not operate on the basis of any pre-set financial limits. Consequently, his agenda was to introduce basic budgetary procedures into the management of the public hospitals system, which was to remain within its overall spending limits, but redeploy existing resources. It became the accepted discourse that the financial difficulties facing public hospitals emanated not from a lack of resources, but an inefficient distribution of resources within the public hospital service, with too many beds given over to psychiatry

in particular. The global budget, within the framework defined by Naouri, would provide the necessary constraints on hospital spending thereby forcing hospitals to shake-out inefficiencies within the service.

Naouri's concerns were mirrored in two reports published by the *Inspection des Finances* and IGAS, the social affairs inspectorate, in July and August 1982 respectively. Both reports stressed the inadequacies of the budgetary process within public hospitals and the disparities that existed between hospitals.<sup>117</sup> They found that the 'across the board' application of the TD had frozen inequalities between hospitals, thereby artificially favouring medical services with a declining level of activity. More importantly, in a third of departments, public hospitals, not averse to 'creative accounting' measures, went beyond the increase in spending dictated by the TD.<sup>118</sup> Such were the inadequacies of accounting procedures and the reliance upon outdated information from the CNAMTS that at no time could the government be sure how much was being spent by public hospitals.

Against this background, Bérégovoy and Naouri obligingly triggered the introduction of the global budget; the final decision to do so remaining the prerogative of this strategic axis within Social Affairs. Matignon voiced its concerns about the political backlash that could follow the implementation of the global budget. Indeed, the presentation of the Bérégovoy Plan at the end of September 1982 coincided with the demonstration, led by *Solidarité Médicale*, of 5000 liberal professionals defending their professions against the threat of bureaucratisation.<sup>119</sup> However, Matignon neither supported the *prix de journée éclaté* nor opposed the global budget. More importantly, Kervasdoué at the head of the DH was the sole representative of the Health Ministry involved within policy negotiations at Social Affairs, and he was not opposed to the introduction of the global budget. He used the reports by the *Inspection des Finances* and IGAS to put the weight of *grands corps* behind the hospital reform agenda.<sup>120</sup> However, he was far from an integral member of the team surrounding Bérégovoy. He had been presented with a *fait accompli* over the return of the CNAMTS advances to public hospitals. Naouri excluded any other actors from influence on the final decision, stressing that the implementation of the global budget was approved 'by ourselves.'<sup>121</sup> It remained to be seen whether the SNCH could overcome this exclusion.

### *The SNCH neutralised*

The Vincent leadership underwrote the lessons of the DH report on the trials of the global budget. In any case, the conclusions of the report supported the SNCH demands for managerial reform, as did those of the *Inspection des Finances* and IGAS. Like the DH report, the SNCH advocated a bottom-up budget that was freely negotiated between hospitals and local health boards, against the background of an established contract setting out the medical objectives of public hospitals.<sup>122</sup> SNCH internal working groups had previously advocated decentralised management by objectives and *a posteriori* external assessments of public hospitals in relation to the attainment of its previously agreed contractual objectives; a philosophy which was to form the backbone of the *200 Propositions* (see Chapter Four).

Following the steps taken at Mâcon, the SNCH leadership continued to project the trade union as a 'responsible' manager of public funds. It publicly supported, in the interests of national solidarity, the wages freeze imposed by the June 1982 economic policy reversal of the Mauroy government.<sup>123</sup> Indeed, the Vincent-Paillé tandem exploited the crisis of relations between the medical profession and the Mauroy government to interpose hospital directors in the dispute as the agents of government ministers. In early July, the SNCH subsequently attacked hospital doctors, blaming the medically induced organisational fragmentation of public hospitals as the source of ever-expanding costs.<sup>124</sup> Perpetuating its calls for the globalisation of hospital budgets, the Vincent leadership commented that: 'If all doctors have not yet understood the notions of public service and general interest, directors have not given up the hope of getting them to understand, even if it will take a long time'.<sup>125</sup>

These public statements promoted the SNCH as an agent of central government within public hospitals, emphasising the hierarchical relations between the ministry and public hospitals. Nevertheless, the union progressively adopted an ambiguous discourse to government policy as the Bérégovoy Plans were announced in the summer of 1982. Despite acknowledging sacrifices in the name of national solidarity, Vincent argued that the September Social Security Plan wrongly asked public hospitals to take the blame for the budgetary deficit of the health sickness funds, the CNAMTS. In contrast, the SNCH leadership blamed the social reforms of the Mauroy government for already having

imposed increased costs upon public hospitals without matching increases in funding. The union refused to countenance the imposition of cost containment measures upon public hospitals and the ending of supplementary budgets for 1982. It questioned the very parameters of the government's discourse, doubting the validity of the rises in hospital spending which were advanced by the CNAMTS.<sup>126</sup> The union position was that claims that public hospital spending accounted for approximately half of the budget of the CNAMTS could not justify budgetary controls on public hospitals without consultation: 'the budgetary restrictions imposed on hospitals cannot be presented as economic rigour, but as arbitrary measures because they are general, blind, and brutal.'<sup>127</sup>

In fact, the modernist leadership was progressively hampered by the conditions attached to the acceptance of the global budget at Mâcon. With the government's decision to implement the global budget already taken, Vincent was publicly obliged to acknowledge the conditions which the previous uncertainty surrounding the global budget had enabled him to relegate in earlier discussions. Indeed, in response to the Bérégovoy Plan, the SNCH leadership resurrected the Mâcon compromise. First, it announced its fears that the global budget would be reduced to a top-down, across-the-board annual percentage increase, calculated upon predicted inflation rates and superimposed upon existing hospital budgets. Second, it demanded the inclusion of a mechanism which both enabled hospitals to re-negotiate their annual budgets after six months of the financial year and took account of rising prices and the changing objectives of public hospitals. Finally, to simplify administrative procedures, the union further argued that the global budget should end individual billing of patients and lead to the automatic coverage of all patients by the Social Security funds.<sup>128</sup>

This combative negotiating policy realigned the SNCH with the positions adopted by FO and the FHF. The modernist leadership was constrained by both the pressures emanating from its rank-and-file members and by competition from its rivals. The SNCH leadership faced a tension between the promotion of its modernist discourse and the fears of a rank-and-file membership still attached to the 'externalist' strategy pursued by Charlotte (see Chapter Four). Neither could the SNCH in its battle with FO and the FHF allow its rivals to monopolise the 'moral high ground' as the sole defenders of public hospitals. The public service ethos permeated the *corps* and had to frame the discourse

of Vincent and the modernist leadership too. However, the SNCH's support for the introduction of the global budget did not falter. At this stage the Vincent leadership was able to maintain an illusion that it could influence the formulation of the global budget, thereby balancing support for the global budget with rank-and-file concerns and competitive pressures.

However, the SNCH had no channels of influence to drive home its demands. Ralite and his *cabinet* were isolated. Naouri and Bérégovoy had little regard for hospital directors. Naouri stated that the SNCH and its Mâcon conference endorsement had no influence on the decision to introduce the global budget (see Chapter 4 and 6).<sup>129</sup> Indeed, the SNCH was unable to cement anything other than a tacit alliance with Kervasdoué at the DH. At best, the SNCH could call on the *corps*-based loyalties of four hospital directors within the offices of the DH in 1982 and five in 1983.<sup>130</sup> Yet, more importantly, Kervasdoué criticised the quality of public hospital management, generating shockwaves in the *corps* of hospital directors, for which collectively he had little esteem: 'He despised it [the *corps*]: he beat us, he said everything to us.'<sup>131</sup> In 1982, Kervasdoué introduced a five-week training programme in private sector management techniques, reserved initially for general directors and then extending to the First Class, at the *École des Hautes Études Commerciales* (HEC), choosing the widely-recognised business school over the *corps*' own ENSP. This programme contributed to the grassroots change within the *corps* as it redefined its best practice (see Chapter 4). Thus, although there was obvious common ground between Kervasdoué and the SNCH, the trade union leadership and the Director of Hospitals:

'didn't have a easy dialogue, it wasn't simple... What has always struck me, personally, is that we [SNCH] were in fundamental agreement with Kervasdoué on loads of things, loads, and that it seems to me that the contact never took'.<sup>132</sup>

Unlike the SNCH, the DH argued that the only form of global budget that would guarantee the control of public spending was a top-down, pre-determined financial envelope.<sup>133</sup> This form of the global budget was tested at Hôtel-Dieu by Vincent, although it was under the 'special' circumstances of the trials. In fact, Kervasdoué merely saw the global budget as the first step towards the development within French public hospitals of the system of Diagnosis-Related-Groups introduced in the United States; a system widely rejected in its early stages by hospital directors.<sup>134</sup>

Consequently, the SNCH was far removed from the core decision-making process which was increasingly internalised in the government. The SNCH leadership was also struggling to advance its Mâcon strategy, given the constraints imposed upon its support for the global budget by the demands of the rank-and-file. However, the Bill had yet to pass through the National Assembly, an arena more suited to lobbying by the SNCH.

#### 5.4 FORMULATING THE FINAL POLICY

The Bérégovoy Plan was put before the National Assembly in late October 1982, slotted by the Mauroy government within a series of measures relating to the management of the Social Security funds.<sup>135</sup> The Bill mapped out the basic principles of the global budget. These principles, responding to the concerns of the DH report, enshrined lead social security funds to manage global budgets in each area, maintaining the patient-day rate for certain payments, and extended the rights of the CNAMTS to assess treatment within wards.<sup>136</sup> However, most of the procedures governing the implementation of the global budget were left to be finalised in administrative decrees. Faced with such a skeleton global budget, opponents to the Bill in the National Assembly persisted in their attacks on the introduction of a hotel charge for hospital patients and taxes on tobacco and alcohol.<sup>137</sup> The Social Affairs parliamentary committee did insist upon the opportunity to revise the global budget during the financial year, but only under the vague terms of an important and unforeseen modification of economic conditions or medical activity. The rightwing majority in the Senate subsequently condemned the global budget as a mechanism that would lead to the rationing of health care.<sup>138</sup> However, designated a 'measure of urgency', the skeleton global budget passed uneventfully through the National Assembly and the Senate, appearing in the *Journal Officiel* on 19 January 1983.

The writing of the decree in spring 1983 coincided with the appointment of Edmond Hervé, Health Minister in the first Mauroy government, who replaced Ralite as a Junior Minister for Health working under Bérégovoy (see Chapter 6). Like Ralite, Hervé and his *cabinet* were excluded from negotiations over the introduction of the global budget.<sup>139</sup> The formulation of the decree was monopolised by a Social Affairs working group composed of Naouri and the Bérégovoy *cabinet*, Marmot from the DSS and

Kervasdoué from the DH. This internalised policy-making even excluded the technical services of the CNAMTS led by Coudreau and the DB who placed its trust in Naouri and Bérégovoy. 'It [the global budget] was done by Naouri, ... me [Kervasdoué], and Marmot. Fullstop. Three people.'<sup>140</sup>

These three dominant protagonists were divided over the extent to which they should associate bottom-up managerial changes with the implementation of the global budget.<sup>141</sup> In keeping with the conclusions of the DH report, Kervasdoué stressed the necessity to introduce new managerial systems within public hospitals. He was opposed by Marmot who was keen to impose merely budgetary and accounting procedures. The head of the DSS argued that the introduction of cost centres and devolved budgetary negotiations within public hospitals over-estimated both the computer services at the disposal of hospital directors and their knowledge of the internal distribution of budgets. He promoted no counter proposals, but saw the propositions for managerial change as unrealistic, claiming that 'in any case, this is not what happens in hospitals, we're going therefore to do a budget ... we'll see [for the rest].'<sup>142</sup>

The deciding vote fell to Naouri who neither supported nor opposed the introduction of new managerial procedures. His primary concern was to impose a restrictive global budget which did not enable hospital spending to rise out of control. Once he ensured that the departmental budget was fixed and controlled by the central administration and that the conditions surrounding the revision of the global budget were set in the vaguest of terms, Naouri was not at all concerned to block the managerial reforms that Kervasdoué wanted. He considered their inclusion was a necessary means of camouflaging the draconian cost-containment measures within the global budget thereby making the reform more palatable for hospital directors who had to implement it: 'I didn't believe in it .... I didn't really believe in that type of thing, but it was put in, I didn't think that it was crucial.'<sup>143</sup>

A compromise which isolated Marmot was negotiated because Kervasdoué was prepared to accept the top-down approach of the global budget as a temporary measure before the introduction of Diagnosis-Related-Groups. He further saw the fixed nature of the departmental budget as a means of altering the disparities between hospitals and between regions. For Marmot, the outcome was, therefore, a global budget that, whilst

adopting new managerial procedures, imposed a top-down budget upon public hospitals in the knowledge that the managerial measures would not be borne out in practice:

‘The launch of the global budget necessitated a whole series of technical, administrative, accounting and computerisation measures which didn't exist. This being the case, they [Naouri and Kervasdoué] put in place a mechanism that could not exist, that only existed in their imagination.’<sup>144</sup>

The decree was made public on 30 May 1983.<sup>145</sup> It put in place a top-down budget set by departmental Prefects by reference to an average increase in hospital budgets which was determined nationally by the government. In other words, the *taux directeur* was retained. Indeed, although budgets could be re-negotiated during the financial year, the terms of their renegotiation were no more defined than they were by the National Assembly. Within public hospitals, the decree confirmed the introduction of individual cost centres, *centres de responsabilités* (CRs), which were to correspond to existing services (or future departments) and be led by head doctors. Hospital directors were to devise statistical records of the activity of each CR in order to monitor its use of resources. Every semester these tables were to provide the basis for an analysis of gaps between results and provisions. Externally, social security funds would form local committees, known as *Commission des 35* after the article of the decree, to monitor hospital spending. However, global budgets were not to cover all hospital spending. They excluded long-stay treatment, ambulance transport until 1987, and outpatient treatment indefinitely.

The decree signalled the introduction of the global budget in regional hospitals from January 1984. The proposed general application of the global budget from 1984 was therefore withdrawn. However, the timetable for implementation was far more extensive than that proposed by the September 1982 DH report which argued that the global budget was best introduced progressively in four regions in 1984, 9 regions in 1985 and 16 regions in 1986. More importantly, an intervention by Mauroy dictated that the new system should not apply to private clinics. Against the background of further disputes with hospital doctors, the Prime Minister committed himself to this stance in an open letter on 29 April 1983.<sup>146</sup>



### *The Mâcon conditions come home to roost*

Until the draft decree was released for consultation at the end of May 1983, the BN devoted little time to discussing the global budget. With no opposition within the BN, Vincent and the SNCH leadership manoeuvred behind the Mâcon compromise, throwing their support behind the global budget whilst pacifying the rank-and-file with the conditions attached to its implementation. However, the utility of the Mâcon compromise for Vincent lessened as the formulation of the draft decree progressed in the spring of 1983: 'I knew that I would have many days ahead criticising the government saying: "Global budget, yes, but not like you're proposing ... you are not negotiating enough".'<sup>147</sup> Once the draft decree was made public, the Vincent leadership was obliged to choose between pacifying the rank-and-file or pursuing its modernist agenda.

In fact, Vincent and the SNCH leadership chose to reject the global budget and accept the now constraining Mâcon stipulations. The SNCH leadership continued its attempts to divorce itself from the cost containment imposed by Bérégovoy. Vincent immediately alleged that the decree openly questioned the legitimate management expertise of hospital directors.<sup>148</sup> The SNCH leadership questioned the failure of the Naouri-inspired global budget to cover all elements of hospital spending, and argued that this move would produce a false globalisation of budgets. Equally, it derided the maintenance of references to the patient-day rate, the failure to reduce the weight of administrative tasks and the absence of inducements for alternative treatments to hospitalisation. Finally, it alleged that the global budget threatened to 'freeze' the existing uneven distribution of public hospital services, prompting Vincent to argue that the decree introduced 'a system that it [SNCH] judges to be, at the same time, truncated, reactionary and sacrificing, in the long-term, the public hospital service.'<sup>149</sup>

This sacrifice was to the interests of private clinics and the CNAMTS, the traditional twin evils of the *corps*. First, the Vincent leadership feared that patients would desert public hospitals for private clinics free from the financial constraints of the global budget. Second, they argued that, in the overriding concerns to balance the books of the CNAMTS, Bérégovoy and Naouri had elevated the CNAMTS to the role of 'second *tutelle*' for public hospitals. Indeed, the draft decree invited the CNAMTS to control hospital doctors at the level of each cost centre or *centre de responsabilité*, fuelling fears

about its influence over medical practice within public hospitals.<sup>150</sup>

However, whatever its criticisms, the SNCH had little access to the triumvirate of decision-makers dictating the new policy's progress. Like other hospital directors involved in the global budget trials, Vincent was a member of a DH working group created in January 1983 to consider the formulation of the global budget.<sup>151</sup> Equally, with Paire and Yves Barrot, assistant director at *Hôtel-Dieu* and the union organiser within the *Assistance Publique*, Vincent met repeatedly with the Bérégovoy *cabinet* as part of the consultation process surrounding the global budget.<sup>152</sup> However, Vincent himself acknowledges that the SNCH at this stage was 'not truly on the inside.'<sup>153</sup> Relations with Kervasdoué were strained (see above) and Naouri and Bérégovoy had little esteem for the *corps* of hospital directors (see Chapter 4).

In addition, Bérégovoy's decision to implement the global budget through administrative decree closed off the 'privileged' policy arena of the Vincent leadership. The decree did not return to the National Assembly for approval thereby removing from the SNCH its possible veto points via deputies, whose multiple office-holding through the *cumul des mandats* meant they often doubled as mayors (see Chapter Two). The decree route weakened the SNCH's capacity to lobby for changes to the global budget: 'We didn't hold the pen. We held the pen much more, in my opinion, ... in laws rather than decrees at the time.'<sup>154</sup> To try and steer the discussion surrounding the global budget back into the wider political arena<sup>155</sup>, Vincent tied the SNCH rejection of the global budget to the alleged threat posed by the CNAMTS to the independence of local politicians on the boards of trustees within public hospitals. Indeed, the SNCH lobbied members of the National Assembly with a letter-writing campaign outlining the financial consequences of the global budget decree upon public hospitals.<sup>156</sup>

At the same time, the SNCH jettisoned its confrontational discourse about the medical profession, opting instead for the supposed benefits of a 'local actor' coalition against the Bérégovoy-Naouri rationalization plans.<sup>157</sup> In general, hospital doctor trade unions criticised the global budget as a 'tourniquet',<sup>158</sup> equating it to no more than the previous system of national guidelines and mistrusting its devolution of the management of the financial crisis to hospital doctors.<sup>159</sup> The *conférences* for regional and general hospitals, concerned over the speed of the introduction of the global budget, were keen to

make it clear in public that hospital doctors would not accept the task of rationing health care for the central administration.<sup>159</sup> However, the SNCH was unable to drag hospital doctors into the policy arena. Despite the rejection of the global budget, the introduction of cost centres, *centres de responsabilités*, run by doctors, was supported by the Vincent leadership. More importantly, hospital doctors were preoccupied with the introduction of departments, the development of the single statute and the ending of private pay beds. The global budget issue did cross over through the question of the boundaries of cost centres into the reorganisation of public hospitals. But, even though the contacts with Bérégovoy ‘were good’:

‘We did not talk a great deal, unfortunately, not enough, about the global budget.... We saw him [Bérégovoy] on two or three occasions, then at the time of... the strike of the internes... but, unfortunately, we didn't talk enough about the global budget’.<sup>160</sup>

In any case, hospital doctors felt that they lacked the reputational resources and expertise to participate fully in the formulation of the global budget:

‘Financial techniques are so complicated ... we are absolutely not competent. And medical trade unions in France have never tried to act as a counterweight [to the *financiers*] because even if we had competent people, they would have told us “it is not your problem”’.<sup>161</sup>

Thus, despite its pretensions to use the global budget to signal its modernist discourse, the Vincent leadership fell back in line with the positions held by the FHF and FO. Indeed, FO and the FHF shared the SNCH's principal reservations about the implementation of the global budget: its top-down determination and vague conditions for supplementary budgets, its elevation of the CNAMTS and its deficit, its maintenance of billing and, its non-application to private clinics.<sup>162</sup> Essentially then, the SNCH returned to the externalist positions defined by Charlotte: for all its changing rhetoric, the union failed to influence the final formulation of the global budget. Bérégovoy and his *cabinet* made minor concessions, extending the global budget to include outpatients and long-stay care from 1985 and ambulance services from October 1987. However, although the 30 May decree was rejected at the second meeting of the consultative *Conseil Supérieur des Hopitaux* on 4 July 1983,<sup>163</sup> sparse account was taken by Bérégovoy of the amendments it tabled. Within two weeks of the *Conseil Supérieur des Hopitaux* finishing its examination of the global budget, the global budget decree was published in the *Journal*

*Officiel* and had passed into the realm of law. It was little different from that presented on 30 May 1983.<sup>165</sup>

## CONCLUSIONS

The twists and turns in government thinking about global budgets partly account for the SNCH's own contortions in responding to the idea. Farge had viewed the global budget not as a short-term, but as a long-term strategy for savings: he had simply tightened the spending limits imposed by the *taux directeur*. But, by 1982, the idea of global budgets stood at the centre of a number of different conceptions of how to control the apparently inexorable growth of public hospitals costs - some emphasizing much shorter term fiscal imperatives to curb budget increases, and some focusing on fundamental management and accountability reforms inside hospitals. This ambivalence allowed the modernist Vincent leadership to edge the union towards accepting the principle of reform on global budget lines, and, then, sustain a distant supportive role during the legislative phase of its implementation. But, the union leadership took fright at the administrative implementation of the project, affronted by their exclusion from decision-making and the all-too-clear cutback intentions of the eventual solution, and conscious that they could not anyway hold their rank-and-file behind such an outcome. Faced by competition from rival unions, some of them better placed to attract the attention of policy-makers, the SNCH leadership saw insufficient basis for anything, but outright opposition to the decree, and were unmoved by the still symbolic concessions to managerial reform which it included.

The SNCH's *volte face* on global budgets, switching from pioneering support to fierce denunciation, highlights the extraordinary difficulties of changing its conventional 'externalist' strategy, and achieving the rebalancing of professional/managerial and trade union orientations upon which Vincent had set his policy. The modernists in the union leadership needed a stable commitment from government to expanding the hospital directors' role before they could hope to persuade their membership to accept potentially disruptive reforms with an eye to the *corps*' long-term future. But, in the crisis conditions of 1982-3, the government itself could not commit to any coherent strategy for rebuilding policy networks. Its immediate cutback imperatives were bound to predominate, but they

were additionally reinforced by the scepticism of the trio of key policy-makers about the hospital directors' capacity to implement meaningful changes.

## ENDNOTES TO CHAPTER FIVE

1. Total medical consumption is defined as the total spending on public and private hospital services, ambulatory care, transport of patients, medicines, prothesis and preventative medicine. Figures based on *Comptes nationaux de la Santé*, Séries 1960-1986 (nouvelle base), SESI, no.4, July 1987.
2. G.A. Freeman (1990), 'Financial Crisis and Policy Continuity in the Welfare State', in P.A.Hall, J. Hayward, H. Machin, (eds), *Developments in French Politics*, Basingstoke: Macmillan, pp. 188-200.
3. D. Coudreau, interview, 26 November 1992.
4. See, V. Ansquer (1984), 'La politique économique de Raymond Barre' in T. Grjebine (ed), *Récession et Relance*, Paris: Economica, pp. 198-205.
5. See, A. Maynard and A. Ludbrook (1983), 'The Regional Allocation of Health Care Resources in the UK and France', *Social Policy and Administration*, vol. 17, no. 3, pp. 232-248.
6. *Le Quotidien du Médecin*, 03 and 24-25 December 1976.
7. M. Mougeot (1986), *Le système de santé: centralisation ou décentralisation?*, Paris: Economica, p. 104; C. Maillard (1986), *Histoire de l'hôpital*, Paris: Dunod, p. 135.
8. See, C. Maillard (1986), *Histoire de l'hôpital*, Paris: Dunod, pp.134-146; M. Mougeot (1986), *Le système de santé*, Paris: Economica, pp. 104-107; Commissariat général du Plan (1986), *Une décentralisation du système de santé*, Paris: documentation Française, pp. 50-52.
9. *Informations-Hospitalières* (1992), no. 34, p. 27; P. Rollandin (1987), *La santé en danger*, Paris: Editions de l'Instant, p. 61.
10. *Le Quotidien du Médecin*, 31 December 1976.
11. *Le Quotidien du Médecin*, 31 December 1976.
12. B. Jobert (1981), *Le Social en Plan*, Paris: Editions Ouvrières, p. 215.
13. *Le Quotidien du Médecin*, 23 December 1977; C. Renon, D. Gautier, J-M. Rodrigues, V. Vu Tien (1982), *Rapport à Monsieur le Ministre de la Santé relatif à l'évaluation de l'expérience de nouveaux modes de financement et de gestion des établissements hospitaliers*, unpublished report to the Minister of Health, September, Paris, p.1.
14. Hospitals testing the global budget were *Saint Germain-en-Laye*, *Hôtel-Dieu* and the *Institut Gustave Roussy*. Hospitals testing the *prix de journée éclaté* were *Chartes*, *Antoine-Beclère* and the traumatology and orthopaedic centre at Nancy. Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, p.1.
15. Separate charges were made for prothesis over 1000 French Francs. See Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*.
16. Article 52 of the 1970 Hospital Law envisaged the introduction of a new system of hospital financing within twelve months.
17. *Le Monde*, 02 February, 1979; *Le Quotidien du Médecin*, 15 and 29 May 1979.
18. Coudreau, interview, 26 November 1992.
19. *Le Quotidien du Médecin*, 29 May 1979.
20. Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, p. 1.
21. M. Lépinay (1991), *Sécu. Faillite sur ordonnance*, Paris: Calman-Lévy, pp.153-160.
22. Tours, Argenteuil, Gonesse, Marmande, and the Charles Perrens specialised hospital at Bordeaux. Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, p.12.

23. From January 1980, the global budget was tested at the Fondation Bergonié in Bordeaux. The four hospitals added to the trials in January 1981 were Amiens, Saint-Etienne, Sarrebourg and the psychiatric hospital at Charleville Mézières. Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, p. 7.
24. See, C. Maillard (1986), *Histoire de l'hôpital*, Paris: Dunod, pp.134-146; M. Mougeot (1986), *Le système de santé*, Paris: Economica, pp. 104-107; Commissariat général du Plan (1986), *Une décentralisation du système de santé*, Paris: documentation Française, pp. 50-52.
25. J. Farge, interview, 14 May 1993.
26. See, C. Maillard (1986), *Histoire de l'hôpital*, Paris: Dunod, pp.134-146; M. Mougeot (1986), *Le système de santé*, Paris: Economica, pp. 104-107; Commissariat général du Plan (1986), *Une décentralisation du système de santé*, Paris: documentation Française, pp. 50-52.
27. Farge, interview, 14 May 1993.
28. Coudreau, interview, 14 May 1993.
29. Farge, interview, 14 May 1993.
30. 'L'Hospitalisation en France', *Informations Hospitalières*, no.34, December 1991, p. 65.
31. 'Modalités du financement d'une politique de santé', *L'Hospitalier* (1976), no.336, 1976, p.105.
32. *L'Hospitalier* (1979), no. 350, p. 33 and pp. 43-49; *Le Quotidien du Médecin*, 14 May 1979.
33. *L'Hospitalier* (1978), no.344, p.82.
34. *L'Hospitalier* (1978), no.344, p.81.
35. *L'Hospitalier* (1978), no.344, p.82 and (1979), no. 353, p.24.
36. *L'Hospitalier* (1978), no.344, p.100.
37. *L'Hospitalier* (1978), no.344, p.81.
38. *Le Quotidien du Médecin*, 14 May 1979.
39. *Le Quotidien du Médecin*, 14 May 1979.
40. *Le Quotidien du Médecin*, 26 April and 14 May 1979.
41. *Le Quotidien du Médecin*, 26 April and 18 June 1979.
42. *Le Quotidien du Médecin*, 28 April and 06 May 1980.
43. The FHF suggested two or three elements: either the existing *prix de journée* with the addition of a breakdown of expensive prosthesis or a *prix de journée* with a single hotel charge, a charge according to medical discipline or speciality and a charge for expensive prosthesis.
44. Jobert, *Le social en Plan*, p.
45. P. Legrand, interview, 17 May 1993 .
46. *Le Quotidien du Médecin*, 28 April 1980.
47. Legrand, interview, 17 May 1993.
48. Legrand, interview, 17 May 1993.
49. Farge, interview, 14 May 1993.
50. Coudreau, interview, 26 November 1992.
51. The other ministries were Transport, Civil Service and Professional Training, see P. Favier and M. Martin-Roland, (1990), *La Décennie Méditerranée 1. Les Ruptures*, Paris: Editions du Seuil, p. 83-89.
52. Ralite was the former cultural editor of the communist daily, *L'Humanité* and collaborator of Vilar, the founder of the Avignon popular theatre festival.
53. D. Jembar, (1984), *Le PC dans la Maison*, Paris: Calmann-Lévy, p.128.

54. The other advisors were F. Dreyfus, H. Gresh, A. Léger and Y. Talhouarn. Ralite also appointed F. Rodriguez as head of his personal office, and C. Joseph as his press officer. See Jeambar, *Le PC dans la Maison*, p.128-129; J. Latrille, interview, 23 June 1992.
55. *Le Monde*, 11 November 1981. For an account of this episode, see also T. Pfister, (1985) *Matingon au temps de l'union de la gauche*, Paris: Hachette.
56. J. de Kervasdoué, interview, 18 February 1992; Latrille, interview, 23 June 1992.
57. For an account of this whole period of economic policy-making, see P. Hall (1986), *Governing the Economy*, Cambridge: Polity.
58. Latrille, interview, 23 June 1992.
59. The following circulars were repealed: 01 August 1977 blocking increases in beds through infrastructure improvement programmes except for ministerial derogation; 03 March 1978 preventing investment programmes financed by over 60 percent private borrowing; 12 December 1978 subjecting the creation of laundries to ministerial approval; 17 January 1979 dictating the writing of supporting documents to justify improvements to the technical capacity of public hospitals; 04 September 1979 and 27 May 1980 imposing efficiency savings to offset any increased running costs of development; law of 29 December 1979 giving Ministers the right to unilaterally close hospital beds. See J. Ralite (1982), *Retour de France*, Paris: Messidor/Editions Sociales, p.106-119.
60. *Le Monde*, 07 January 1982.
61. The tour which all ministers were encouraged to undertake by Mitterrand was known as the *Tour de France de la Santé*. For a review of this tour, see Ralite, *Retour de France*.
62. G. de Pouvourville (1985), 'L'Hôpital en Chantier: les enjeux des réformes hospitalières entreprises en France', *Connexions*, no.46, pp. 144-151.
63. *Le Quotidien du Médecin*, 18-19 December 1981.
64. *Le Quotidien du Médecin*, 21 December 1981 and 28 May 1982.
65. *Le Quotidien du Médecin*, 14 December 1981 and 08 January 1982.
66. *La Lettre du ministre de la santé. Spéciale Charte de la Santé*, no.4, May-June 1982; *Le Monde*, 14 May 1982.
67. *Le Monde*, 15 January, 30 March, 03 April 1982; see, D. Wilsford (1991), *Doctors and the State*, Durham: Duke University Press; P. Bedier, M. Desaulle and I. Denencie, (1985), *Le Corps Médical Hospitalier et son Syndicalisme: L'Evolution d'une Profession*, Ph.d, Rennes: ENSP; P. Rollandin (1987), *La santé en danger*, Paris: Editions de l'Instant.
68. *Le Monde*, 15 January 1982.
69. For example, the one-day strike organised by 14 unions on 03 March 1982, *Le Monde*, 05 March 1982.
70. *Le Monde*, 26 March, 03 April 1982; Rollandin, *La santé en danger*, p. 105; *Le Figaro*, 15 April 1982.
71. Its *États Généraux de la Médecine Hospitalière*, on 08 January 1982, brought together over 3000 participants and 50 trade unions and associations, *Le Monde*, 10-11 January 1982. For its membership, see *Le Quotidien du Médecin*, 15 December 1981.
72. B. Debré, interview, 20 July 1992.
73. Bedier, Desaulle, and Denencie, *Le Corps Médical Hospitalier et son Syndicalisme*, p.356.
74. *Le Monde*, 05 March 1982.
75. J. Attali (1993), *Verbatim*, Paris: Fayard, pp. 120, 128 and 332.
76. de Kervasdoué refers to a 'political will' within the medical profession not to assist the Left in its reforms, see *Le Quotidien de Paris*, 01 October 1982.
77. Y. Rochet, interview, 23 April 1992.



78. *Le Quotidien du Médecin*, 28 May and 06 April 1982.
79. The SNCH actually received a letter from Mitterrand confirming his intention to reform the rights of public hospital doctors to treat private patients. See Rollandin, *La santé en danger*, p. 88.
80. *Libération*, 17 December 1981; *Rouge*, 09-15 April 1982.
81. C. Paire, interview, 06 July 1992.
82. G. Vincent, interview, 17 May 1993.
83. Vincent, interview, 17 May 1993.
84. Vincent, interview, 17 May 1993.
85. *Le Quotidien du Médecin*, 20 October 1982.
86. L. Rolland, interview, 01 July 1992.
87. Rolland, interview, 01 July 1992; *Le Quotidien du Médecin*, 03 May 1982.
88. Paire, interview, 06 July 1993.
89. Rolland, interview, 01 July 1992; *Le Quotidien du Médecin*, 03 May 1982.
90. Paire, interview, 06 July 1992.
91. Latrille, interview, 23 June 1992.
92. *Hospitalier-Actualités* (1982), no. 17, p.5.
93. Rolland, interview, 01 July 1992.
94. Hall, *Governing the Economy*, p.198.
95. Attali, *Verbatim*, p.266.
96. J. Marmot, interview, 14 February 1992
97. P. Bauchard, (1986), *La guerre des deux roses. Du rêve à la réalité*, Paris: Grasset, p.102.
98. Attali, *Verbatim*, p.266.
99. Bauchard, *La guerre des deux roses*, p.107.
100. On 27 September 1982, Mitterrand announced that the priority of his government was to stabilise the rise in statutory payments imposed upon private firms, see C. Rimbaud (1994), *Bérégovoy*, Paris: Perrin, p. 205.
101. P. Favier and M. Martin-Roland, (1990), *La décennie Mitterrand. 1.Les ruptures.*, p.442; J-C. Naouri, interview, 12 May 1993.
102. de Pourville, 'L'hôpital en chantier', p. 153.
103. Rimbaud, *Bérégovoy*, pp. 200-201.
104. R. de la Baume (1993), *Les Socialo-Capitalistes*, Paris: Albin Michel; J-C Naouri, interview, 12 May 1993. The report with Nora, released to the public, argued in favour of the introduction of a mixed system of financing which combined the existing insurance-based system with a system based on general taxation.
105. Marmot, interview, 14 February 1992; Coudreau, interview, 26 November 1992.
106. Bauchard, *La guerre des deux roses*. p.319; Rimbaud, *Bérégovoy*, p. 200.
107. *Le Monde*, 22 July and 01 October 1982.
108. Naouri, interview, 12 May 1993.
109. *Le Monde*, 22 July and 01 October 1982.
110. Renon, Gautier, Rodrigues and Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, pp. 13-19 ; *Le Quotidien du Médecin*, 02 and 03 December 1982.
111. Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, pp. 19-23.
112. The report also expressed fears that the global budget would encourage patients to enter regional teaching hospitals and that the workings of the fund for non-salaried non-agricultural workers would need to be adapted to match the global budget.

113. Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, pp. 13-19.
114. Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, p. 77.
115. Renon, Gautier, Rodrigues, Vu Tien, *Rapport à Monsieur le Ministre de la Santé*, p. 59-66; G. de Pourville and A. Jeunemaître (1988), *La naissance d'un instrument de gestion hospitalière: le groupe homogène de malades*, Paris: Centre de Recherche en Gestion, Ecole Polytechnique, p.38.
116. Naouri, interview, 12 May 1993.
117. M. Cedelle (1982), *Rapport de synthèse sur certains aspects de la gestion des hôpitaux*, Inspection Générale des Finances, July, Paris; J. Allain (1982), *Rapport de synthèse du contrôle hospitalier fait sur les 20 établissements*, Inspection Générale des Affaires Sociales, August, Paris.
118. Cedelle, *Rapport de synthèse sur certains aspects de la gestion des hôpitaux*, p. 4.
119. *Le Monde*, 02 December 1982.
120. G. de Pourville (1991), *La diffusion des DRG en France, 1982-1991*, Paris: Centre de Recherche en Gestion, Ecole Polytechnique, p. 34.
121. Naouri, interview, 12 May 1993.
122. *L'Hospitalier* (1982), no. 373, pp. 53-54; *Hospitalier-Actualités* (1983), no. 23, p. 5.
123. *Hospitalier-Actualités* (1982), no. 17, p. 4
124. *Le Matin*, 09 July 1982.
125. *Le Matin*, 09 July 1982
126. *Hospitalier-Actualités* (1982), no. 17, p.4.
127. G. Vincent, *Hospitalier-Actualités* (1982), no. 18, p.1.
128. *Le Quotidien du Médecin*, 04 October 1982.
129. Naouri, interview, 12 May 1993.
130. In 1982, hospitals directors occupied only three positions as *chef de bureaux* out of a total of 22 in the DH and one position in the Kervasdoué *cabinet*. In 1983, the *corps* held an additional position in the Kervasdoué *cabinet*. The hospital directors who held positions as *chefs de bureaux* in 1982 were M. Bitouze, G. Vergnes, and G. Échardour. A. Ramin worked in the *cabinet* of Kervasdoué. In 1983, C. Degardin joined the *cabinet* and M-T. Chabot replaced Vergnes. Source: *Le Bulletin administratif*.
131. P. Rayroles, interview, 27 February 1992.
132. Paire, interview, 06 July 1992.
133. de Kervasdoué, interview, 18 February 1992.
134. de Pourville, *La diffusion des DRG en France, 1982-1991*, p. 15-16.
135. Loi no.83-25 du 19 janvier 1983 portant diverses mesures relatives à la Sécurité Sociale, *Journal Officiel de la République Française*, 20 January 1983, p.375.
136. The lead Social Security funds were known as *caisses pivots*. The patient-day rate was maintained, for example, to bill patients not covered by the Social Security funds. The Bill proposed to extend the right of funds to evaluate the treatment given to patients to the right to evaluate treatment practices within whole medical services.
137. For a summary of the debate within the National Assembly, see *Le Monde*, 20 October, 21 October and 10 December 1982.
138. *Le Monde*, 17 November 1982.
139. E. Hervé, interview, 24 February 1992.
140. de Kervasdoué, interview, 18 February 1992.

141. de Kervasdoué, interview, 18 February 1992; Marmot, interview, 14 February 1992; Nouri, interview, 12 May 1993.
142. de Kervasdoué, interview, 18 February 1992.
143. Naouri, interview, 12 May 1993.
144. Marmot, interview, 14 February 1992.
145. *Le Quotidien du Médecin*, 30 May 1983.
146. Rollandin, *La santé en danger*, pp. 112-113.
147. Vincent, interview, 17 May 1993.
148. *Le Quotidien du Médecin*, 31 May 1983.
149. *L'Hospitalier* (1983), no.377, p.4.
150. *Le Quotidien du Médecin*, 31 May 1983; *Le Monde*, 01 June 1983.
151. *Fédération hospitalière de France* (1983), Circulaire, no. 2.
152. Paire, interview, 06 July 1992.
153. Vincent, interview, 17 May 1993.
154. Paire, interview, 06 July 1992.
155. For a discussion of how groups try and steer issues into different policy arenas, see F. Baumgartner (1989), *Conflict and Rhetoric in French Policymaking*, Pittsburgh: University of Pittsburgh Press.
156. D. Wilsford, (1991) 'The continuity of crisis: patterns of health care policymaking in France, 1978-1988', in J. Ambler (ed), *The French Welfare State*, New York: New York University Press, p. 110.
157. See, for example, its declarations in support of hospital doctors against the CNAMTS, *Le Quotidien du Médecin*, 31 May 1983.
158. Bédier, Desaulle, and Denencie, *Le corps médical hospitalier et son syndicalisme*, p. 218.
159. See, for example, *Le Quotidien du Médecin*, 19 September 1983.
160. *Le Quotidien du Médecin*, 19 September 1983.
161. Rochet, interview, 23 April 1992.
162. E. Weill, interview, 28 April 1992.
163. *Le Quotidien du Médecin*, 10 February, 01, 24 June 1983; *Libération*, 22 June 1983.
164. *Le Quotidien du Médecin*, 22 June and 06 July 1983.
165. *Le Quotidien du Médecin*, 23 August 1983.

## CHAPTER SIX

### **THE PUSH FOR ORGANISATIONAL REFORM: DEPARTMENTS WITHIN PUBLIC HOSPITALS AND THE POSITION OF HOSPITAL DIRECTORS**

The introduction of departments aimed to redesign the operating core of public hospitals, whose structures previously enshrined clinical autonomy in medical services headed by head doctors appointed for life. The language of departments attacked the economic and professional inefficiencies induced by the fragmentation of hospitals into disparate services which channelled responsibilities to heads of services and complicated responsibility for the overall treatment of patients. Instead, departments would replace services with larger and more integrated structures, varying from wider coordination between services to the fusion of services within a common budgetary, medical and administrative hierarchy. Equally, they would increase participation in decision-making, offering opportunities for junior doctors experiencing a promotion bottleneck due to the expansion of the medical population and the life-long appointments and responsibilities of heads of services.<sup>1</sup> Junior doctors had been obliged to create their own services to advance their career, heightening the organisational fragmentation of public hospitals.

The concept of departments undermined the fundamental bargains of the state-profession compromise in France, attacking both the entrenched positions of head doctors and the established boundaries between medical and administrative domains. It challenged medical self-regulation, abandoned the principle of beds as the primary organisational principle, and threw doubt on established positions. This chapter analyses the SNCH's evolving strategy throughout the introduction of departments, which cannot be divorced from Vincent's demands for improved pay and conditions for hospital directors. Indeed, the Mâcon strategy depended upon its capacity to deliver pecuniary benefits for the rank-and-file at the same time as it delivered managerial reform for the leadership. The first section examines the SNCH's initial positions on the crisis in government-medical relations induced by Ralite's management of departments. The second investigates Hervé's attempts to quell this evolving crisis and the SNCH's refusal to engage in a public defence of departments. The third section examines the continued failure of the PS government

to advance the implementation of departments in public hospitals and the rupture of its relations with the SNCH. The Vincent leadership's strategy came to focus more and more on demands for improved pay and conditions for hospital directors. The final section analyses the return to office by the Right under Chirac and its reversion to medical services, at the same time as the SNCH reaped the statutory rewards of its Mâcon strategy.

### 6.1 THE LEFT GOVERNMENT'S CONFRONTATION WITH THE DOCTORS

The SNCH came out in support of departments at Mâcon at the same time as it endorsed the global budget.<sup>2</sup> Within its newly-entrenched modernist leadership, Paire, Vincent's lieutenant, sponsored the reorganisation of public hospitals in front of conference, tapping the support of *Grenoble 80* for such a move.<sup>3</sup> The hospital doctor trade union subscribed to the oft-quoted benefits of departments, such as increased participation, improved efficiency and patient care.<sup>4</sup> It held services responsible for the fragmentation of public hospitals and condemned the monopoly leadership of heads of services as a barrier to the expression of demands by junior doctors.<sup>5</sup> However, their conference held that moves to departments were acceptable only if their implementation was founded upon a pre-established consensus within hospitals, with no externally imposed change or alienation of hospital doctors. Throughout, the autonomy of hospitals was to be maintained, ensuring local discretion and warding off attacks on medical teams and their responsibilities.<sup>6</sup>

In the SNCH leadership, the endorsement of departments was overshadowed by Vincent's decision to use the global budget to launch his presidency. The SNCH was not the lead sponsor of departments, first mooted in 1967 and provided for in a vague legislative framework in May 1976.<sup>7</sup> In June 1980, the Barre government even went as far as to commission a report on the introduction of departments from Dr. Gallois, the designer of departments at Mâcon general hospital.<sup>8</sup> The FHF and most hospital doctor trade unions were in favour of some reform of services, with even the conservative *Solidarité Médicale* supporting 'horizontal' divisions in public hospitals.<sup>9</sup> Within the PS, *Santé et Socialisme*, whose ideology revolved around a strong attack on the medical elite

in regional teaching hospitals, the *mandarinat*, lobbied for departments, pushing the reform onto the *110 Propositions* of Mitterrand; a measure confirmed by Ralite both in early October 1981 and the 1982 Health Charter.<sup>10</sup>

After losing the Health Ministry to Ralite, members of *Santé et Socialisme* moved into key positions within the DH and behind Questiaux (not least Kervasdoué at the DH and Cohen-Solal at the Ministry of Social Affairs).<sup>11</sup> They profited from a division of labour which saw Ralite front the introduction of departments, but leave the progress of the dossier to be monitored by the DH as Ralite's *cabinet* immersed itself in the Health Charter. Underscoring the opposition between Ralite and Kervasdoué, Jacques Latrille, Ralite's *directeur du cabinet* argues that the development of departments was the work of members of *Santé et Socialisme* and the PS Health Commission within the DH:

‘This project, it was truly drawn up ... outside the *cabinet*. I was the only one [within the *cabinet*] to go from time to time to seek information, to say things, but we let them get on with it’.<sup>12</sup>

For the PS, departments shadowed its broader commitments to self-management in the workplace through the dilution of the hierarchical authority of head doctors. Equally, like the SNCH, it accepted the wider discourse of the inefficient use of resources and fragmented patient care produced by the organisation of over-specialised services.<sup>13</sup> However, despite the best intentions of *Santé et Socialisme*, the PS did not arrive in office in 1981 with an established conception of what departments should be like.<sup>14</sup>

In fact, the widespread acceptance of departments in principle belied the absence of an accepted model of departments. Organisational reform exposed the cleavages within the established hospital community because it endangered established interests, particularly within the medical profession. A number of secondary cleavages developed, such as the role of the different units within departments, personnel participation, appointment procedures and the voluntary acceptance or not of departmentalisation. But, two principal cleavages essentially structured the configuration of interests. First, those supporting wider co-ordination between services clashed with those wishing to introduce new medical and administrative structures. Second, those supporting structural reorganisation were divided into those supporting a ‘parliamentary’ department focused on a departmental council, and those supporting a ‘presidential’ department revolving around the managerial demands of a head doctor.<sup>15</sup>

In early March 1982, the DH built upon the December 1981 consultation groups, by assembling a consultative commission to report on the development of departments within public hospitals.<sup>16</sup> Led by Professor Hirsch, the commission involved 25 individuals, of whom approximately half were hospital doctors, including such luminaries as Professor Escat, president of the national *conférence* of chairs of hospital medical commissions in regional teaching hospitals.<sup>17</sup> Its report concluded that to retain the hospital doctors' allegiance for change, the government should set no strictly defined norms, thereby allowing public hospitals to remain 'masters' of the implementation process. Hirsch and his colleagues stressed the reticence in hospitals towards departments and the concurrent obligation to undertake a significant process of consultation and explanation of the reform.<sup>18</sup> However, the working group did not agree with the super-head of department concept and instead advocated either an elected directorate of hospital doctors or a departmental council headed by no more than a medical coordinator.<sup>19</sup> Nevertheless, as the Hirsch Commission began its deliberations, strikes against changes to the private sector rights and the terms and conditions of hospital doctors hit public hospitals. Departmentalisation was not divorced from these issues and became caught up in the wider strike movements (see Chapter 5). In September 1982, somewhat prematurely, hospital doctors began four days of strikes against departments and the introduction of a single statute for hospital doctors.<sup>20</sup>

In fact, Ralite fanned the flames of medical opposition with the release of a draft decree on 27 October 1982 which ignored the findings of the Hirsch Commission.<sup>21</sup> Rather, Ralite drew inspiration from a 1982 report on hospital organisation (by Fullet, Rebuffel and Escarguel) which proposed the participation of personnel in the management of services as a means of putting an end to the monopoly of control exercised by the medical profession and the administration.<sup>22</sup> Ralite's proposals went against the Hirsch Commission views in several ways. First, his decree imposed a uniform model of departments which left little room for local discretion (see Table 6.1). Although Ralite had earlier intimated that trials would take place and that departments would be based upon the initiatives of local doctors,<sup>23</sup> hospitals were expected to formulate plans for departmentalisation by October 1983. Second, Ralite opted for a presidential structure which concentrated responsibility for running a department in the hands of its head, rather

than its 'parliament', the *conseil de département*. More importantly, Ralite broke two established rules of medical organisation, those of self-regulation and appointment through co-optation. The decree advocated that head doctors should be elected by an electoral college which gave three-quarters representation to doctors, but also involved non-medical staff with 12.5 percent of the votes. Even heads of functional units which made up the department were to be designated by the departmental council, which involved non-medical personnel.

**Table 6.1: The Shock Wave - The Draft Decree October 1982<sup>24</sup>**

Organisation	Two-tier departments, with between 5 and 20 doctors divided into functional units.
Head of Departments	Head of departments to be full-time doctors with minimum of five years tenure. The head of department allocates resources in department (with help of head nurse of his choice) and oversees the meeting of budgetary and medical targets, with all departments engaging in permanent evaluation. He presents an annual report to the chair of the hospital medical commission.
Functional Units	Units headed by a doctor designated by the departmental council for four years. Present heads of service would by right be heads of units. Size of Units decided by Board of Trustees upon proposal of Departmental Council and opinion of hospital medical commission.
Departmental Council	The departmental council comprised of the head of department (chair by right), three full-time doctors, a representative of other doctors, 2 representatives of non-medical staff. Departmental council designates heads of functional units.
Head Nurse	Helps in management of department; responsible for nursing care; consultative voice in departmental council.

With the release of the draft decree, Ralite appeared to usurp the DH and its prior consultations with hospital doctors. Indeed, the mismanagement of the decree's release reinforced the mobilisation of hospital doctors against Ralite, already hampered by his communist affiliation and the over-play of reforms (See Chapter 5). Professor Escat led the doctors' claims of pseudo-consultation, arguing that Ralite did not wait for the publication of the Hirsch working group report in early November 1982.<sup>25</sup> His charge was echoed by hospital doctor trade unions including *Solidarité Médicale* and the *conférence* for general hospitals.<sup>26</sup> In his defence, Ralite claimed that, on 28 October 1982, the *cabinet* met with the *conférence* and ran through all the details of the draft decree.<sup>27</sup>



However, the row spread to the Health Ministry, with the DH keen to avoid blame for the emerging debacle.<sup>28</sup> With one misjudgment of the climate of government-medical profession relations, departments became an over-riding symbolic issue for hospital doctors, exploiting its connections with other reforms. Debré, leader of *Solidarité Médicale*, soon exploited the propaganda that cleaners were to elect head doctors.<sup>29</sup>

Distracted by the introduction of the global budget, the SNCH did no more than keep a watchful eye on the progress of departmentalisation. The Ralite decree ignored the conditions which the union laid down at Mâcon. However, hospital doctors, in tacit alliance with the SNCH, were voicing concerns which matched those of Vincent and his BN. The SNCH had few channels of influence within the Ralite *cabinet* and the team surrounding Kervasdoué at the DH (see Chapter 5), and hospital directors were an insignificant minority within the Hirsch commission, with no leading SNCH activists on the commission.<sup>30</sup> Throughout the summer of 1982, the SNCH attended consultation meetings, but was crowded out there by the massed ranks of hospital doctors. Thus, the Vincent leadership left hospital doctors to impose conditions on the government, and the union only made responsible noises on the sidelines as befits the nascent partners of the Mauroy government. The SNCH tacitly conceded that the medical profession must be lead negotiators on the departmental dossier.

By early February 1983, a revised decree dated 10 January 1983 was in circulation as Ralite attempted to backtrack on his October debacle.<sup>31</sup> The revised decree went some way to answering the general demands of hospital doctors who sought the removal of non-medical participation in the election of heads of departments and delays to the January 1984 deadline for implementation.<sup>32</sup> The decree created more areas of discretion in the implementation of departments, making no reference to either the implementation date of January 1984 nor the maximum and minimum number of doctors involved in one department. In addition, head doctors were to be elected for four years by the departmental council, which itself was elected according to distinct colleges thus ensuring that doctors on council remained elected by peers. Equally, doctors were ensured a majority in the council, thereby reducing the weight of non-medical staff in the election of head doctors. But, in addition, Ralite did not fail to offer concessions to other hospital personnel. He made overtones to the hospital directors as he placed all departments under

their authority and gave them the formal power to appoint head nurses on proposition of the council.<sup>33</sup>

However, the divisions between hospital doctors negated Ralite's advances as he set about staving off the complaints of a profession divided between those who likened departments to the 'sovietisation' of hospitals and the 'ideology' of the mass extinction of intellectuals in Cambodia<sup>34</sup>, through to those who saw it as the transformation of doctors into 'little shivering civil servants'<sup>35</sup> and on to those who accepted departments without compromise but contested their very organisation.<sup>36</sup> The Left was not without its allies. One was the *Intersyndicale Derenne*, classified as close to the Mauroy government, created in November 1983 and led by the left-wing stalwart, Professor Derenne.<sup>37</sup> Yet, the most pro-departments stance came from the INMH or the *Intersyndicale du 12 février* led by Francis Peigné. Indeed, Ralite, speaking on 18 February 1983, mirrored the demands of the Peigné Intersyndicale.<sup>38</sup> However, there was no way back for Ralite from the release of the draft decree in October 1982. Even the Economic and Social Council argued that it was not possible to undertake a rapid and generalised application of departments.<sup>39</sup> As strikes by doctors progressed, Ralite was finally moved on 24 March 1983 from Health to make way for Edmond Hervé, a PS stalwart, mayor of Rennes and Junior Minister for Health in the first Mauroy government before the June 1981 legislative elections. For the SNCH leadership, Hervé's arrival presented new opportunities.

## 6.2 NEGOTIATIONS OF A COMPROMISE

The removal of Ralite ended the conflict between the DH and the *cabinet*, and gave the circle of *Santé et Socialisme* renewed influence over policy formulation. Although a junior minister, Hervé and his *cabinet* were left by Bérégovoy to manage the introduction of departments, with the support of the DH. However, Hervé did have to contend with sporadic interventions from both Mauroy and Mitterrand, although the introduction of departments was not a primary concern of the Mauroy government.<sup>40</sup> These interventions were provoked both by the Elysée's and Matignon's frustrations with Ralite's activism and, by the need to placate hospital doctors who exploited their personal networks and reputational power (particularly at the Elysée) to usher in policy change.

Strikes persisted throughout the spring with departments forming only one of the bones of contention between the Mauroy government and hospital doctors.<sup>41</sup> However, Hervé unilaterally declared a six month 'ceasefire' from March to September 1983.<sup>42</sup> He aimed to adopt a more consensual approach to negotiations than Ralite, 'to negotiate, to convince rather than to constrain.'<sup>43</sup> On 28 April 1983, Hervé and Kervasdoué met with the *conférences* with the hope of reviving consultation between hospital doctors and the government.<sup>44</sup> Underpinning these steps, Matignon and the Elysée intervened to accelerate the moves towards deflating the crisis. In an open letter, read at the *Assises Nationales de la Santé* on 29 April 1983, Mauroy made propositions to ameliorate the situation, while Mitterrand took the initiative of appointing a team of well-reputed hospital doctors, the *Médiateurs*, to unblock the growing confrontation with hospital doctors.<sup>45</sup>

From the end of May 1983, Hervé undertook a series of conciliatory steps towards hospital doctors. He abandoned Ralite's January 1984 implementation deadline, reassured hospital doctors over medical representation within departments and tampered with the procedures surrounding the appointment and responsibilities of head doctors. His *note d'orientation* on 24 May suggested that heads of departments should be appointed by hospital directors after being proposed solely by doctors within the department, thereby responding to the concerns to maintain medical self-regulation. Equally, it proposed that departmental councils should be composed solely of doctors and nursing personnel. Finally, the conception of a *super-mandarin* was diluted as heads of department were to have organisational responsibilities, but no direct medical authority over other doctors.<sup>46</sup>

In seeking to repair the collapse of relations under the stewardship of Ralite, Hervé quickly moved to isolate the *conférences* and elite hospital doctors who were initially reinstated by the Elysée and courted by the Junior Minister. Their opposition to departments, as they hid behind a technical apolitical discourse, obliged Hervé to seek or construct other partners.<sup>47</sup> The measures endorsed by Hervé at the end of May were designed to fragment opposition to departments by divorcing those unions on the fringes of departments from those preaching total rejection. The pivotal interlocutors of the Ministry became people such as Peigné, Derenne and the leader of doctors in general hospitals, Gatelmand, at the head of the emerging hospital doctor trade union movement. Most importantly, Hervé started to elevate the concerns of moderate trade unions,

particularly Peigné, above other interlocutors. Thus, the Junior Minister followed the path already briefly sketched out by Ralite.

However, the Mauroy government could not rest easy on departments because its other hospital reforms, particularly the single statute for doctors and the global budget, rested upon departmentalisation. After responding to the confused demands of the medical profession, Hervé tested the water on 18 August 1983 with the release of a Bill introducing departments and cleaning up a number of articles of the 1970 Hospital Law. (The renovation of hospital planning promised to the SNCH was quietly dropped). This Bill, published six days after the global budget decree, introduced departments as the basic unit of medical organisation within public hospitals. However, reflecting the uncertainty of the medical reaction, it did no more than sketch out the basic parameters of future hospital departments, ‘a little like a return to the Fourth Republic: a very loose law, leaving all latitude to the Minister to take decisions by statutory means.’<sup>48</sup> Hervé employed the tactical advantage of administrative decrees to delay opposition to departments whilst obtaining the legitimacy derived from parliamentary approval. In contrast, Ralite had taken the opposite approach, unwisely beginning the moves towards departments with the release of a draft decree.

### *The SNCH and Article Two*

With the appointment of Hervé, the SNCH leadership acquired ‘privileged’ channels of access to the Health Ministry: Coz knew the Junior Minister for Health and Louis Rolland was a personal friend from his days at University. Merhle, who remained in the *cabinet*, was brought back into the heart of policy discussions after his isolation under Ralite; as a member of the PS, he was no longer treated with suspicion.<sup>49</sup> However, throughout Hervé’s protracted negotiations, the Vincent leadership did no more than maintain its conditional support for departments, calling for an extended implementation period in which to undertake trials and cultivate grassroots support for organisational change within hospitals.<sup>50</sup> Typically, with the publication of the Bill, the union welcomed departments, but insisted that the final approval of local plans to introduce departments be left to hospital Boards of Trustees. Such conservative positions were coupled with whatever actions seemed necessary to ensure the legitimate place of directors within future

departmental structures (see Table 6.2). Defending its managerial prerogatives, the SNCH was concerned that departments be placed within the wider framework of the global budget, the setting of medical objectives and improved participation within public hospitals.<sup>51</sup> The union leadership had no wish to witness the replacement of fragmented heads of service with either ‘super-chefs’ endowed with electoral legitimacy at the head of reinforced medical strongholds with their own departmental budgets or, the creation of an uncoordinated *régime d’assemblées* characterised by departmental councils with extensive controls over budgetary and personnel management.<sup>52</sup>

**Table 6.2: The SNCH and its safeguards**

Department	No imposed model but departments <i>à la carte</i>
Departmental Heads	To be no more than coordinators
Heads of UFs	Hospital directors or Boards of Trustees to have roles in their appointment
Departmental Councils	To have no extended powers which would lead to a ‘ <i>régime d’assemblées</i> ’
Hospital directors	To preside over the Departmental Commission which formulates reorganisation in hospitals
Staff Nurses	To be appointed alongside each head of department by hospital directors

Over one third of the membership of the SNCH’s national executive, the BN, was against an endorsement of departments precisely because they felt that it was a no-win issue for hospital directors. Enthusiastic supporters of departments, like Paire and Coz, were relatively isolated.<sup>53</sup> Within the *corps*, departments were widely considered to be neither a primary nor a legitimate concern of hospital directors. Even within the BN, directors were wary of stepping outside the traditional boundaries of hospital management: ‘as though .. we were going to touch something that would light the powder keg.’<sup>54</sup> Although Vincent was a supporter of departments, he questioned the wisdom of the SNCH contesting medical opposition to organisational change within public hospitals. He was not prepared to enter into conflict with the medical profession when the outcome of the reform process was far from certain: ‘The beliefs of hospital doctors are not ready

[for departments], we are not going to go to war against hospital doctors, we are not going to tackle them head-on.’<sup>55</sup>

However, Vincent was prepared to engage in sporadic skirmishes with hospital doctors in the hope of raising the morale of the rank-and-file. In discussions of the Hervé Bill, he elevated into a *cause célèbre* Article Two which gave hospital directors formal authority over all hospital personnel including hospital doctors. The precedent for such a clause existed in the authority of the general director of the *Assistance Publique*, although its inclusion within the Bill owed much to the lobbying of Vincent and the SNCH leadership.<sup>56</sup> As far back as 19 November 1982, at a meeting with Ralite's *directeur du cabinet*, Vincent reportedly convinced the ministry that the decentralisation of managerial responsibilities inherent within departmentalisation necessitated the confirmation of ‘a single line of command within hospitals.’<sup>57</sup> This elevation of Article Two answered the short-term failings of the Mâcon strategy. Although in the autumn of 1983 Vincent could point to the beginning of negotiations to merge the Fourth and Fifth Classes,<sup>58</sup> the absence of direct pecuniary gains since Mâcon led Vincent to still believe that he:

‘needed something showy. In the absence of being able to give money to hospital directors, it was necessary that I showed them that they were becoming more important, that their power was increasing. ... It's all symbols, every profession needs its symbols’.<sup>59</sup>

Through the consultation surrounding the Bill, the SNCH repeated its standard attacks on alleged incursions into the managerial freedom of public hospitals by the departmental health boards, the DDASS, and local prefects, denouncing any top-down controls upon public hospitals under the guise of ‘tidying up’ the 1970 Hospital Law.<sup>60</sup> Both Vincent and the rest of the BN were aware that Article Two would have little influence upon the day-to-day running of hospitals:

‘a single ‘boss’ in the hospital: it was very theoretical. I always said, even at the time, that those who have the powers will keep them and those who haven't got any ... will never have any’.<sup>61</sup>

Article Two neither specified in what areas of medical decision-making hospital directors would ‘outrank’ hospital doctors nor answered the question of possible areas of opposition between hospital directors and future heads of departments. However, maximising the symbolic resonance of Article Two, the Vincent leadership demanded the replacement in it of the words ‘authority over’ with a new phrase giving directors

‘hierarchical power over’ hospital personnel.<sup>62</sup>

The wrath of hospital doctors was duly unleashed upon the *corps* of hospital directors as a broad medical coalition, ranging from Yves Rochet, the newly-appointed chair of the *conférence des présidents des CMCs des CHUs*, through to Garbay, Derenne and Peigné, attacked any extension of the authority of hospital directors.<sup>63</sup> This coalition objected to the encroachment of Article Two into the sacrosanct boundaries of clinical freedom which they alleged would devalue medical expertise and raise unnecessary ethical questions.<sup>64</sup> The *Syndicat Garbay* wrote to Mitterrand in an attempt to draw the Élysée into the fray.<sup>65</sup> However, in reply, the Vincent leadership stressed that it was asking simply for the generalisation across France of the formal authority exercised, with little complaint, by the general director of the *Assistance Publique*.<sup>66</sup> The union continued to argue that no organisation, whether public or private, could function efficiently while certain personnel remained outside the authority of its management. Upping the stakes in an open letter to the Elysée, Vincent portrayed directors as defenders of the general interest against the individualistic self-interest of the medical profession:

‘Such a measure [Article Two] would considerably aid hospital directors in the search for improved management. Hospital doctors still too often adopt, in fact, independent behaviour, respecting neither the objectives, the organisation nor the means of the institution’.<sup>67</sup>

As the SNCH put it, the Mauroy government could not control public hospital spending if hospital directors were not given the legal authority necessary to assert their predominance over hospital doctors.

However, the Elysée and Matignon feared fuelling medical discontent by maintaining Article Two within the Hervé Bill. And hospital doctors ensured its rejection by the consultative body, the *Conseil Supérieur des Hôpitaux*, at the beginning of September 1983.<sup>68</sup> Shortly after this meeting, hoping to quell medical discontent, Hervé backtracked, declaring that the end of the clause was mistakenly deleted before its release for consultation. The clause should have read that hospital directors exercised formal authority over hospital doctors, but only outside the confines of clinical autonomy.<sup>69</sup> This omission permitted Hervé to satisfy the socialist group within the National Assembly which, on 10 October, refused to withdraw the clause, arguing that it was wrong to ‘quibble about this sentence and ask hospital directors at the same time to act like heads of business leading teams.’<sup>70</sup> However, the Elysée and Matignon summoned Professor

Raymond Villey, chairperson of the professional body, the *Ordre des Médecins*, to intervene. He came up with an agreement that later was put to the Senate and accepted. This agreement simply clarified that the authority of directors had no bearing on the medical issues surrounding the treatment of patients; it was ‘rubber-stamped’ by both Vincent and Peigné.<sup>71</sup>

With the passing of the Bill through the National Assembly, Vincent was again happy to engage in timely contests with hospital doctors. He identified the SNCH once more as the willing agents of central government hampered by the outdated management systems of public administration. The compromise thrashed out with Peigné left Vincent able to declare to his members that ‘it was our thesis that won out, thanks to the support of the Minister of Health, the National Assembly and the Senate.’<sup>72</sup> However, the BN refused to engage in overt support for departments, preferring to remain on the sidelines until the final negotiations between Hervé and hospital doctors. This conditional acceptance of organisational reform betrayed the weakness of the Vincent leadership’s strategy. Its pragmatic endorsement of departments clashed with its willingness to do battle over the symbolic issue of the preserved domain of medical self-regulation. Yet, Article Two failed to placate the growing demands of the SNCH rank-and-file for pecuniary improvements.

### *Hervé jumps in the deep end*

The cursory diversion towards Article Two did little to ease the implementation of departments. The January 1984 Law enshrined no more than the skeleton of departments, leaving the administrative decree still to be negotiated. Hervé released another draft decree for consultation on 1 March 1984, hoping finally to publish the decree at the end of June. The text confirmed the removal of the major stumbling block under Ralite which was the election of heads of departments by hospital personnel (see Table 6.3).<sup>73</sup> However, it returned to the presidential model of departments from which Hervé had recoiled in the spring of 1983. He now argued that heads of department had to be bolstered in order to counterbalance the influence of hospital directors.<sup>74</sup> The new heads of departments were not only to nominate heads of functional units, but also to define medical objectives, allocate resources and contribute to budgetary discussions within



hospitals.

Such inconsistencies brought immediate criticisms from hospital doctor trade unions who feared that the creation of *super-mandarins* would blur the individual responsibility of doctors and confer excessive control over departmental councils and functional units to head doctors.<sup>75</sup> Derenne, one of the Left's supporters, expressed his federation's preference for a parliamentary department, arguing that 'the text of 01 March 1984 left no solution to the head of department other than to be an autocrat ... or a lazy king.'<sup>76</sup> These criticisms were matched by concerns over the length of the mandate for the heads of department and the election of councils by the use of the list system. Doctors argued that lists would introduce personnel trade unions into the privileged technical and professional domain of medical self-regulation. Hospital doctors demanded control of the implementation of departments, aiming to form the majority of the *commissions de départementalisation* which were to determine the re-organisation of hospitals at the grassroots.<sup>77</sup>

**Table 6.3: Hervé's presidential departments**

Heads of Departments to be full-time doctors, elected for four years. Power to nominate heads of functional units, to define medical objectives, to allocate resources. Participates in wider budgetary discussions within hospitals.
Departmental Council, elected by electoral colleges with a majority of seats attributed to doctors, to advise heads of departments. Council to have a purely consultative role.
Departments based upon functional units the size of existing services.
Departmental Commissions, with majority representation to doctors, to devise local plans to introduce departments.

However, after further consultation,<sup>78</sup> Hervé brokered a series of compromises which appeared to lay the foundations for an acceptable decree. The Ministry released a revised decree on 4 May, accompanied three days later by the first *Guide de la Départementalisation*.<sup>79</sup> The revised decree maintained the managerial responsibilities of future heads, but ensured that these were to be exercised 'on the proposal' of departmental councils, with the responsibilities of heads of functional units fixed by decree rather than left to the discretion of heads of departments. This revision responded to the likes of Derenne and Peigné. Equally, though, to pacify the criticisms of existing heads of

services, Hervé conceded that they could become heads of functional units for life. Finally, the members of the *commissions de départementalisation* were to be elected not appointed thereby warding off medical concerns over the composition of local commissions.<sup>80</sup>

Thus, Hervé continued to downgrade the influence of the *conférences* whilst elevating left-wing and pro-departments supporters within the fragmented hospital doctor trade union movement. The backbone of this support were the federations led by Derenne and, more especially, Peigné, who both believed that there was finally a workable decree in place.<sup>81</sup> However, the support of Derenne fluctuated as he demanded the installation of a 'parliamentary' department once the decree neared its completion.<sup>82</sup> The INMH was racked by internal divisions which weakened Peigné, although he remained 'a faithful ally right until the end, against winds and tides'.<sup>83</sup> Although the INMH made minor procedural criticisms of the decree, its internal fragmentation, particularly between doctors in regional and general hospitals, prevented it from formulating an official position on the introduction of departments.<sup>84</sup> Indeed, its largest member, the *Syndicat Garbay*, walked out of consultations with Hervé in protest at departmentalisation.<sup>85</sup>

Despite further rounds of consultation held by Hervé, the final version of his decree differed little from that of early May.<sup>86</sup> After passing relatively unscathed through the *Conseil Supérieur des Hôpitaux* on 20 June, Hervé's decree arrived at the end of the month in the office of Mauroy for his final signature.<sup>87</sup> Hervé appeared to have quelled the crisis cultivated by Ralite and at least advanced beyond the issue of the decree to the process of its implementation in public hospitals. He did so through concessions over medical appointments, but also by cultivating the demands of Peigné and his supporters.

### *The SNCH responds to its grassroots*

Through the first half of 1984, the Vincent leadership did not deviate from its cautious defence of departments and the prerogatives of the *corps*. In response to the March decree, it lobbied for minimal coordinating roles for heads of departments and asserted the position of the nursing manager within departments. Indeed, it claimed the 'natural' role for directors both in the appointment of nursing managers and heads of functional units and, as chair of the departmental commissions designed to implement the organisational

changes.<sup>88</sup> True to its cautious stance, the Vincent leadership couched these demands in terms of the defence of the autonomy of hospitals and even that of the medical hierarchy.<sup>89</sup> However, territorial clashes still erupted as hospital doctors contested the revision through departments of the division of labour between hospital directors and doctors.<sup>90</sup> Unfortunately, these territorial clashes dragged the SNCH into a public row with Peigné and the INMH who rebuffed the demands of hospital directors to chair departmental commissions and exercise a nominal role in the appointment of the heads of functional units.<sup>91</sup>

As with his opposition to Article Two, Peigné exploited his support of departments to bolster his negotiating stance, threatening to withdraw from consultation if Hervé bowed to the SNCH demands. Such conflicts revealed the SNCH's weakness in the negotiations surrounding departments. Conceding to SNCH demands would have required Hervé to work against the interests of hospital doctor trade unions which he had assiduously elevated in negotiations, and this without a concrete commitment to the implementation of departments by the SNCH. More importantly, Hervé and his *cabinet* considered that the *corps* lacked legitimacy and 'quite simply, they did not have the weight'.<sup>92</sup> Instead, he wished to create a counterweight within hospitals to offset any administrative hierarchy. This view was supported by Bérégovoy who sought to modernise the training and expertise of hospital directors (see Chapter 4). Indeed, Bérégovoy wanted to create a general advisory board on hospital management, the *Conseil Général des Hôpitaux* (CGH), as a final resting place for those general directors whom he wanted to replace, pleading to Mitterrand that 'it is impossible for me to move the directors of regional hospitals for lack of outlets.'<sup>93</sup>

The prospect of a CGH surfaced during negotiations to revise the *corps*' terms and conditions as the Mauroy government undertook a general reform of the working conditions of the civil service.<sup>94</sup> The SNCH approved the development of the *Conseil* because it promised to increase both the reputational resources of the *corps* and to provide extra posts at its summit. However, meeting with Hervé and his *cabinet* on 7 March 1984, one week after the release of the March draft decree on departments, Vincent and a SNCH delegation were quick to label Hervé's proposals to enlarge the First and Second classes and to evaluate the head directors of the regional hospitals every five

years as a mere 'réformette'.<sup>95</sup> Indeed, Vincent and his Mâcon strategy faced mounting pressures to deliver pecuniary gains, particularly from directors within the Third Class, whose careers were stalled by the bottleneck created by the expansion of the *assistanat* and subsequent moves to cost containment. The skirmish provoked by Article Two could in the long-run do little to convince the rank-and-file of the utility of the Mâcon strategy. However, the Vincent leadership did derive some advantage from the fact that the merger of the Fourth and Fifth classes finally appeared to have negotiated the obstacles posed by the Finance Ministry.

In fact, the conclusion of the negotiations with Hervé was far from near. When meeting with Hervé, the Vincent delegation had no validated negotiating stance with which to counter the minister's proposals. The BN delegated Coz and Paire to report on the measures required to prevent hospital directors being denied promotion opportunities. At a meeting at the end of March 1984, the union's forum for regional and departmental delegates, the *Conseil National*, put back its discussion of the counter-proposals emanating from the BN until its meeting on 15 May at the annual conference at Angers (see Table 6.4).<sup>96</sup> At the second meeting with Hervé on 28 March, the DH and Merhle set a timetable for future negotiations which loosely called for a third meeting of discussions before the summer, once a synthesis of government proposals had been sent to hospital director trade unions. However, the SNCH was still able to lead the way because its electoral partners, the CGT and the CFDT had similar proposals to the SNCH, and they united behind Vincent's call for a complete overhaul of the terms and conditions of hospital directors rather than any piecemeal measures. Meanwhile FO, happy to support Vincent's calls for a revision of terms and conditions, had no definite project to put forward at the meeting.<sup>97</sup>

**Table 6.4: The Principal Themes Developed by the BN<sup>98</sup>**

<p>Division of the corps into two classes with improved classification of existing posts.  Maintenance of the existing appointment process.  Fine-tuning of access to ENSP and rules governing the entry of other civil servants into the <i>corps</i>.  Introduction of sabbatical leave for hospital directors.  Improved access to other corps, in particular, IGAS.  Creation of a General Inspection of Hospitals.  Improved conditions for assistant directors within the framework of future reform of their training.</p>
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However, the prospect of drawn out negotiations against the short-term failure of the Mâcon strategy led *Grenoble 80* to rally behind calls for strike action at the 1984 conference (see Chapter 4).<sup>99</sup> Vincent acknowledged that hospital directors felt cheated over the global budget.<sup>100</sup> From the rostrum he praised the hospital directors' victory in the fight for Article Two of the 1984 Hospital Law. However, rank-and-file support for the Mâcon strategy was being undermined by the stringent controls imposed on hospital budgets by Bérégovoy - notably limited national guidelines for global budgets, *taux directeurs*, for 1984 and 1985 and constraints on investment in hospitals by the Social Security funds in 1984. Bérégovoy vaunted his intention to use the stringent controls to force hospital directors to improve efficiency and management techniques, ushering in a budgetary policy based upon the redeployment of existing resources (see Chapter 4). In response to attacks on his budgetary policy, he merely concluded that directors were unhappy to have to undertake managerial tasks.<sup>101</sup>

The breakdown of its relations with the Mauroy government loomed up because the SNCH, 'a trade union which up until now had so associated itself with the building site of reforms since 1981,' opposed the Bérégovoy-inspired budgetary policy.<sup>102</sup> The Vincent leadership progressively entwined its management of departments with its negotiations for a revised statute for hospital directors. It concluded that hospital directors were not reaping the expected rewards from their loyalty to reform policies, and now faced an uphill struggle to gain recognition from Bérégovoy and Hervé. However, uncertainty soon reigned, because whilst the Hervé decree on departments remained in Mauroy's office waiting to be signed, Mitterrand replaced his Prime Minister with Laurent Fabius.

### 6.3 STOP-START IMPLEMENTATION

The ensuing government reshuffle brought to Social Affairs, Georgina Dufoix, a loyal Mitterrandist who combined her ministerial office with that of the role of spokesperson for the Fabius government. Her arrival threw doubt on the future of the Hervé decree. For whilst she supported departments, she immediately voiced concerns over the hostility of the medical profession to their introduction in public hospitals.<sup>103</sup> Unfamiliar with the decree, she reviewed it over the summer, placing the introduction of departments on hold.

However, her refusal to endorse the organisational reform persisted well into the autumn of 1984 as little emerged from the Ministry of Social Affairs. On 2 October, she confirmed to the SNCH that she was still in the process of reviewing the decree.<sup>104</sup> Such hesitation sent a far from coded message to hospital doctors that the compromise assembled by Hervé was open for re-negotiation. By early December, rumours circulated predicting the demise of the reform altogether.<sup>105</sup>

In fact, Dufoix revoked the autonomy granted to Hervé by Bérégovoy who retained his hold over budgetary policy as Finance Minister (no doubt, one of the motivations behind Dufoix's intervention in departmentalisation). However, with doubt hanging over the future of departments, Hervé exploited his privileged access to Mitterrand on an official trip to Africa to by-pass Dufoix's hesitations. On the airplane, he convinced the President of the necessity to forge ahead with the introduction of departments.<sup>106</sup>

'I knew that certain erroneous comments had been addressed to the President of the Republic... as it was a subject that I held close to my heart and which was for me very strongly symbolic,... I allowed myself to say what was the philosophy of departmentalisation, to explain'.<sup>107</sup>

His intervention convinced the Elysée to override the minister's hesitations and force the publication of the decree. Thus, somewhat unexpectedly on 29 December 1984 the decree surfaced in the *Journal Officiel*, in a form that was not dissimilar to that prepared in the summer by Hervé (see Table 6.5). The belated publication of the decree left Dufoix with little more than twelve months to manage the implementation of departments successfully before the coming legislative elections in March 1986 returned the Right to office. The first hurdle to negotiate was the election of local commissions to plan the reorganisation of public hospitals. However, opponents of departments met the publication of the decree with widespread hostility, resurrecting immediately the arguments voiced under Hervé and Ralite. Nine hospital doctor trade unions created a cross-union coalition, CLASH, which pledged itself to a policy of local obstructionism.<sup>108</sup> The *Syndicat Autonome* launched a boycott of elections to local commissions to scuttle departments until the expected electoral victory of the gaullist RPR which pledged to return to services.<sup>109</sup>

Trying to manage this hostility widened the cleavage between Health and Social Affairs. With little of her reputation invested in the policy, Dufoix was prepared to appease the stringent opponents of departments within the medical community to ease

their implementation. In contrast, Hervé believed that Dufoix should not risk losing what support existed for departments in a futile attempt to reach a compromise with those intent on scuttling their introduction altogether. He argued that the Fabius government was best to proceed with departmentalisation, relying upon the support of the INMH led by Peigné and, to a lesser extent, the inconsistent Derenne. The internal constraints surrounding Peigné fell away from September 1984 as three anti-department unions including the *Syndicat Garbay* left the INMH only to be followed by six further unions in November 1984.<sup>110</sup> However, despite his public appearances alongside Dufoix, the lines of communication between Hervé and Dufoix had deteriorated as had those between the Ministry of Social Affairs and the DH: ‘Hervé kept some contact, but he was nevertheless, a little on the sidelines.’<sup>111</sup>

From the end of March 1985, Dufoix prepared the ground for a government retreat from the December 1984 decree. This flurry of conciliatory measures under the guise of flexibility sought to avoid a mass boycott of the elections to local departmental commissions.<sup>112</sup> Dufoix extended deadlines for setting up commissions and formalising plans to introduce departments. Existing head of services were enticed with the suggestion that a department could possibly be no more than a single functional unit, thereby paving the way for existing services to continue.<sup>113</sup> In fact, Dufoix announced that departments as portrayed in the December 1984 decree would not be obligatory, arguing that whilst anything was possible within the framework of the decree, the actual decree could eventually be ignored.<sup>114</sup> Thus, disavowing Hervé completely, she finally announced that she was prepared to reduce departments to little more than the improved coordination of care and the ending of life appointments.<sup>115</sup>

These last-ditch compromises did not prevent the threatened boycott of elections to local commissions.<sup>116</sup> However, the boycott only served to encourage Dufoix to increase her overtures to hospital doctors. On 10 May 1985, from the rostrum at the Caen conference of the SNCH, she declared that she would fundamentally remodel the December 1984 decree.<sup>117</sup> At the end of May, she announced that the responsibilities of heads of department were to be watered down to that of coordinators, with the appointment of heads of functional units becoming the prerogative of Prefects rather than heads of department (see Table 6.5).<sup>118</sup> The rewritten draft decree, made public on 4 June

1985, instigated a catch-all strategy, tempting junior doctors with the creation of a third tier of responsibility, *subdivisions à vocation médicale*, below departments and functional units. And to outmanoeuvre local obstructionism, Boards of Trustees were empowered to designate *ad hoc* committees to fulfil the roles of the commissions where they were absent. All deadlines structuring the implementation of departments were abandoned for a single final deadline of 28 December 1987.<sup>119</sup>

**Table 6.5: The search for a compromise - ‘Innovations’ in the June 1985 Decree**<sup>120</sup>

<i>Organisation</i>	<b>December 1984</b>	<b>June 1985</b>
Heads of Departments	Extensive powers: draws up medical objectives for department, nominates head of functional units.	Flexible powers which could be reduced to those of no more than a simple administrative co-ordinator.
Heads of Functional Units	Nominated by head of department for four years with possible tacit reappointment. After 12 years must be formally reappointed by CMC, after proposal by doctors in departmental council.	Nominated by Prefect for four years with tacit reappointment after submission of acceptable progress report. After 12 years must be formally reappointed by medical instances of department.
Departmental Council	Proposes nomination of heads of functional units and medical objectives. Determines how heads of functional units associated to department.	Determines roles of heads of departments and relations between the two.

In fact, during early 1985, Dufoix entered into private negotiations with the leadership of the *conférence des présidents des CMC des CHUs*, in particular, its chair, Professor Rochet and vice-chair, Professor Pellerin. These informal negotiations culminated in a private dinner party that Dufoix arranged for members of the *conférence* in Paris at the end of April.<sup>121</sup> Neither Hervé and his *cabinet* nor Kervasdoué at the DH, sidelined by Dufoix, were invited to the dinner party. Indeed, Dufoix and her close advisors worked alone and outside of the formal channels of negotiations:

‘Dufoix did what she did by herself [...] she was doing it herself [...] when we learnt that she was negotiating with people [Rochet and Pellerin] like that without talking to us about it... truly on her own, we were flabbergasted’.<sup>122</sup>

Discussions at this dinner party sealed the final contours of the revised decree, with



Dufoix accepting the demands imposed by Rochet:

‘We [Rochet] said, ... that there was a minimum and a maximum ... beyond which we cannot go. If you do that, then that should work ... they allowed us to believe that they would do it’.<sup>123</sup>

The product of Dufoix's covert negotiations was to be put before the consultative *Conseil Supérieur des Hôpitaux* on the 26 June 1985. Her negotiations with Rochet and Pellerin appeared to have borne the necessary fruit at the expense of the privileged access given to trade unions and in particular, Peigné. Many of the defining characteristics of departments were swept away as Dufoix retreated towards no more than the improved co-ordination of existing services. Indeed, her attempts to find a palatable reform for those most hostile to departments successfully alienated the support of junior doctors and left-wing trade unions. However, with each rejection of her policy, Dufoix became further tied to a strategy of appeasement which left her continually chasing the demands of the hostile *mandarins* led by Rochet and Pellerin.

### *The SNCH withdrawals*

The appointment of Dufoix signalled a temporary ceasefire in the developing hostilities between the PS government and hospital directors. Dufoix adopted a conciliatory stance towards the *corps* which stood in marked contrast to the dismissive announcements of Bérégovoy and Naouri. Bérégovoy's announcement in June 1984 of the pending reform of the statute of the *corps* reinforced the constructive dialogue engendered by the appointment of a new Prime Minister.<sup>124</sup> The Vincent leadership was quick to welcome Dufoix, recognising that, unlike her predecessors, she had ‘understood that you do not win a war with discouraged officers.’<sup>125</sup> However, she appointed no hospital directors to her *cabinet*.

The stalemate over departments passed the SNCH by as its leadership became further obsessed by the demands of its protracted negotiations over the new statute for hospital directors. It was the demands of its statutory negotiations, rather than any positions on departments, which produced a series of tergiversations by the SNCH leadership in its dealings with Dufoix. In July 1984, provisional agreement for the merger of the Fourth and Fifth classes was reached within the Fabius government. These negotiations were primarily led by Hervé and hospital directors within his *cabinet*.

François Grateau joined the *cabinet* from his post as assistant director at Lille regional hospital to replace Merhle who left to become general director of the *Assistance Publique de Marseille*. Merhle's departure ended SNCH representation in the *cabinet*: Grateau was a member of FO. On 1 August 1984, in a meeting with the SNCH, Grateau informed Vincent that he, like FO, saw little interest in the merger of the two lowest classes.<sup>126</sup> However, ENSP membership apart, neither Merhle nor Grateau were utilized by the SNCH to promote the interests of the *corps*: 'I [Vincent] had contacts with the Ministers, their *directeurs de cabinet*, with Matignon, but virtually never with my colleagues in the *cabinet*'.<sup>127</sup> Those hospital directors who entered the Ministry were not regarded with 'respect' by colleagues: professional standing came through grassroots management of hospitals rather than through playing the 'political cards' of *cabinet* membership.<sup>128</sup>

In fact, negotiations over the revision of the *corps*' statute stalled in the autumn of 1984. By 12 September, the merger of the Fourth and Fifth classes had remained blocked in Hervé's office for six weeks, and the rival *corps*, the *Inspection Générale des Affaires Sociales* (IGAS), was lobbying forcefully against the creation of a *Conseil Général des Hôpitaux* (see below).<sup>129</sup> After its tribulations at Finance, the merger of the two lowest classes was further delayed at the Civil Service Ministry who rejected the decree on 16 November 1984.<sup>130</sup> In response, the SNCH, meeting on 20 November, mandated Vincent to make radical proposals for reform such as limited time contracts rather than proceeding with the 'réformette' proposed by the Fabius government or pursuing the threat of strike action.<sup>131</sup> Indeed, Vincent refused to support the general civil service strike called on 25 October 1984 because the demands of the SNCH were not concerned solely with pay and conditions.<sup>132</sup> However, the fusion of the Fourth and Fifth classes was not finally accepted by the Fabius government until the SNCH membership agreed, on 13 February 1985, to strike action by hospital directors.<sup>133</sup> Matignon gave the go-ahead the following day, allowing Vincent to remove, albeit temporarily, the threat of strikes from the SNCH's agenda.

However, the merger of the two lowest classes failed to address the career bottleneck facing the first three classes which was fuelling the pressure on Vincent and his Mâcon strategy. Exploiting the leeway for radical initiatives provided by the CN, the SNCH leadership endorsed *la sortie du Titre IV*, the removal of hospital directors from

the general statutes governing the French civil service and the creation of their own specific statute. The shift towards this position was finalised at the meeting of the BN in mid-March 1985 where it received unanimous support.<sup>134</sup> The leadership legitimised such a negotiating stance through references to the statute of hospital doctors and the singular role of hospital directors within the French civil service.<sup>135</sup> Meeting on 22 March, the BN mandated Christian Paire in the next round of consultations to vote against the government *réformette* and declare that the SNCH sought for hospital directors to exit from the constraints of the general statutes.<sup>136</sup> In particular, the SNCH objected to the proposed ending of both hospital director representation on the consultative body for hospital civil servants, the *Conseil Supérieur de la Fonction Publique*, and to the absence in the proposals of any guarantee of reciprocal access for hospital directors into other *corps*.<sup>137</sup>

Within the SNCH, support for the removal of directors from the general civil service statutes came from Rolland and rightwing directors such as Gusching, the union's national delegate for hospital directors, as well as the leaders Trazzini and Grenon. However, although happy to resurrect arguments voiced at the 1976 Strasbourg conference, the SNCH leadership had little intention of leaving the *Titre IV*. Vincent, and Paire who led the negotiations for the SNCH, believed they could employ such a maximalist demand to advance the union's arguments as it attempted to 'perfect' the existing government project.<sup>138</sup> It was a tactical move which positioned the SNCH as modernisers, divorcing the Vincent leadership from its trade union competitors and drawing criticisms from the FHF. In fact, the majority of the SNCH membership, led by the leadership of *Grenoble 80*, would not have accepted a move outside the *Titre IV*.<sup>139</sup>

Vincent progressively began to trade SNCH support for departments for an improved statute. Dufoux's concessions during spring 1985 brought little from the SNCH which went 'through the motions' in its criticisms of the revision of the Hervé decree. At its May 1985 conference at Caen, the SNCH repeated its demands for the representation of all personnel in departmental councils, for grassroots discretion in the implementation of departments and for a role for directors within the appointment of the heads of functional units.<sup>140</sup> However, Vincent threatened to withdraw entirely from the implementation of departments, berating the Fabius government for its failure to consider

the interests of hospital directors. His speech was a qualitative change from the union's previous non-committal stance and attacks on budgetary policy. In a letter to Dufoix, Vincent bemoaned the minor role of directors in the setting up of departments.<sup>141</sup> At Caen the SNCH leadership formally opted-out of any constructive broker role facilitating the implementation of departments. In front of Dufoix, who arrived waving the decree finalising the merger of the Fourth and Fifth classes, Vincent recognised that that it was too late to 'save' departments and that hospital directors would not promote their introduction when successive PS governments had never recognised such a role for hospital directors:

'Hospital directors can no longer, whatever the government decides, lead for the [public] good this reform rejected by a large part of the medical profession ... It is now too late to ask them to play the leading roles on a dossier from which they have been deliberately pushed aside from the beginning.'<sup>142</sup>

Here, Vincent was following the lead of his rank-and-file membership. Within hospitals most directors hesitated to prepare for departments, which would complicate the introduction of the global budget - given the confusion about whether the future departments were automatically to be *centres de responsabilités*. In more than two-thirds of regional and teaching hospitals, the departmental commissions had never met.<sup>143</sup>

At no stage within departmentalisation had the BN been prepared to risk a prolonged confrontation with hospital doctors, fearing that, with medical hostility to organisational change, little would come of departments. And the SNCH leadership was divided over Vincent's attempt to exploit support for departments as a bargaining resource within negotiations for a new statute. This debate was heightened as the BN discussed the stance to be taken when Dufoix's rewritten decree came before the *Conseil Supérieur des Hôpitaux* on 26 June 1985. There remained defenders of departments such as Vallet and even Trazzini who wanted the SNCH to support the decree so as to maintain the idea of the text. However, others wanted the SNCH to abstain, notably Grandjean, Paire, an original supporter of departments, and Paillé. Within the CN, individuals such as Romanens and Marie were keen to make the connection between the lack of returns for the SNCH from previous support for government reforms. Eventually, the compromise which emerged was for the SNCH to abstain if a global vote was taken, and to reject the article on appointment of heads of functional units if the vote was article by article.

The SNCH leadership was intent on drawing attention to the dependency tying government to hospital directors. At Caen, Vincent flaunted the spurned grassroots influences of hospital directors, sending the message that to win back the confidence of the SNCH the Mauroy government had to unblock negotiations over statutory improvements. Indeed, the SNCH now lost interest completely in departments except as a tool for advancing its statutory gains. However, in searching for the acceptance of the *conférence*, Dufoix had signed a pact with known supporters of the RPR - Pellerin was one of a small policy group working in Paris for Chirac.<sup>144</sup> However, the pact was inevitably unstable. Perhaps inevitably, the *conférence* reneged on its agreement with Dufoix, provoking Fabius to withdraw the decree the night before it was to be discussed at the *Conseil Supérieur des Hôpitaux*.<sup>145</sup> With the decree dropped, supporters of departments seized the opportunity to lobby Matignon and the Elysée against what they considered to be the abandoning of departments. Indeed, Peigné put personal pressure on the Elysée to relaunch departments. The Elysée responded with the appointment on September 1985 of Jean Terquem, one of the 1983 *Médiateurs* and a former advisor to Mitterrand. The introduction of departments was once again relaunched.

### *Flogging a dead horse: Terquem*

Coming as it did after a summer of inactivity, the appointment of Terquem, who quickly acquired the title of 'Mr. Départementalisation', was little more than a last ditch attempt to accelerate the introduction of departments before the legislative elections of March 1986. Given the approaching elections, Terquem did not engage in yet another round of consultations, preferring to make his proposals public by mid-September.<sup>146</sup> He assembled a small team of advisors which relied upon Kervasdoué and Gilles Johannet, the former member of *Santé et Socialisme* from Dufoix's *cabinet*. He reinforced these ministerial collaborators with Peigné and Gatelmand, who although on the right wing supported departments because his members were mostly from general hospitals or *mono-appartenants*: 'I came to an agreement with Johannet and Kervasdoué. And, then in the evening, I met up with Peigné and Gatelmand. And, that was it.'<sup>147</sup>

In fact, by September 1985, there was no ministerial leadership on the dossier. Both Dufoix and Hervé were not prepared to take responsibility for the decree:

‘Hervé who, I consider to be an honest bloke, serious-minded, competent, was a strong supporter of departmentalisation, but he was a timid, scrupulous man, “I am only a Junior Minister”... so much so that discussing with Hervé and ... his advisors, he said “Okay, okay, you're right, very well, you have to go and see what they think of it at Dufoix's”. Then, I went to see, well, she thought nothing, Dufoix and her advisors: “well, very good, but what do they think of it at Fabius's!”’<sup>148</sup>

Likewise the Elysée and Matignon, although keen to minimise opposition in the approach to the 1986 legislative elections, left Terquem to formulate the decree, trusting his judgement: ‘Nobody telephoned me to tell me that heads of service should retain the majority [in the departmental council]... there is a climate.’<sup>149</sup> Indeed, within the Fabius government, there was a general recognition that the PS had missed the opportunity to move towards departments within public hospitals.<sup>150</sup> Terquem recognised himself that he was on a ‘suicide mission.’<sup>151</sup>

The Terquem decree was released for consultation, before going to the *Conseil Supérieur des Hôpitaux* on 27 September 1985. To ease its implementation, Dufoix promised that there would be budgetary and personnel ‘rewards’ for hospitals reorganising in departments. However, the decree was published in December 1985 just three months before the legislative elections at which opinion polls strongly predicted a victory for the Right. In short, the anti-department lobby within the medical community had achieved their short-term goal of delaying implementation. Thus Terquem’s work merely threw out a symbolic line to those who supported departments. However, after the dominance of the *conférence*, the Fabius government returned to the likes of Peigné and *Santé et Socialisme* to guide departments through in a period of strictly controlled internalised policy-making.

### *The SNCH prepares for the RPR*

Not part of the restrained team of advisors surrounding Terquem, the SNCH remained divorced from the formulation of the September 1985 decree. Terquem relied upon Kervasdoué to inform him about the climate of opinion within the *corps*: ‘Hospital directors discussed [departments] with Kervasdoué and when I discussed with Kervasdoué, ... he said “Take into account hospital directors”.’<sup>152</sup> Within the Hervé *cabinet*, Pierre Rayroles, the ENSP graduate and leader of the SNCH 1983 working group at Roubaix, now tracked the work of Terquem, but remained divorced from the

decision-making process. However, in anticipation of the Right's return to office, the Vincent leadership had already abandoned departments in the interests of assuring the necessary statutory gains for the *corps*. At the *Conseil Supérieur des Hôpitaux*, it voted against the Terquem decree, blocking the introduction of departments for the first time; a decision motivated by the continued obstruction of the reform of the statute of hospital directors rather than the Terquem decree: 'There were fundamental reasons, but equally there were tactical reasons.'<sup>153</sup>

Rayroles inherited from Grateau the statutory negotiations with the *corps*, but here his work foundered repeatedly upon the continued obstructionism of the DB coordinated by Marie-Hélène Bérard, a member of the RPR, and ironically, a personal friend of Vincent.<sup>154</sup> Rayroles accused Bérard of deliberately obstructing the dossier for political gains: 'When she crushed me on my decree in 1986 ... Marie-Hélène told me "The statute for hospital directors, I'll grant it in a year".'<sup>155</sup> Rayroles' failure to force through the revised statute strained his relationship with the SNCH. As with other hospital directors previously within the *cabinet*, the Vincent leadership failed to nurture its ties with Rayroles who, despite his ENSP origins, defined himself as everything but a relay within the Ministry for the SNCH leadership:

'The profession held it against me,... not against the Minister, but against me. As I said, at the time, to a certain top official of the trade union [SNCH]: "By what mandate do you believe that I am ordered by you... I am not here to serve you, I am sorry"'.<sup>156</sup>

On 13 November 1985, the BN hardened its negotiating stance towards the Fabius government. Aware of the DB's desire to stall negotiations, Vincent was prepared to bank upon the defeat of the Left and pursue a strategy designed to 'entice' the Right: 'We felt that government was going to change; the only way to get something was to frighten the Right.'<sup>157</sup> First, Vincent organised a walkout of hospital directors whilst Dufoix was speaking at the *Assises de l'Hospitalisation Publique* in December 1985.<sup>158</sup> Second, on the initiative of Coz, in early December the SNCH bought a page in the national daily, *Le Monde*, to publicise the danger facing public hospitals under the headline of 'French men and women, the SNCH is telling you: your public hospitals are in peril.'<sup>159</sup> Spurred on by its stalled statutory negotiations and the allegedly unrealistic increases in hospital budgets for 1986, the SNCH took a public swipe at PS management of public hospitals:

‘Annual budget increases are less than real inflation and medical progress is thus threatened; investments are still blocked; organisational reforms, clumsily imposed are putting the internal cohesion of hospitals in danger; finally, the petty bureaucratisation of hospital directors is the first step towards the nationalisation of our establishments’.<sup>160</sup>

In fact, Vincent and Paillé concluded an informal understanding with Bernard Debré, who was an advisor to the RPR leader Jacques Chirac, as well as being leader of *Solidarité Médicale*.<sup>161</sup> This agreement called for the SNCH to fail to promote departments in order for the RPR to accept Article Two of the 1984 Hospital Law. Indeed, the RPR and the UDF in an effort to win the support of hospital directors agreed that hospital directors could leave the *Titre IV*.<sup>162</sup>

From January 1986, the SNCH withdrew from further confrontations with Dufoix or Hervé. Vincent justified this withdrawal by both the need to preserve the union’s neutrality during the electoral campaign, and the belief that the rank-and-file did not have the necessary will to see the demands of the SNCH met.<sup>163</sup> However, relations between the SNCH and the Fabius government deteriorated. First, the government began to place its supporters on the *Conseil Général des Hôpitaux* before the institution had been formally agreed. Second, it threatened the autonomy of the *corps*, undermining the hold of Maurice Rochaix over his post as general director at the *Hospices Civils de Lyon*. Finally, it refused to countenance the SNCH’s demands to improve the statutory revisions offered to hospital directors.<sup>164</sup> Thus, the SNCH simply dropped departments and waited for the election of the RPR and UDF opposition. The statutory reform negotiated by Rayroles was finally pushed through, but remained unacceptable to the SNCH. Indeed, it was the first such statute published against the union’s wishes. As Paire recognised, the SNCH had been absent from the discussions concerning the development of the *Conseil Général des Hôpitaux*.<sup>165</sup> However, as expected, the March 1986 legislative elections returned a RPR-UDF majority to the National Assembly and Mitterrand appointed Chirac as Prime Minister to lead the first government of cohabitation under the Fifth Republic.

#### 6.4 THE CONSERVATIVES' REVERSAL OF THE REFORM

The Chirac government failed to appoint a Health Minister, leaving Philippe Séguin, as Minister for Labour and Social Affairs, to combine health with the management of the



social security funds. However, lobbying by RPR *mandarins* soon forced Chirac to rectify what was portrayed as a mere oversight with the nomination of Michèle Barzach as Junior Minister for Health.<sup>166</sup> The former RPR delegate for social affairs was not one of the Debré band of vocal *mandarins* who waved the flag of the RPR whilst in opposition. Instead, her professional background was as a gynaecologist:

‘It was at times, quite amusing because [...] people asked her what her hospital titles were ... You could hear a pin drop ... they could not imagine that a Minister who was a doctor did not have hospital qualifications.’<sup>167</sup>

To compensate for such deficiencies, Barzach was shadowed within her *cabinet* by Pellerin, the vice-president of the *conférence* and leading member of RPR health policy working groups when in opposition.<sup>168</sup> His appointment reflected the decision by the Chirac government to ignore its most vocal supporters in opposition, not least Debré and the *Syndicat Autonome*. Indeed, Chirac bowed to the traditional avenue of medical influence, that of the *conférence*.

In opposition, the Giscardian and Gaullist parties pledged to reinstate private pay beds and return to services. However, they left unsaid whether the return to services implied a return to the pre-1981 organisation of public hospitals. As the newly-installed Chirac government began to formulate its hospital legislation, Séguin clashed with Barzach as he lobbied for the continued promotion of departments rather than a return to life-long appointments in services.<sup>169</sup> However, after sporadic early interventions, Séguin withdrew, leaving the formulation of the Bill to the Barzach *cabinet*: ‘For Séguin, the world of hospitalisation, hospital directors all that did not exist.’<sup>170</sup> His withdrawal left Pellerin facing little opposition. The vice-president of the *conférence* possessed a reputation and technical experience which Barzach and her technical *directeur de cabinet*, Guy Berger a ‘nobody’<sup>171</sup> from the Court of Accounts could not possibly match: ‘Barzach did not know a great deal and I [Pellerin] was considered in the team as the one who knew all the problems the best.’<sup>172</sup> The DH under Kervasdoué was isolated because both his socialist loyalties and the conflict over his successor between Séguin and Barzach sidelined its influence.<sup>173</sup> The post finally went to a compromise candidate, François Delafosse, an *énarque* and former advisor to Pompidou, who met the demand for a safe pair of hands, but had no experience of public hospital management. By the time of his arrival, the skeleton of the reform was already in place, and Delafosse did no more than

attend one interministerial meeting chaired by Chirac on 30 October 1986 to confirm the Bill:

‘The day I took up my duties, ... I asked one of my collaborators to give me the dossier of the reform, the bill, but he did not have it... They did not have the text in its entirety, that had been communicated from the *cabinet*’.<sup>174</sup>

Thus, the Chirac government swung behind the organisational reforms formulated by the *conférence* and endorsed by Pellerin within the *cabinet*. In line with the proposals of the Senate, these reforms recognised the necessity to repair the state-profession compromise through a return to private pay beds and services. However, they acknowledged the undesirability of a return to traditional services, accepting a balance between self-regulation and external evaluation. First, departments were reduced to voluntary associations, initiated by doctors and headed by a medical co-ordinator, but not having to conform to any common organisational model. Second, heads of services were no longer to benefit from life-long appointments, but instead to be subject to five-year evaluations based on reports of achievements. If they so desired, heads of service could create *pôles d'activités*, functional units delegating responsibility over certain tasks within services to junior doctors. Third, the managerial accountability, albeit mild, behind the evaluation of heads of services was supported by the transformation of hospital medical commissions which were attributed reinforced roles in the choice and modalities of treatment. Finally, to ram home the changes in professional self-regulation, the use of private pay beds was to be monitored by specific commissions, the *commissions d'activité libérale*, in each department.<sup>175</sup>

By November 1986, the Bill was ready to be forwarded to the National Assembly. It was adopted by the *Conseil Supérieur des Hôpitaux* although most articles were approved only by a narrow majority. Opposition focused upon the constraints on the right of doctors to treat private patients. Stripped of their substance, departments raised little opposition, apart from Peigné and the INMH who were keen to see the Bill withdrawn.<sup>176</sup> However, only minor changes were suggested to the Bill; the most significant of which was the removal of the reference to technical and economic evaluation from the remit of the revised hospital medical commissions, because doctors refused to be caught up in the logic of the global budget. Its proposals mirrored the influence of the *conférence* and

Pellerin who had assiduously courted Chirac whilst in opposition. Debré and his fellow *mandarins*, the more vociferous supporters of the Right, had been sidelined along with those like Peigné who had associated themselves with the move towards departments.<sup>177</sup> However, with the Bill ready for the National Assembly, student strikes against university reform tied to industrial action in the public sector led Chirac to announce a pause in government action.<sup>178</sup> Barzach pushed through the return of private pay beds, due to be phased out by socialist legislation at the end of 1986 and delayed the rest of her Bill.

### *The SNCH reaps its rewards*

Like Dufoix, Barzach immediately courted the SNCH, writing to its 1986 Bordeaux conference in support of the reinforcement of the authority of hospital directors as heads of enterprise.<sup>179</sup> Indeed, she espoused the discourse of *hôpital-entreprise* deliberately pushed to the fore by Vincent. However, there were no hospital directors within her *cabinet*, although Trazzini, Grenon and Le Guennec were invited by Barzach to suggest reforms to the global budget and public hospital line-management (see Chapter Four). The corps had to content itself with appointments removed from the formulation of the hospital law, notably Christian Anastasy, part of the Vincent network, as advisor to Delafosse at the DH. However, the ‘absence’ of a *Directeur des Hôpitaux* weakened the influence of the SNCH throughout the formulation of the Bill.

However, to all intents and purposes, the Vincent leadership had long since opted out of departments. Under Barzach, with departments devoid of any substance, it had even less incentive to rally for a stringent definition of departments than it had under the PS. It left any opposition against the relegation of departments to Peigné and the INMH. Indeed, supporting the general framework defined by Barzach, the SNCH leadership touted five-year evaluations of heads of services as one of its own earlier proposals.<sup>180</sup> Instead, it made its fundamental bargaining issues the restoration of pay beds and the prerogatives attributed to revised hospital medical commissions. Meeting with Séguin, the SNCH, confirmed as early as 16 June 1986, its opposition to the private beds, which it saw as a poor response to the crisis of hospital doctor recruitment, a stance asserted by the union’s conferences at both Monaco and Bordeaux.<sup>181</sup> Equally, it opposed the increased responsibilities attributed to hospital medical commissions which threatened the

influence of Boards of Trustees and hospital directors. Indeed, the SNCH argued that no *hôpital-entreprise* could work with a plurality of decision-makers at its strategic apex.<sup>182</sup>

This move away from departments belied the overriding concerns of the Vincent leadership to negotiate a revised statute as the elite consensus underpinning the Mâcon strategy fragmented (see Chapter 4). However, the SNCH leadership had to convince the Chirac government not to apply the socialists' March 1986 settlement whose very legality it challenged. A delegation led by Vincent met with the Barzach *cabinet* on 10 April 1986 to discuss its statutory reform, employing the meeting to criticise the statute promulgated by the PS, particularly its absence of equity.<sup>183</sup> The SNCH demanded that directors leaving the ENSP be able to reach the top posts within the *corps* within 18 years, that the posts of general directors not be separated from posts in First Class, and that a Paris office of the ENSP and more radical reforms to training programmes be established. In addition, it considered the *Conseil Général des Hôpitaux* to be an ill-defined second rate IGAS used to provide for PS dignitaries such as Dr. Georges Benedetti or Jean Blocquaux (a former technical advisor to Dufoix).<sup>184</sup>

The BN remained preoccupied with leaving the *Titre IV*. Support for such an eventuality continued to unite an eclectic coalition stretching from Paillé and Rolland, through to the reluctant Romanens (who saw it as a tool to improve the image of the SNCH externally), and Paire (who saw it as a means of protecting posts from other civil servants).<sup>185</sup> However, opponents such as Vallet, the *Grenoble 80* stalwart who feared exposing posts, raised concern that what began as a tactical move to enhance the bargaining power of the SNCH was developing into a fundamental principle of the union with little debate from the BN.<sup>186</sup> Progressively, the majority of the BN endorsed the move to remain faithful to the entrepreneurial logic of public hospitals. In fact, regional delegates in the CN endorsed the exit of *Titre IV* on 6 May 1986 with only three dissenting voices. It agreed to put forward a bill to senators and deputies proposing the withdrawal of directors from *Titre IV*.<sup>187</sup>

However, Barzach admitted to the SNCH that she faced political difficulties in allowing hospital directors to leave the *Titre IV*.<sup>188</sup> Preparing her retreat from promises made whilst in opposition, she tried to convince directors that leaving the *Titre IV* was not as important as the specific pay and conditions devoted to directors within its general

framework. Concerned about recent nominations to the *Conseil Général*, she also prepared to renege on its implementation.<sup>189</sup> In response, the SNCH lobbied heavily during September 1986 meeting with Chirac, Séguin and Barzach.<sup>190</sup> Paire was particularly concerned to promote the *Conseil Général* into a quasi-general inspectorate modelled on the IGAS and the *grands corps*.<sup>191</sup> However, the IGAS and the FHF successfully lobbied Matignon to withdraw the issue from the Barzach Bill.<sup>192</sup> In response, Matignon delayed its decision until the finalisation of discussions over the reform of the statute of hospital directors. To offset the possible loss of the *Conseil Général*, the SNCH demanded ten places for hospital directors in IGAS.<sup>193</sup>

As under the PS, the statute was held up in the corridors of Matignon and the Finance Ministry. This delay occurred despite the appointment of Bérard, Vincent's friend from the DB, as social policy advisor to Chirac, although Bérard quickly formed an effective partnership with Barzach.<sup>194</sup> When the SNCH was informed in mid-November that the Prime minister's office had agreed to change its statute, the 1986 student crisis and 'pause' decided by the Chirac government further hampered the issue. The 'pause' only served to increase the pressure upon Vincent, who had offered minor rewards to the rank-and-file, but appeared once more to be shut out of negotiations.

In fact, with spring 1987 approaching, the Vincent leadership was drawn into threats of strike action to advance its claims. On 10 March 1987 the SNCH held a *congrès extraordinaire* where the assembled delegates agreed to march from the National Assembly to the Health Ministry in defence of their statutory demands. The demonstration was to coincide with the parliamentary debate on the 1987 Hospital law.<sup>195</sup> This threat of action appeared to relaunch negotiations with Barzach. The day after its Paris conference, Barzach informed the SNCH leadership of the proposed statutory decree for hospital directors and agreed to discuss the terms of other administrative categories. In return the SNCH leadership withdrew its strike action, claiming that it was difficult to organise, fell in the school holidays and would clash with the demonstration of medical students. This withdrawal permitted the Vincent leadership to maintain its stance of responsible trade unionism, but opened it to attacks by delegates at the 1987 Lyon conference.<sup>196</sup> However, most importantly for the Vincent leadership, negotiations were relaunched, with meetings held between the government and the SNCH throughout April.<sup>197</sup> The final interministerial

meeting on the statute was signalled to take place on 14 May.<sup>198</sup>

The negotiations paralleled the parliamentary debate over the Barzach Bill. Its first reading took place on 28 April, with Debré leading the calls of RPR *mandarins* for the automatic reappointment of heads of services.<sup>199</sup> The SNCH lobbied for reduced attributions of responsibility for hospital medical commissions, and assurances that directors chaired local commissions on private pay beds.<sup>200</sup> Equally, it set out positions against the grouping of private clinics and for the application of the global budget in private clinics. However, the Vincent leadership had no intention of jeopardising its concurrent negotiations for improved pay and conditions. Areas of contention still remained between the SNCH and Barzach over the *tour du ministre*, the capacity of ministers to appoint from outside the *corps*, the maintenance of the *Conseil Général*, the reform of the ENSP and bonus payments for directors. However, the SNCH was ready to compromise and accept both the maintenance of *tour extérieur* in the First and Second classes and the evaluation of general directors every five years. This last position was in keeping with its culture of new public management and was no more than what the unions accepted for heads of service. As for exiting the *Titre IV*, the SNCH decided to accept the Barzach statute, but maintain its lobbying of the National Assembly for change.

The final arbitrage for the statute came at the end of July. The Mâcon strategy finally delivered as Bérard gave what she said she would: ‘They [the modernist leadership] pulled their iron out of the fire because... [the Chirac government] took great care of them, .... a new financially advantageous statute. They pocketed that.’<sup>201</sup> In return for accepting that general directors were nominated for renewable five year periods dependent upon their performance in post, the *corps* received an opening of its classification, improved pay and conditions, and changes to the ENSP training programme (see Table 6. 6).<sup>202</sup> Indeed, the Chirac government withdrew its claims to appoint individuals from outside the *corps* to the posts of general directors and threw in ten sabbatical leaves, known as *congès spéciaux*, for First class directors 55 years old or above. These sabbatical leaves increased the prestige of the *corps* and by-passed the problem of the *Conseil Général des Hôpitaux* by providing the *corps* with the ten end-of-career exits that it had expected from the *Conseil Général*.

**Table 6.6: Chirac's Presents - the 1988 Statutory Gains**

<p>Fourth Class to join other classes in Category A. Increased opening to one-third of Fourth Class to Third Class and improved career bonuses.</p> <p>Reclassification of existing classes, with directors to move from Third to First Class in 12 years.</p> <p>Twenty five percent of directors rather than existing 13 percent to reach First Class from Third.</p> <p>First Class directors to move to Letter A payment scales (amongst top salaries in civil service). Ten general directors to move to Letter C.</p> <p>General directors appointed for five-year renewable terms dependent on assessment of managerial performance.</p> <p>ENSP training programme to be lengthened to 27 months (same as ENA).</p> <p>Ten sabbatical leaves as in <i>grands corps</i> to be introduced.</p>
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With the publication of the statute in January 1988, Vincent publicly thanked Chirac and Barzach for pushing ahead with the reform against opposition.<sup>203</sup> Such a successful end to negotiations quelled opposition to the strategy. However, although the SNCH reaped the pecuniary rewards of the Mâcon strategy, Vincent and the BN were aware of its constraints and there were fears that the union had reached the end of the road with the 1988 settlement on pay and working conditions.<sup>204</sup> Not only had the Mâcon strategy subordinated the demands of non-hospital directors within the SNCH, it had also failed to deliver the hospital management reforms necessary for the professionalisation of the *corps*.

## CONCLUSIONS

The extended saga of a contested and ultimately failed endeavour at organizational reform, intertwined with the hospital directors' much less contentious quest for greater state recognition, reveals a great deal about the complexities of policy-making in the French health care sector. The departmentalization battles most clearly revealed the strength in depth of the medical profession, and the extent of their points of access and pressure - ranging from the mobilization of defensive grassroots public protests and strikes (especially against Ralite's attempted *fait accompli*) through to the direct access of senior doctors to Mitterrand in the Elysée, and their ability to persuade the opposition to emasculate a move towards greater managerialism and efficiency gains which right wing politicians might have been expected to support. At times, the doctors' opposition verged towards the ludicrous, notably in public statements which equated the introduction of

departments to the mass extinction of intellectuals in Cambodia. But, the doctors' influence was so great that their professional reputation could survive both the lurch into strong forms of anti-government protests and the cleavages between the diehards wedded to services and life-long posts, through those who supported the principle but were never quite satisfied with the practical details of its application, to the minority of doctors who supported the reform and would countenance no compromise. At all stages the lead actors holding the dossier were strongly influenced by different shades of medical opinion.

By contrast, the hospital directors played a much less important role in the wings of the departmentalization controversy, and pursued throughout a much more sensitive, complex, tactical and carefully modulated policy line which spoke volumes for their own awareness of the comparative weakness of their position. The SNCH especially had to tread a fine line both because of its relatively weaker access to senior politicians, ministers, their *cabinets* and other policy-makers than the doctors, and because the modernizing leadership were bound by the careful compromises of the Mâcon conference resolutions into maintaining an internal balance of rank-and-file and leadership interests. That the long series of battles in which they were fairly tangentially involved should culminate in the SNCH's acquiring significant new state concessions which greatly boosted the professionalization of hospital directors is only partly a tribute to the wisdom of their shifting line. The union leadership played a long game, throwing their weight conditionally behind departments at the start of the process, withholding further commitment later as the government seemed unlikely to face down the doctors' resistance, and in the end going with the wind for rejecting the PS government's later efforts in time to establish a good relationship with the Chirac government. But, the renegotiation of the *corps*' status proceeded on a separate, more routinized track, where the connections with departmentalization were never firmly established. And the Chirac government's final concessions to hospital directors on professionalization reflected in part the cumulative experience of the Left's partly successful and partly unsuccessful reforms - all of which tended to confirm the central government's dependence on securing allies within the public hospitals system if they were to secure any changes at all in directions that they wanted.

The SNCH's relatively conditional access to ministers and policy-makers during



the departmentalization phase mattered less than it might have done under other circumstances, since the Left government's initiatives were doomed from the outset to make little progress. Ralite was greeted with suspicion because of his Communist party affiliation, and the manner of his initial launch of the departmentalization proposals. His subsequent inability to manage the rupture in relations with the doctors, left his successors fighting uphill, unable to attract the stronger support from bodies like the SNCH which might have acted as a bit of a counterweight to medical lobbying, and with progressively less clear visions of the changes they were anyway trying to achieve. In these circumstances, the SNCH's tactical shifts could allow it to edge its interests ahead, despite its rather conditional access to influence, and the Vincent leadership's inability to show much concrete progress on professionalization before the 1986 election. But, the fears of exhaustion of the Mâcon strategy already apparent under the new government reflected the SNCH's clear need to ratchet up its influence another notch if it was to secure the expanded role in the hospital system which the hospital directors' *corps* had set itself as a target.

## ENDNOTES TO CHAPTER SIX

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19. Commission Hirsch, *Rapport sur la départementalisation*, pp. 13-15; Steudler, 'Le département hospitalier', p. 14; *Le Quotidien du Médecin*, 22 November 1982.
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22. Marie-Aude Poisson, (1985), 'Le département à l'hôpital', p. 141.
23. *Le Matin*, 11 December 1981.
24. *Le Quotidien du Médecin*, 10 November 1982.
25. Prof. J. Escat, letter to Jack Ralite, 24 November 1982; *Le Quotidien du Médecin*, 22 November 1982.
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## CHAPTER SEVEN

### PLANNING SYSTEMS AND THE MANAGEMENT OF HOSPITALS: THE 1991 HOSPITAL LAW

The global budget and the reorganisation of services failed to address satisfactorily the absence of mechanisms to regulate the allocation of resources in the French public hospital service. As implemented, the global budget was a blunt instrument which froze the existing distribution of resources between hospitals. It did little to shake out the surplus 60,000 hospital beds commonly acknowledged to exist in the French public system; beds already targeted by the 1979 measures put in place by Veil (see Chapter Five). In 1991, the Rocard government introduced a renovated system of regional planning which sought to combine extended managerial freedoms for public hospitals with the top-down regulation of the delivery and allocation of resources within the public hospital service. This new legislation completely rewrote the 1970 Hospital Law, and so the Rocard government went one step further than previous governments which had simply rewritten selected articles or passages of existing legislation.

The renovation of the hospital planning system mirrored the policy discourse promoted by the SNCH earlier in the mid-1980s. The reforms accommodated both the regional planning of the *200 Propositions* and the managerial freedom of *hôpital-entreprise* (see Chapter Four). Indeed, the formulation of the 1991 legislation brought to the fore a network of ENSP directors who invaded the key loci of decision-making at the various stages of the passage of the Bill through the processes of consultation, inter-ministerial negotiations and parliamentary scrutiny. The opening section of the chapter examines how the SNCH was advantaged by the changing institutional configuration brought about by the presidential and legislative elections of the spring and summer of 1988. The second part analyses the formulation of the law and the changing strategy of the SNCH as it lobbied the Rocard government. The third section examines the inter-ministerial negotiations surrounding the 1991 legislation and how, this time, the *corps* of hospital directors managed to ward off the territorial aspirations of the *Inspection des Finances*. The final part of the chapter analyses the passage of the 1991 Law through a



National Assembly with reinvigorated deliberative powers after the electoral consequences of the events of 1988.

## 7.1 RELAUNCHING THE REFORM PROCESS

At the 1988 national conference of the SNCH, Vincent acknowledged the impotence of the trade union in face of the cross-party consensus against further upheavals in the management of public hospitals.<sup>1</sup> The Barzach legislation had patched up the state-profession compromise, restoring calm to the troubled waters of organisational reform under the French Socialists. Preaching stability in numerous policy areas, Bérégovoy, Mitterrand's spokesperson throughout the 1988 presidential campaign, insisted that the PS would not subject public hospitals to "legislative ping-pong" upon its return to office.<sup>2</sup> However, the presidential strategy pursued by Mitterrand to assure his second term in the Elysée did have important repercussions for the resources at the disposal of the SNCH. The union's leadership was advantaged by a series of contingent events triggered by the ramifications of the strategy employed by Mitterrand for both PS support in the National Assembly and the composition of the Rocard government in 1988.

Mitterrand owed his re-election to his successful portrayal of himself as a neutral referee above political parties and sectional interests. To this end, he sponsored a strategy of *ouverture* which endorsed the entry into government of representatives of civil society and politicians from outside the ranks of his 'own' party, the PS. This successful presidential strategy translated poorly in the right-wing National Assembly where it hinged upon enticing sufficient centrist deputies in the *Centre des Démocrates Sociaux* (CDS) away from the RPR-UDF opposition. Obligated to dissolve the National Assembly, Mitterrand then contributed to a confused PS campaign at the June legislative elections where, in any case, the bipolarisation of the majority run-off legislative elections tied the centrists to the Right. Mitterrand and his Prime minister failed to gain an absolute majority within the National Assembly.<sup>3</sup>

To maximise his freedom of manoeuvre within the National Assembly, Mitterrand had appointed his fellow socialist and longstanding competitor, Michel Rocard, as his Prime minister. Rocard was the politician best identified with the strategy of *ouverture*,

vaunting his own style of government, the *méthode Rocard*, which privileged consensus and consultation.<sup>4</sup> However, he was unable to drive a wedge between the CDS and the RPR-UDF opposition. Following intense negotiations, only centrist personalities joined the government, although the CDS created its own parliamentary group, the *Union du Centre* (UDC), as it publicly weakened its ties with the traditional Right.<sup>5</sup> The UDC adopted a policy of constructive opposition to the Rocard government, predicated upon a case by case examination of its legislation. To compensate, the PS lowered the number of deputies required by a party to qualify as a formal parliamentary group; thereby ensuring the short-term favours of the weakened communists on the Left.

However, the Rocard government possessed an armoury of constitutional weapons to force its legislation through the National Assembly.<sup>6</sup> In particular, Article 49.3 permitted governments to identify legislation as a matter of confidence, ensuring its passage through the National Assembly unless the opposition successfully mobilised a vote of no confidence against the government. This said, the strategies of *ouverture* and the publicly-professed *méthode Rocard* placed symbolic restraints on the use of such weapons. They obliged Rocard to construct *ad hoc* majorities with the communists or more particularly, the UDC, elevated by the underlying orientations of *ouverture*.<sup>7</sup> This search for *ad hoc* majorities potentially reinforced the policy-making influence of the National Assembly to the benefit of the SNCH leadership which, frozen out of the central administration by competing *grands corps*, had purposely forged its own organisational networks within political parties. Indeed, Paillé had privileged access to the UDC, standing as the 'number two' to a CDS candidate in 1988 and resigning from his post as national delegate in November 1988 to work in the National Assembly for the UDC, although he remained vice-president of the union and member of its BN until 1991.<sup>8</sup>

In fact, the access of the SNCH to ministers and *cabinets* was bolstered in the summer of 1988 by the appointment of Claude Evin as Minister of Solidarity, Health and Social Protection in the second Rocard government. *Ouverture* dictated that the Health Ministry was initially attributed to a representative of civil society, Pr. Léon Schwartzberg. However, Schwartzberg resigned within a week of taking office and, when Mitterrand vetoed as his replacement, Bernard Kouchner, founder of the medical charity, *Médecins du Monde*, the Health Ministry fell into the hands of Evin.<sup>9</sup> Evin was

one of Rocard's lieutenants within the PS and was firmly-entrenched within the organisational networks of the *corps* of hospital directors. He was one of the vice-presidents of the FHF, but more importantly, chair of the Saint-Nazaire general hospital managed by Coz with whom he had collaborated in the past.<sup>10</sup> These ties were further strengthened by the appointment of the hospital director, Edouard Couty, to Evin's *cabinet*. Couty, a fellow rocardian, rose, like Merhle, within the ranks of the PS Health Commission in the mid-1980s (see Chapter Four). He held no post within the SNCH, but was an *assistanat* graduate from the Vincent generation. Unlike his predecessors in *cabinets*, Couty enjoyed a reputation throughout the *corps* as an innovator; his appointment was suggested by Coz.<sup>11</sup> He was later joined within the *cabinet* by Gilbert Chodorge, an ENSP graduate, who transferred from the DH to give support.

Thus, the 1988 legislative elections and subsequent appointments in the Rocard government upgraded the resources that the SNCH leadership could tap into. The SNCH harvested the fruits of its networking within political parties during the 1980s, and was advantaged by the interventions of actors who did not intentionally seek to advance the interests of the hospital director trade union. However, hospital management reform at first remained off the agenda of the incoming Rocard government. It emerged within the Evin *cabinet* over the autumn and winter of 1988 as a means to quell the short-term political difficulties facing the Minister of Solidarity, Health and Social Protection.

### *Short-term political constraints*

On his arrival in office, Evin, as befits one of Rocard's lieutenants, put his faith in a series of pragmatic and incremental managerial initiatives. He intended, at most, to swing the pendulum back in favour of departments, informing the Director of Hospitals that: 'You mustn't rush things, you must consult fully, advance with small strokes, pragmatically. All these big reforms, No. You must do little concrete things.'<sup>12</sup> Under his leadership, the Ministry began trials of state-hospital contracts with the signing of a five-year development contract with Lille regional hospital, in line with one of the *200 Propositions* of the SNCH.<sup>13</sup> In addition, in October 1988, Evin commissioned a series of reports on managerial reform within public hospitals. One such report was attributed to Peigné as the PS sought once more to elevate the INMH or, at least to quell its expectations of a return

to departments. Initially imposed by Mitterrand, Peigné included in his team the former general secretary of the ENSP, Guy Collet, and his former collaborator, Gatelmand.<sup>14</sup>

Evin inherited from the Chirac government a long-running conflict with nurses over the non-application of previously agreed improvements in their pay and working conditions. Delafosse, the Director of Hospitals, informed Evin in the first days of his ministry, of the pressing need to agree a settlement with nursing trade unions if he was to avoid strikes by nurses in the autumn.<sup>15</sup> However, Evin ignored the advice of his Director of Hospitals, with the result that strikes broke out in the second half of October 1988, led by grassroots *coordinations* of nurses rather than established trade unions.<sup>16</sup> From the beginning of 1989, these strikes triggered pay demands from hospital doctors and student doctors.<sup>17</sup> Not to be outdone, in March 1989, Vincent deemed it necessary to berate Evin for ignoring the role of hospital directors within public hospitals, although he remained keen to stress that the SNCH was not in disagreement with the overarching policies pursued by the Minister.<sup>18</sup>

Somewhat obligingly, Evin pledged to deal, in turn, with the difficulties facing all hospital personnel after reaching agreement with striking nurses.<sup>19</sup> This pledge risked locking the Minister of Solidarity, Health and Social Protection into an endless round of negotiations and unwelcome media coverage from strikes and demonstrations. Within his *cabinet*, this looming threat encouraged support for a radical reform of the 1970 Hospital Law. The interventionists were led by Couty, Marcel Atlan, former advisor to Hervé, and Didier Tabuteau who was plucked by Evin from the Council of State. They argued that the complete rewriting of the 1970 Hospital Law could be a 'political exit', enabling Evin to go 'beyond all these [pay demand] problems by undertaking a large reworking of the whole of the system with a big project, with a big law.'<sup>20</sup> Accordingly, it would by-pass the spending constraints imposed by Matignon and draw the sting from pay demands as it interpreted unrest as the product of progressive failures to modernise hospital management. With this pressure from the interventionists, Evin moved progressively away from dissenting voices which preached caution, arguing that reform actually ran the risk of mobilising hospital staff against the Rocard government.<sup>21</sup> Indeed, he came to endorse the stance of the interventionists, despite his faith in incremental initiatives and piecemeal change.

However, with their battle won in their own ministry, the interventionists still had to overcome the caution voiced by other ministries. Notably, the *Direction du Budget* (DB) questioned the necessity of a full-blown hospital law, advocating instead piecemeal changes to existing legislation so as to maintain control over hospital spending. However, Evin's proposals underwrote the Prime Minister's own government-wide initiative to renovate the management of French public services.<sup>22</sup> As Rocard's lieutenant, Evin was able to count upon the support of Matignon to overcome resistance to reform, voiced as it was by the ministerial divisions of one of his rivals in the PS, Pierre Bérégovoy. The Rocard government could not contain the internal divisions within the PS which increased as the influence of Mitterrand waned.<sup>23</sup> Bérégovoy was a supporter of the former Prime Minister, Laurent Fabius, who was a key rival of Rocard for control of the party. For once, health and social affairs possessed organisational resources to counteract the traditional predominance of the Finance ministry.

The Rocard government duly announced its reform of the management of public hospitals after a meeting of the Council of Ministers on 12 April 1989.<sup>24</sup> From the outset, Evin sought to make planning the backbone of the reform.<sup>25</sup> His orientations envisaged the generalisation of hospital-government contracts, such as that signed with Lille regional hospital. These contracts would be negotiated in line with the strategic objectives of regional plans and would usher in moves to *a posteriori tutelle* or regulation of public hospitals, evaluating how far hospitals met the objectives stated within each contract. These proposals built upon a discourse of modernisation through planning which replicated regional planning and contractualisation in other policy sub-systems. But, it also acknowledged a plethora of past reports and initiatives, including the 1985 Étienne report commissioned by Bérégovoy and Dufoix, and the proposed reform withdrawn by Ralite in 1983. In addition, they mirrored proposals contained within the reports commissioned in October 1988, particularly those of Peigné and the IGAS inspectors, Silland and de Camas. Silland advocated moves to *a posteriori* controls on public hospitals with heightened managerial autonomy in the implementation of top-down financial and health objectives as laid down within regional plans covering both public and private hospitals.<sup>26</sup> Working in collaboration with Silland, the DH acknowledged the findings of her report, but deemed that it 'only furthered the outlines [of projects] begun over the last few

years.<sup>27</sup> However, Peigné (who had worked closely with Couty<sup>28</sup>) handed Evin a progress report in early April 1989 and broke ranks to demand a set of improved pay and statutory conditions for hospital personnel. This recommendation misread Evin's motivations for undertaking the reform in the first place.<sup>29</sup>

### *The corps of hospital directors takes the DH*

The SNCH was not divorced from this policy discourse of modernisation through planning, despite its moves towards a more autonomist managerial stance. Its leadership claimed a direct line of policy inheritance from the orientations defined by Evin to its own earlier policy programme: 'The *200 Propositions* were formulated in the years around 1985. The legislator was inspired by them five or six years later.'<sup>30</sup> In fact, Coz took on an advisory role at a series of informal 'brainstorming' dinners organised by Evin in March 1989: 'We quite rapidly saw him play an unofficial role within the entourage of the Minister without having an official post.'<sup>31</sup> Coz sat alongside other hospital directors, in particular, the *cabinet* members, Couty and Chodorge. Thus, the SNCH found itself in the current of a policy stream to whose creation it had contributed as

'several people who were saying the same thing at the same time, (...) because these were the ideas in the air which were circulating and which rose up like that. Well, it is true that certain [ideas] came out of the Étienne report, others (...) came out of the works of the SNCH (...). Other ideas (...) came out of the whole discourse that was born at the time and [formalised] under the name of *hôpital-entreprise*.'<sup>32</sup>

More importantly, for the SNCH, the rewriting of the 1970 Hospital Law signalled the end of Delafosse's tenure at the DH. Evin employed Delafosse as a dispensable front man in his disputes with nurses.<sup>33</sup> However, having won the case for reform, the interventionists within Evin's *cabinet* lobbied for his removal because he was identified with the Right. And, with no grassroots experience of public hospitals, he lacked the requisite managerial profile to front the reform process.<sup>34</sup> This reasoning was favourably received by Evin, who recognised that the appointment of a new Director of Hospitals presented him with the opportunity to mobilise support within public hospitals, to 'bring together an alliance of modernisers' - if not within the ranks of the medical profession, at least within the ranks of hospital personnel.<sup>35</sup> Like socialist ministers before him, Evin was plagued by the requirement of the PS to 'soften up the medical trade unions and the

hospital world to make it understand that we are quite reasonable interlocutors.<sup>36</sup>

The replacement of Delafosse paved the way for the *corps* of hospital directors to make further inroads into the administrative networks from which it had been previously excluded. SNCH personnel were already present within Evin's coterie. He now turned once again to the *corps* to fill the vacant post of Director of Hospitals. The planning orientation of the forthcoming Bill mirrored the demands of the SNCH manifesto. Equally, the proposals generated increased responsibilities and strategic roles for hospital directors within public hospitals. Their successful implementation relied, in part, upon the cooperation of hospital directors and the grassroots support that Evin required in public hospitals. On 19 April 1989, Gérard Vincent was officially appointed as Director of Hospitals: the first hospital director to hold the post.<sup>37</sup> Given his previous criticisms of the Left, his nomination was not appreciated by the Elysée. However, Vincent was imposed by Evin who, once again, exploited his support within Matignon. Significantly, nursing managers within the SNCH dropped their strike plans on the same day that Vincent was appointed to the DH.<sup>38</sup>

Thus, driven by the interventionists within his *cabinet* (not least Couty), Evin moved progressively towards the acceptance of hospital reform to ward off short-term political difficulties. Triggered by strikes of nurses, his response to these immediate constraints strengthened the resources at the disposal of the SNCH. So too did the management of the hung parliament resulting from the June 1988 legislative elections and events over the summer of 1988. The SNCH and the *corps* of hospital directors were projected into a coalition of modernisers leading the reform of hospital management. The trade union's previous dissemination of the orientations contained in the Evin April declaration facilitated Vincent's nomination, an institutional foothold which gave the hospital directors' union entry into the core of decision-makers.

## **7.2 BUILDING A CONSENSUS FOR REFORM**

Through June and July 1989, the DH brought together eight working parties to flesh out the implementation of the Evin proposals.<sup>39</sup> The members of these groups were drawn from public hospitals, departmental and regional health boards and administrative divisions

within the central ministry. Each working party met on average four times over the summer. Their findings were supported by an additional report from the Mengual group, named after its chairperson, which was invited to collaborate in the development of the proposals concerning both the reform of hospital planning and the renovation of the *tutelle* exercised over public hospitals. This working party was initially established by Evin under the impetus of the *projet d'administration*, the ministry's response to the government-wide initiative for reforming the civil service. It embodied the specific contribution of the departmental and regional health boards to the formulation of the Bill: seven of its eleven members were directors of DRASS or DDASS.<sup>40</sup>

Within the DH, Vincent brought together his own team of advisors to oversee the formulation of the hospital reform. This team was led by two hospital directors from the SNCH, Patrice Barberousse and the former regional organiser, Jean-Luc Chassaniol. Chassaniol, with the support of the DH, coordinated the contributions of the working parties, reducing the DGS and the DAS to minor supporting roles. However, in keeping with Rocardian principles, Evin put in place a pilot committee of practitioners to oversee the formulation of the law, which met with working groups in September. This committee was composed, in the first instance, of Silland, Couty who 'resigned' from the *cabinet*, and Peigné who was further integrated into the reform process to weaken the criticisms emanating from the INMH. They were later joined by Professor Nicolas, head of cardiology at Nantes, and, as the necessary representative of the nursing occupation, by Dominique Kerroux, general nurse at Brest and, a former president of the national associations of general nurses.<sup>41</sup>

At the beginning of October 1989,<sup>42</sup> the committee took on an acknowledged public role because it was officially endorsed by Evin as the *Mission d'Information, de Concertation et de Proposition sur la Réforme hospitalière*, commonly known as the Couty Commission. In its working practices, the Couty Commission, which was constructed as a vehicle for consultation, embodied the *méthode Rocard*.<sup>43</sup> It spent over seven months, punctuated by the publication of its report on 5 April 1990, interviewing 150 individuals, visiting 25 establishments, and undertaking 12 regional forums beginning in late May 1990 in Lille and ending in Marseille in mid-June.<sup>44</sup> This practice of regional forums was initiated during the Rocard government's reform of telecommunications. In



preparation, the members of the Commission were all trained in public relations by Jacques Séguéla, who masterminded Mitterrand's presidential campaign in 1981.<sup>45</sup> Silland, more accustomed to working behind closed doors, remained in Paris to address regional feedback as the forums progressed.<sup>46</sup>

However, after the reports and, with the working parties already in place, the Couty Commission was very much seen by Evin and his *cabinet* as paving the way for the hospital reform in local hospitals rather than inspiring its formulation. Indeed, Evin publicly aired the emerging legislative details of the Bill for the first time in early December 1989 in front of the assembled ranks of the *Fédération Hospitalière de France* (FHF). From the rostrum, he confirmed the renovation of regional planning, the removal of the *a priori* approval of health boards on all management decisions except budgetary issues, as well as increased participation for nurses in the management of hospitals, the creation of departments and changes to the management of personnel. More importantly, he announced a significant departure from the general orientations presented in April because public hospitals were to be given a new *statut*, the framework which defined their legal status and operations. To provide public hospitals with increased managerial flexibility including the possibility of cooperation with new partners, they were to lose their designation as public administrative institutions and instead become *établissements publics de santé* (EPS).<sup>47</sup>

The emergence of the EPS framework owed much to the tactical awareness of the Evin *cabinet* who believed it to be a valuable asset in the forthcoming round of inter-ministerial negotiations.<sup>48</sup> The EPS framework masked a whole series of measures behind the principle of whether or not to accept the evolution of the statute governing public hospitals. In doing so, it avoided repeated confrontations with the DB. Indeed, Evin legitimised the EPS framework by having his speech to the FHF sanctioned by Matignon four days before the conference.<sup>49</sup> Despite the rejection by the Bérégovoy *cabinet* of the EPS framework as a source of rigidity rather than flexibility, Evin won an important negotiating resource for the forthcoming round of interministerial negotiations. Once again, the utility of Evin's ties to Rocard were heightened as Mitterrand's hold over the PS fell apart and rival factions fought for control of the party.

In keeping with its mission statement, the Couty Commission mirrored Evin's

proposals in favour of contractual regional planning and common accreditation mechanisms for public hospitals and private clinics (see Table 7.1 ).<sup>50</sup> In its April 1990 report, it supported the removal of controls from public hospitals, leaving them free to develop their own strategic responses to the changing needs of the local environment, within the confines of the goals identified by regional plans. Indeed, the report echoed previous statements that public hospitals would be obliged to formulate development strategies, *projets d'établissement*, in order to compete for service contracts in the areas of market expansion identified by regional planning commissions. In line with the declared programme of hospital closures and expansions, regional health boards would evaluate the development strategies of hospitals, entering into specific contracts with individual hospitals. In return, public hospitals would be freed from the extensive *a priori* controls exercised by DDASS on their management arrangements.<sup>51</sup> Inside hospitals, the Commission proposed the creation of new nursing structures, *services infirmiers*, to respond to the pressures for the participation of nurses in management. In addition, it sought to reinforce the tandem of hospital director and the chair of the hospital medical commission. This invigorated strategic apex would together devise the *projet médical*, the starting point for the *projet d'établissement*.<sup>52</sup> For Couty and his colleagues, the management of hospitals was to become more concerned with dynamic entrepreneurial responses to market change and competition to deliver services and local needs.

However, like Peigné's earlier report, Couty and his colleagues identified the expectations of hospital personnel as highest in the areas of resource redistribution (staffing levels, budgets and investments), and the internal rigidity of hospital management (in particular, the weakness of internal communication and absence of responsibility).<sup>53</sup> Deciding the appropriate response to these expectations of funding and internal organisational change triggered disputes between the members of the Commission. In particular, Peigné was on the verge of leaving the Commission on several occasions.<sup>54</sup> He relayed the positions of the INMH which refused to discuss legislation before the Rocard government dealt satisfactorily with the pay and working conditions of hospital doctors and personnel.<sup>55</sup> Equally, his steadfast support of departments brought him into conflict with Nicolas and Couty. Peigné saw departments as the solution to the demands for increased participation. However, Nicolas and Couty, supported by the concerns of the

DH working party to avoid repeating the upheavals of 1984, believed that there were more important issues to deal with and that the Commission had to go beyond the fractious debate of the early 1980s.<sup>56</sup> As a result, Peigné 'little by little, [...] distanced himself from the mission.'<sup>57</sup>

**Table 7.1: Couty report, regional planning for public hospitals and private clinics<sup>58</sup>**

<p><b>Health Map, Health Organisation Schemes, and Annexes</b> Formulated by regional consultative bodies, composed of local professionals and health representatives, and assisted by expert committees.</p>
<p><b>Health Map</b> to set the optimum level of services and equipment for the region for five years <b>Health Organisation Scheme</b> to lay down the allocation and distribution of services <b>Annexe</b> to indicate the creations and closures of beds and services necessary to achieve the targets of the health organisation schemes.</p>
<p><b>Renovated system of accreditation</b></p>
<p>Common system of accreditations for public hospitals and private clinics no longer on first-come-first-served basis. Introduction of fixed accreditations with periodic evaluation and minimum rates of activity and technical support for the delivery of services .</p>
<p><b>Contractualisation</b></p>
<p>Development contracts to meet objectives of regional plans to be signed between the State and hospitals, after consultation with Social Security funds, and in association, if desired, with local authorities</p>
<p><b>Public hospitals</b></p>
<p>Public hospitals to propose own <i>projet d'établissement</i> setting out for the next five years its general medical and development objectives and associated costings. These plans are based upon the <i>projet médical</i> which determines medical objectives in line with the health organisation scheme and integrates nursing objectives as defined by the <i>service infirmier</i>.</p>
<p><b>Freedom to Manage</b></p>
<p>Fewer decisions referred to departmental health boards, with moves to a posteriori regulation and shorter time delays for boards to respond. Justification for rejection of hospital planned decisions increasingly limited to threats to budgetary equilibrium of hospitals. Directors able to sign external contracts without reference to DDASS. Budgets only controlled at level of minimal mass categories and no longer line by line. Reform of traditional division of responsibilities between directors and comptables. Hospitals to be able to undertake commercial activities and cooperate with public and private actors through the signing of <i>groupements d'intérêts publiques</i>.</p>

However, this cleavage between Peigné and his colleagues was offset by Silland's support of stringent top-down regional planning which isolated her from her professional

colleagues who argued for flexible and indicative plans.<sup>59</sup> Members of the Commission accepted that a top-down compulsory framework would ensure that planning targets would be met, but recognised difficulties in their application to private clinics and, for that matter, to public hospitals.<sup>60</sup> The issue of including the private sector within regional plans gave ammunition to those in favour of indicative planning. However, as the DH working party pointed out in September 1989, an indicative framework would simply leave regional health boards at the mercy of the goodwill exercised by hospitals and clinics.<sup>61</sup> In a compromise which relegated the concerns of Silland, the Couty report argued that health organisation plans were to incite change, orientating choices rather than imposing them, although hospital-state contracts were to be the privileged means of implementing change. Typically, the CNAMTS was to provide an annual report to regional planning committees in order to increase the awareness of their members about regional health costs.<sup>62</sup>

In fact, these cleavages within the Commission mirrored clashes between the DH and the DSS; clashes which were fuelled by the institutional interests of the two administrative divisions (see Chapter Two). As well as conflicting views over the function of the Health Map, the DH consistently clashed with the DSS over the extent of the top-down controls to be imposed upon public hospitals by regional planning authorities. Its conception of hospital-state contracts as the product more or less of the sum of the grassroots development plans of public hospitals clashed with the DSS view which saw hospital-state contracts as the tools of the DRASS to implement the necessary reconversion of hospital beds. Indeed, the DH led by Vincent was in broad agreement with the planning system envisaged by the Couty Commission, with its criticisms directed at technical concerns of implementation rather than matters of principle.<sup>63</sup> However, the DH's acceptance of the necessity of top-down controls on hospital spending was tempered by Vincent's demand that planning contracts were supported by additional funding and that evaluation of results rather than controls on actions should serve as the key means of auditing the management of public hospitals. For instance, Vincent advocated annual reports on how hospitals were meeting the targets established in contracts.<sup>64</sup>

As Couty acknowledges, the DSS set out its store much like the DB: 'We knew

that the arguments that they were developing were the arguments that we would hear later at interministerial meetings from the mouth of the Budget.<sup>65</sup> As late as January 1990, the DSS argued (like the DB) that a full-blown hospital law was unnecessary or, at the very least, that the DH should undertake trials before any confirmation of reform. It questioned the feasibility of the planning system conceived by Evin and the Couty Commission, citing insufficient resources at the disposal of the DRASS, inadequate indicators and information, and persistent doubts over its legal application to private clinics. Much like Silland, it wanted to exploit regional planning as the tools to force through the reallocation of existing services between hospitals. It attempted to introduce financial criteria into the physical planning devised by the Evin *cabinet*, with additional safeguards to ensure that the Health Map and regional plans were determined in line with general medium-term economic objectives.<sup>66</sup> Regional financial envelopes, based upon the spending of the health insurance funds in the region, would operate as overall spending limits.<sup>67</sup> These regional financial constraints would determine the granting of authorisations to public hospitals, rather than regional medical needs. Hospital development programmes would have to include indicative financial costings which demonstrated how increased costs matched with the expected rise in spending by the health sickness funds.<sup>68</sup> Finally, it argued that the annexe attached to regional plans should establish the required creation and closure of beds and services, with the redeployment of hospital personnel managed regionally.<sup>69</sup> Sanctions could then be imposed on hospitals which failed to meet minimal safety and technical standards.

In fact, the concerns of the DSS betrayed the inter-*corps* rivalry between the client groups of the DH and the DSS. Vincent and his team of fellow directors were concerned to protect the prerogatives of hospital directors, even though, within the DH, both medical professionals and hospital directors were divorced from the civil administrators issued from the ranks of ENA. Protecting its own, the DSS envisaged an interventionist state operating through the regional DRASS, despite its criticisms of the resources at the disposal of the DRASS. Whatever the alleged qualities of ENSP graduates, the DSS doubted that hospital directors could be trusted to control the inflationary spending tendencies of hospital doctors. The Mengual Group even raised its concerns about the extensive managerial freedom being granted to hospital directors:

If the wind of enterprise must blow through hospital bureaucracy, it must not be transformed into an anarchic *laissez-faire* which would lead to a financial wastage from which it is not sure that the state would exit winning.<sup>70</sup>

Overall, throughout the negotiations at Solidarity, Health and Social Protection, the DH hoisted the DSS on its own petard, claiming that its financial planning could not work because of the incompatible funding mechanisms of private clinics and public hospitals. The government could not oblige private clinics to participate in financial planning. The DH's trump card was the argument that, given the far from stable support of the governing majority in the legislature, the announcement of financial planning would be badly received in the National Assembly (particularly as it would not apply to private clinics).<sup>71</sup> Throughout these discussions, the dominant axis of decision-making was provided by Silland and Couty and the DH. Hospital directors were at the core of this network of actors, through Vincent and his *cabinet* and the role of Couty, and also through Chodorge within the *cabinet* of Evin. The first draft of the bill was drawn up by Silland and a team from the DH<sup>72</sup>, and was circulating at the beginning of February, although the contribution of the Couty Commission was only complete at the end of July 1990.<sup>73</sup> In fact, as the work of the Couty commission progressed, Evin and the *cabinet* came to dominate the formulation of the Bill. The limited supporting role of the Commission was badly accepted by the likes of Peigné because Couty, the lynchpin between Commission and *cabinet*, acted as a 'brake' on proposals considered to be too radical to be put forward.<sup>74</sup> However, in the middle of February 1990, the *cabinet's* hold over the formulation of the Bill intensified. It rewrote the first draft of the Bill against the wishes of Silland who angrily withdrew her support.<sup>75</sup> For Silland, the *cabinet* version of the Bill went against the philosophy of the Couty Commission which sought to reinforce the medical legitimacy of decision-making, thereby avoiding claims of economic rationing.<sup>76</sup> More importantly, even for Silland, it over-centralised the planning process and introduced within it multiple sources of rigidity.<sup>77</sup> Thus, at the crucial stage of the formulation of the Bill, Evin and his *cabinet* made decisions at the top.

### *The SNCH absent once again*

With Vincent having departed to the DH, the union's national executive, the Bureau National (BN), elected Coz to the presidency of the SNCH (see Chapter Four). The unexpected election of the former *Grenoble 80* stalwart nonetheless ensured continuity in the SNCH's leadership strategy. Coz supported the line pursued by Vincent since Mâcon. His election by the BN further blurred the boundaries between Evin, the DH and the SNCH. Coz operated as an informal policy advisor to Evin, and his election brought the SNCH firmly into the networks established by Evin.<sup>78</sup> Vincent was at the DH, Coz was president of the SNCH, Paillé had entered the UDC and Couty and Chodorge had entered the *cabinet*. Indeed, with Evin in attendance, the SNCH met at its annual conference at Orléans in May 1989 to discuss the theme of the *projet d'établissement* and take pleasure in the adoption by the Rocard government of its manifesto of regional planning and contractualisation.<sup>79</sup> However, few hospital directors were involved within the June and July DH working parties, with only one leading personality of the *corps* (Omnès) in any of the working groups.<sup>80</sup>

Following the April 1989 declaration by Evin, the SNCH established its own working party to draw up its public response to the rewriting of the 1970 Hospital Law. In principle, the working party, with its membership of ten, was a fairly open structure which aimed to mobilise contributions from the regions to fuel its own internal debate. However, as work progressed, both the difficulties in mobilising the regions and the pressures on members of the union working party meant that it became dominated by a core of decision-makers orbiting around Coz: "Very, very quickly, it was reduced to three or four people, people like Roland Ollivier, Christian Paire, Michel Pallot."<sup>81</sup> Like Coz, Ollivier, the leader of the working party, was both a former member of *Grenoble 80* and a supporter of the doctrine of *hôpital-entreprise*. In this instance, his relationship with Coz replaced the former tandem of Vincent and Paillé at the head of the SNCH.

The union working party presented its findings to the BN in late October 1989.<sup>82</sup> These findings were finalised when they were debated without incident by the BN and regional delegates in early December.<sup>83</sup> Within the working party, there was little disagreement over the proposals. Endorsing the new public management discourse of the 'right to manage', its report conceived organisationally of hospital directors as the

strategic apex of public hospitals. Indeed, the bulk of the proposals did not depart from policy platforms raised intermittently at previous conferences (See Table 7.2). In line with past commitments, the working party accepted the necessity of bottom-up regional plans, bolstered by development contracts between hospitals and local health boards, thereby paving the way for *a posteriori* evaluation and the removal of budgetary and personnel management controls. However, the SNCH sought the transformation of public hospitals into *Etablissements Publics Industriels et Commerciaux* (EPIC) or, at least, the right of hospitals to create commercial services or enter into common activities with public or private partners.<sup>84</sup> This demand emerged from the new governing alliance of Coz, Ollivier and Paire which swung the SNCH towards the autonomist positions rejected by Vincent (see Chapter Four). The SNCH now argued that only with the legal character of EPICs could public hospitals possess the increased managerial freedom necessary to compete with private clinics. This freedom was not necessarily guaranteed by the vague EPS statute proposed by Evin.

**Table 7.2: SNCH Proposals, The Right to Manage**

Hospitals to become <i>Établissement Public Économique et Commercial</i> .
Free management of personnel, allowing local recruitment procedures, including incentive schemes, and ending controls on staffing level.
Less control on financial management and signing of external contracts, with regional Court of Accounts acting as external auditor. End to division between <i>ordonnateur</i> and <i>comptable</i> or at least, <i>agence comptable</i> .
Assured role for regional committees in formulation of regional plans, with guaranteed influence of regional councils. Regional plans to apply to both public and private sectors.
Elevation of evaluation and monitoring procedures.
Facilitation of public-private partnerships and mergers of establishments.

However, with its discourse of regional planning and contractualisation accepted within the Evin ministry, the Coz leadership attacked the continued imbalance between hospital and private clinics and prioritised statutory changes to the representation of the *corps*. In addition, it advocated equal treatment by government of public hospitals and private clinics. In the short-term, this meant the modification of the global budget through



the harmonisation of the funding of public and private hospitals. In the long-term, it demanded the introduction of the fee-for-service funding inherent within diagnosis-related groups, the PMSI programme. The union's acceptance of PMSI came belatedly at Reims.<sup>85</sup> Finally, the SNCH demanded the creation of a specific administrative consultative body within public hospitals, a *collège des cadres*.<sup>86</sup> Like Vincent before him, Coz was unable to ignore the pressures for change emanating from the rank-and-file. These demands responded to grassroots members' pressures not only for pecuniary benefits from their leadership role in hospitals, but also for an end to the competitive advantage allotted to private clinics by their continued use of the patient-day rate. In the first week of September 1989, Coz met with Evin to plead for the harmonisation of the financial rules governing the public and private sectors, indicating that a situation existed where on the same pitch one team was playing rugby whilst the other played football.<sup>87</sup> However, the application of the global budget to private clinics had been ruled out by Evin at the launch of the reform.<sup>88</sup>

In fact, the Coz leadership entered into a 'phoney war' with the DH and the Evin *cabinet* where its main concerns were improved pay and working conditions for the *corps*.<sup>89</sup> Its efforts to radicalise the legislation were nullified, despite its protestations, by the union's association and general agreement with the formulation of the Bill. As early as September 1989, these concerns were evident as Coz offered to extend the performance evaluation of general directors to all directors in exchange for improved pay and conditions and increased managerial freedom.<sup>90</sup> The membership of the union was increasingly pushing for pay rewards because the gains by nurses diminished the relative scale of their own gains made in 1988, which in any case, focused upon the expansion of the first two classes of hospital directors. Coz demanded the extension of diverse bonuses for hospital directors, trading with the government over improvements, for example, to the bonuses of hospital directors in return for the ending their perk of buying low-cost provisions from public hospitals. Given his public ties to Evin and Vincent, Coz was obliged to deliver improved pay and conditions or risk being labelled the 'puppet' of the Evin ministry and the DH. However, at Dijon, Coz reminded SNCH delegates that whatever the demands for pecuniary gains, they could not be achieved without the organisational transformation of public hospitals (see Chapter Four).<sup>91</sup>

Within the Vincent *cabinet*, the SNCH had close links to Chassaniol who, along with Barberousse, was recognised by the Coz leadership as a valuable connection to the DH.<sup>92</sup> The SNCH also met regularly with the *cabinet* and, like other unions, with the Couty Commission. However, as negotiations progressed, the SNCH leadership believed the ties with Evin and his ministry simply ‘eased their [members of the *cabinet*] listening.’<sup>93</sup> The SNCH leadership enjoyed difficult relations with Vincent who did not espouse the autonomist stances pursued under Coz.<sup>94</sup> Vincent’s statist orientations were out of step with the liberalising thesis newly adopted by Coz. The DH now pursued a philosophy more in tune with the *200 Propositions* and the managerial culture espoused by Vincent within the *Assistance Publique de Paris*. Indeed, Vincent was quick to point out that he wanted ‘to give a greater freedom of action to hospitals without [...] the state abandoning all control. I’ve never been lax and I never will be.’<sup>95</sup> For the *corps* of hospital directors, he had to some extent become the poacher turned gamekeeper.

As the demand for hospitals to be reclassified as EPICs demonstrated, the union’s differences with Evin were defined by the extent of managerial autonomy to be attributed to hospital directors. The SNCH dismissed the proposed mechanism of regional planning as rigid and top-down: the absence of democratic or bottom-up involvement contradicting the logic of the *projet d’établissement*. In addition, it condemned the limited possibility of co-operation for public hospitals, the ill-defined roles of actors and commissions within hospitals, and the absence of evaluation. Yet, in keeping with its ‘phoney war’ with Evin, the Coz leadership welcomed the principal orientations of the reform and settled upon cautious support for the rewriting of the 1970 Hospital Law. It relegated the findings of the Couty Commission as overly ‘prudent’ or a ‘lost opportunity’, ultimately positioning itself as a foil to the DH to cement its positions against the DSS within the ministry. Typically, Ollivier interpreted the Couty report as making progress, but not going far enough, although he recognised, for example, the advances in managerial freedom and the beginnings of a *collège des cadres*.<sup>96</sup>

It was left to the *conférence* of hospital directors from general hospitals to spearhead the discourse of *hôpital-entreprise*. More than its regional hospital counterpart, this consultative body was under the control of ENSP entrepreneurs from the SNCH throughout the period of consultation by the Couty Commission. Indeed, Trazzini became

its president in January 1988 (see Chapter Four) and assembled around himself fellow entrepreneurs, in particular, Philippe Domy. No longer constrained within the SNCH leadership, Trazzini swung the *conférence* towards the policies of *hôpital-entreprise* with little concern for the difficulties of elite-follower relations within the *corps*. The *conférence* thereby endorsed the modelling of the organisation of public hospitals upon private enterprises. It also advocated changing the statute of public hospitals to that of EPICs, allowing partnerships with private competitors, and transforming the internal personnel consultative body into a private sector style enterprise committee. The culture of contractualisation which permeated state-hospital development projects would necessitate the transformation of hospital director into heads of enterprise; the *conférence* aimed to make sure that directors had the tools to undertake such a transformation.<sup>97</sup>

However, there were few partners for the SNCH to call upon in its lobbying to radicalise the proposals of Evin. The reactionary federation of hospital doctor trade unions, the *Coordination*, marked the Bill with the tag of economic rationalisation, increased centralisation and missed opportunity. It rejected the top-down regulation of the Health Map with its weak consultative committees, as well as the weak autonomy of hospitals and the timid harmonisation of the public and private sectors, but targeted primarily the absence of a package of social measures tied to investment and improvements in the pay and conditions of hospital personnel.<sup>98</sup> This concern over social measures was also voiced by the INMH, along with the retreat from the introduction of departments. Although Peigné had resigned from its presidency, because of his presence on the Couty Commission, the INMH was forced to tread a tight line between opposition and support for the Couty Commission.<sup>99</sup> However, Peigné's successor, Stanislas Johannet, was unable to drag the rank-and-file into a modernist support for the Bill. Thus, hospital doctor trade unions retreated into statutory demands, much like the SNCH. Indeed, the consultative body for regional hospitals boycotted the forums held by the Couty Commission.<sup>100</sup>

After preliminary discussions, the SNCH deliberately banked on the parliamentary debate to advance its positions. The Coz leadership recognised that the Rocard government would seek to entice UDC deputies away from the opposition and believed itself to be in a position to exploit its privileged connections with Paillé.<sup>101</sup> However, Coz

remained constrained by both the re-emergence of pecuniary demands on the agenda of the SNCH, and the absence of coalition partners. Nonetheless, the SNCH leadership now faced a different strategic position than with previous reforms. The boundaries between the SNCH and the administrative networks of the ministry were blurred and the SNCH leadership was to all intents and purposes publicly keen to recognise not only the origin of the Couty proposals, but also its basic agreement with them. Its discourse had in many ways been 'stolen'. Yet, at the same time, the *corps* of hospital directors was boosted by Evin, not through the awarding of 'insider' status to the SNCH or corporatist style arrangements, but through the elevation of key individuals within the ENSP generation. This division between the SNCH and these individuals made it difficult for the SNCH leadership to advance its more recent demands.

### 7.3 BATTLES BETWEEN MINISTRIES AND *CORPS*

At the end of November 1989, the Finance Ministry criticised the absence of inter-ministerial consultation by Evin and his *cabinet*.<sup>102</sup> Preliminary meetings subsequently took place in January and June 1990 between the DH, the DSS and, the DB, the DP and the DCP from within the Finance and Budget Ministries.<sup>103</sup> However, the DH deliberately kept interministerial consultation to a minimum because it was wary that preliminary discussions might compromise the orientations of the law and reduce the DH's margins for manoeuvre in future negotiations.<sup>104</sup> The first round of interministerial consultation only began in earnest in mid-July 1990, proceeding through August to end on 20 September 1990.<sup>105</sup>

The negotiations were held at Matignon, chaired by members of Rocard's *cabinet*. They were attended, for the most part, by the leading members of the *cabinet*: Bruntière, Tabuteau, Couty, Chodorge and Atlan. Members of the DH, including Chassaniol and Vincent, participated intermittently. The Evin *cabinet* were joined in negotiation by advisors from the *cabinets* and administrative divisions of the Civil Service, Education and Interior ministries. However, the primary axis of negotiations was that between the Evin *cabinet* and the DH, and the *cabinets* of the Finance Ministry, its junior partner the Budget Ministry, and their administrative divisions, the DB and the DCP: 'They had

opinions on every article, including medical organisation which could appear quite surprising. That's what they were told at Matignon.<sup>106</sup> Indeed, at the first meeting, the Rocard *cabinet* put in place an interministerial working party to iron out the differences between the rival conceptions of the DB, the DCP, the DH and the Evin *cabinet*.<sup>107</sup>

As it had done from the outset, the DB first sought to block the progress of the Bill, requesting a series of trials before pushing ahead with legislation. These delaying tactics were quickly rebuffed by the Prime Minister's *cabinet* who made it clear that the government had reserved a place in its parliamentary timetable for the first reading of the Bill in December 1990.<sup>108</sup> With the timetable dictated by Matignon, the DB consequently retreated back to its criticisms of the regional planning system; echoing the concerns of the DSS, and to a certain extent those of Silland, and arguing for coercive rather than contractual mechanisms. It condemned the physical planning advocated by the Evin *cabinet* and the DH which it believed would be superseded by technical progress, plagued by political pressures and become unmanageable as it grew in sophistication. It further argued that the over-reliance on physical planning would not control spending, would pass smaller hospitals by, and would not prepare public hospitals to compete against their private counterparts. So like the DSS, the DB advocated that the dynamism and coercion needed to redistribute services could only be provided by financial planning constraints.<sup>109</sup>

To force through the necessary closures of hospital wards and beds, the DB advocated the creation of independent regional authorities.<sup>110</sup> These regional structures, very much the reproduction of regional *Assistance Publiques*, would regroup the staff of existing health boards and be led by elite civil servants appointed by the Council of Ministers. Each regional structure would negotiate its annual budget directly with the DB, DSS and the DH. Through the distribution of budgets to hospitals, the region structure would subsequently determine the necessary closures, redevelopments and conversions within its area, in the process, monitoring budgets and managing staffing levels. The DB did not fail to emphasise that such a restructuring avoided the redefinition of the statute governing public hospitals, and delayed legislation through the necessity to undertake trials in two regions. More importantly, it gave the *corps* of *Inspecteurs des Finances* an opening into the management posts of the public hospital service - threatening at once hospital directors, heads of DDASS and DRASS, and Prefects deemed by the DB as too

busy to coordinate new regional structures. Indeed, the DB contended that these regional *Assistances Publiques* 'would benefit, of course, from the assistance of the civil servants of the DDASS, but equally, from the contribution of people having different backgrounds and approaches.'<sup>111</sup>

Such inter-*corps* rivalry structured the opposition of the DB and DCP to the extension of the hospital directors' financial freedom, particularly the possibility of placing funds on the open market. Any redefinition of the traditional roles of *ordonnateurs* and *comptables* threatened the clients of the DCP, who made the defence of the status quo a '*causus belli* of the Finance Ministry'<sup>112</sup> (see Chapter Two). The DCP feared the atomisation of financial management systems within public hospitals, which it argued would weaken the capacity of central government to oversee the financial management of public hospitals. Equally, it stressed that Evin's proposals would transfer the financial costs of 4000 civil servants onto public hospitals and the Social Security funds with the additional risk of provoking social unrest over changing pay and conditions.<sup>113</sup> Indeed, it claimed that it was possible to loosen the rules governing *comptables* and *ordonnateurs* within existing arrangements.

As in most negotiations, Evin and his *cabinet* sacrificed what they perceived to be minor concerns to the DB and the DCP in order to ensure the overall coherence of the proposed legislation. For example, they retreated from the conflict surrounding the reorganisation of the *comptable* within public hospitals. Here, Vincent argued that the changes presented by the DCP were not substantial. As predicted by the Evin cabinet, its bargaining resources were increased by the prior agreement to the adoption of the EPS:

'in 1990 at the time that we did the bill, we brought out the EPS, [and] the [Finance] Ministry tore into it with an unbelievable violence and we said: "We worked on this together, it's a framework", [...] While we were at it, we won all the rulings on it.'<sup>114</sup>

However, health and social affairs had to suffer the removal from the Bill of the right of hospital directors to place funds on financial markets. The Finance Ministry did not reject the placing of funds, but believed that the remuneration of funds should remain within existing controls and institutions. Health accepted changes in the wording of the article, but sought to maintain the article for 'effect'. The exact measures under the article were left to be decided in the Council of State by decree.<sup>115</sup>

In fact, the Evin *cabinet* believed the coherence of the Bill rested upon its capacity

to refute the DB's criticisms of the proposed system of regional planning. The *cabinet* thus sought to swing debate away from cost containment towards the issue of service delivery, pointing out that the aim of the Health Map was to isolate need rather than match the level of services to the resources of the Social Security funds. In any case, it argued that the combination of both *projet medical* and *projet d'etablissement* provided both financial and organisational approaches.<sup>116</sup> It cast doubt on the *Assistance Publique* as an exemplary case of hospital management, and dismissed regional *Assistances Publiques* as an unnecessary undermining of national-local policy coordination. These arguments were supported by the Civil Service Ministry and the Ministry of the Interior which, in particular, sought to defend the interests of 'its' *corps* of prefects against the expansionist aspirations of the *Inspection des Finances*. The Interior Ministry argued that the DB's proposals undermined the principle of the unity of representation of the state as embodied in the office of the Prefect.<sup>117</sup> Like the Evin *cabinet*, it also poured scorn on the managerial efficiency of the *Assistance Publique*, arguing that individual hospitals under such management structures had little or no incentive to improve their own billing and accounting procedures. It claimed that the DB proposals would reduce the administrative autonomy of public hospitals whilst allowing mediocre hospitals to live off the back of the more dynamic establishments.<sup>118</sup>

However, alongside this vocal support from the Interior Ministry, the Evin *cabinet* exploited the parliamentary concerns of Matignon and its desire to entice centrist deputies to support the legislation. Typically, it stressed that to prioritize only financial concerns within the functions of the Health Map, as argued by the DB, would not only send a disastrous message to the National Assembly, but would also have no medical justification or legitimacy for hospital personnel. Indeed, the *cabinet* assumed that the National Assembly would not accept a Bill creating regional *Assistances Publiques* which were in opposition to decentralisation and, the participation of mayors and boards of trustees in local decision-making.<sup>119</sup> The DB thus won few significant concessions because Matignon lined up behind the Evin *cabinet*: 'the Prime Minister practically accepted all that we proposed.'<sup>120</sup>

Evin and the DH entered the parliamentary debate with its Bill relatively unscathed as the *corps* of hospital directors, or rather Couty and Vincent, fought off the territorial

aspirations of the *Inspecteurs des Finances*. However, the interests of the *corps* did not seemingly dictate all the positions adopted by the DH. The DB argued in favour of increased managerial responsibilities for hospital directors, particularly in relation to boards of trustees. It was the DH that rejected this proposal, arguing that the legitimacy of individuals on boards of trustees made such a course of action impossible.<sup>121</sup> Such incidents revealed the complicated nature of the relationship between the directors inside the ministry and those inside the SNCH's leadership.

#### 7.4 PARLIAMENTARY CONSTRAINTS AND GOVERNMENT CONCESSIONS

In October 1990, Matignon appointed Bruno Durieux to the post of Junior Minister of Health. Rumours of the imminent appointment of a Junior Minister had been circulating since January when Evin signalled his desire to lighten his ministerial workload in order to devote more time to his duties as Rocard's lieutenant within the PS.<sup>122</sup> Durieux, a minister of *ouverture*, was drawn from the ranks of the CDS and was a close ally of Raymond Barre, the former Prime Minister. Barre now advocated a constructive case-by-case examination of legislation proposed by the Rocard government. Durieux's appointment marked the first step in Rocard's attempts to avoid the use of Article 49.3 to force the Bill through the National Assembly, a measure which would vividly demonstrate the failing majority and limitations of the *méthode Rocard*. Indeed, Durieux's own political existence became entwined with his ability to win the support of sufficient UDC deputies to avoid the use of Article 49.3.

Coming after the final round of interministerial negotiations, the new minister's arrival was too late to influence the nature of the Bill to be presented to the National Assembly. The Evin Bill was finally adopted, little changed by its passage through the statutory consultative bodies, at a meeting of the Council of Ministers on 19 December 1990.<sup>123</sup> It subsequently began its passage through the National Assembly on 10 April 1991 monitored by both Evin and Durieux, who appointed another hospital director, Patrice Mordelet, to his *cabinet*. The UDC held out the possibility that its support could be forthcoming if its amendments were accepted by the Rocard government. Méhaignerie, its leader in the Assembly, intimated that the UDC would vote for the Bill.<sup>124</sup> Neverthe-



less, Mitterrand authorised the use of Article 49.3 on the opening day of the debate in the National Assembly.<sup>125</sup>

The hesitations of the UDC leadership triggered a tug of war between the Rocard government and the RPR and the UDF. Evin and Durieux tried to lure the UDC away from the RPR and the UDF. The RPR's negotiations were led by Debré, the former leader of *Solidarité Médicale*. He strived to maintain the allegiance of the UDC to the Right and thereby force Rocard to retreat towards the use of Article 49.3. Indeed, on the opening day of the parliamentary debate, the RPR and the UDF concluded an electoral pact with the UDC; a day later, it dragged the UDC further back into its ranks by laying down a vote of confidence in the government over its involvement in the Urbatechnic financial affair.<sup>126</sup> Caught in the middle, the UDC maximised the number of its amendments accepted by the Rocard government and underlined its importance to the Right. The interministerial decisions taken at Matignon were superseded by new concerns:

‘Suddenly, the debate became political and Matignon reasoned differently and all the technical aspects of the Finance Ministry lost weight in relation to the political objectives of the Prime Minister of the day.’<sup>127</sup>

In fact, Durieux was intent on leaving his personal stamp on the Bill, if possible in the fields of planning and evaluation.<sup>128</sup> In March, as he tabled possible amendments, he returned to the issue of the internal organisation of public hospitals, trying to cultivate medical support by enabling hospitals (and not the Minister) to designate heads of services and redefine the structure of departments.<sup>129</sup> However, this measure was unpopular with medical trade unions, provoking Durieux to offer to withdraw it.<sup>130</sup> The paths open to Durieux were limited because he enjoyed little support within his own party. The UDC announced that it would run a candidate against Durieux in the following legislative elections, maintaining that he had joined the presidential majority despite his claims to have retained his CDS membership card.<sup>131</sup> The majority against Durieux within the CDS had ‘visibly no reason to give any presents to [their] former centrist friend held up today for public humiliation for “treason”’.<sup>132</sup>

For its part, the SNCH proposed 41 amendments to the Bill.<sup>133</sup> These amendments proposed both further bottom-up consultation throughout the definition of regional planning targets and extended managerial autonomy for public hospitals. Planning was to be opened to local politicians and representatives in bottom-up plans which devised

regional objectives after consultation and the completion of hospital development projects. Indeed, for the SNCH, contractualisation should imply reciprocal obligations and rights by all involved. The counterpart of such responsibility, evaluation, was absent in the SNCH's view. They called for the accreditation of hospitals by regional state-led organisations for limited time periods like private clinics. Equally, in defence of the conception of *hôpital-entreprise*, the hospital director trade union pursued its claims for further public-private harmonisation and the transformation of hospitals into EPICs, with participation in public-private partnerships, such as *groupements d'intérêts économiques* (GIEs) or *sociétés d'économie mixte*, where directors could alone manage accounts and place funds. These primary proposals of the SNCH sat alongside a plethora of managerial innovations and time-honoured concerns: the separation of fixed and unfixed costs, the simplification of budgets, the creation of a *collège des cadres*, the presentation of hospital development projects by directors and the involvement of directors in the renewal of heads of services and the appointment of hospital doctors.

Within the rounds of parliamentary negotiations, the SNCH was advantaged by the fact that the negotiations of the UDC were led by Jean-Pierre Foucher, the former minister, Jacques Barrot and, most importantly, Dominique Paillé. The UDC adopted many of the union's amendments, hardly surprising given Paillé's network of links within the *corps*.<sup>134</sup> The UDC trio prioritised amendments which increased the managerial autonomy of public hospitals through reductions in the controls by DDASS and the transformation of hospitals into EPICs or, at least, the right of hospitals to undertake GIEs.<sup>135</sup> However, Paillé was to all intents and purposes constrained by the responsibilities of his office as general secretary of the UDC: 'He played his own personal card [...] his priority was to manage his own group.'<sup>136</sup> This said, he took on a leading role in a network of ENSP directors leading negotiations. Chassaniol paid him daily visits on behalf of Vincent who thought that, as Director of Hospitals, he should not be seen taking on an overt role in policy-making.<sup>137</sup>

Thus, the progress of the Bill through the National Assembly became the concern of a clique of ENSP hospital directors. Indeed, although negotiations were publicly led by the ministers, concessions were hammered out by the directors involved in the formulation of the Bill. The work of the two *cabinets* was coordinated by Couty and

Chodorge who belonged nominally to both *cabinets*. Vincent at the DH exploited the rivalry between the two *cabinets* to generate his own freedom of manoeuvre, particularly since Vincent, Chassaniol and Barberousse, all benefited from the knowledge accumulated since the early stages of the formulation of the Bill.<sup>138</sup> Couty worked hand in hand with Chassaniol who acted as a shuttle between the various individuals. 'It progressively became a law of hospital directors since there was Chassaniol, Vincent on the DH side [...] Couty, Mordelet and myself [Chodorge] in the *cabinets*.'<sup>139</sup> Paillé's contribution simply completed the circle.

With these directors in place, the Coz leadership did not impose any collective organisational response by the SNCH as a whole in the consultative lobbies of the National Assembly. Once again, it pursued its strategy of being an external spur towards more radical reform, attempting more to influence future policy commitments and maintain the SNCH at the forefront of debates rather than to acquire short-term gains. For example, the Coz leadership was aware that the EPIC framework was never considered by the Evin cabinet, the DH or the PS, to be a viable alternative to the EPS. It was thus left to particular directors to lobby politicians personally: 'It was individuals, [...], like Christian Paire who played a role in the shadows. But, it was not the SNCH as an institution.'<sup>140</sup> Rather than the SNCH, the *conférence* led by Trazzini extensively lobbied the National Assembly. Its priority was to force through the acceptance of hospital participation in *groupements d'intérêt économiques*. Once again, its lobbying was organised through the formal channels of discussions with the Commission of Social Affairs, but also through individual *ad hoc* initiatives at the local level:

'Me, I brought together Senators in Picardie and the MPs, chairs of the boards of trustees who are elected politicians and that I did on the basis of the reports of the *conférence*.'<sup>141</sup>

The *conférence* targeted UDC deputies, aware that within the UDC, both Barrot and Méhaignerie were embarrassed by the possibility of not voting for the law.<sup>142</sup> As Chodorge argues, the Coz leadership was more concerned with applying pressure to obtain the settlement over hospital director bonuses which would satisfy the pecuniary demands of the rank-and-file.<sup>143</sup>

The first tentative approaches of the Evin cabinet and Durieux towards the UDC came through the deposition of three amendments clarifying the differences between

services and departments whilst imposing common appointment procedures for all head doctors.<sup>144</sup> The amendments were deposited in the name of the PS because the government believed that amendments emanating from the party would be looked upon more favourably than those from the pen of Durieux.<sup>145</sup> They identified internal organisation as a principal area for negotiation and compromise because it was of symbolic importance to the competing interests of professions within public hospitals, but these issues were not considered by the Evin team to be essential to the success of the Bill.<sup>146</sup> Hospital doctor trade unions also targeted internal organisation as their key battlefield, with the medical lobby within the National Assembly mobilised against any efforts to increase the responsibilities of hospital directors: 'They were not in the RPR or the PS, they were PU-PH [hospital doctors] and they were saying: "We not going to let ourselves be taken for a ride by the hospital directors".'<sup>147</sup> At one point during the parliamentary session, there were just 12 doctors in the Assembly chamber debating the Bill.<sup>148</sup>

Although seeking to broker a negotiation with the UDC, the Rocard government was keen to balance concessions to the UDC against the demands of the PS which refused to sanction the dilution of departments' distinctiveness and the transformation of public hospitals into EPICs. Unlike the Rocard government, the PS preferred to use Article 49.3 rather than to dilute the Bill.<sup>149</sup> With the approach of regional and cantonal elections, the bipolarisation of the French electoral system risked, in any case, denying the UDC leadership its parliamentary autonomy, forcing it back to the RPR-UDF opposition and its traditional electorate. These concerns were amplified by the weight of financial scandals which hung over the government and Rocard's continued tenure at Matignon. While the first reading of the Evin Bill was taking place, Mitterrand obliged Rocard to withdraw plans to reform the electoral system for regional elections. Bérégovoy suspended all debate on the reform of saving banks.<sup>150</sup>

This said, the Evin team began to bow to the demands of the UDC, with Evin intervening on at least two occasions to attempt to force through agreement on planning and systems of accreditation. Opposition to the proposed reforms of planning and internal organisation led Durieux to reserve voting on these articles, having granted concessions to the centrists.<sup>151</sup> Over time, the Rocard government agreed to the inclusion of GIE forms

of co-operation for public hospitals and made concessions on internal organisation.<sup>152</sup> It accepted the right of appeal to the Minister over regional plans and acknowledged the creation of regional medical commissions to evaluate hospitals.<sup>153</sup> In addition, it agreed to the UDC demands to reduce further the controls exercised by DDASS and to shorten the delays to control financial decisions. It also agreed to hospitals raising supplementary funds through, for example, the exploitation of patents.<sup>154</sup> These concessions went some way to responding to the set of amendments tabled by the UDC. In fact, at the end of April, the UDC spent an hour meeting with representatives of the PS and government, but although 'it folded, it did not break.'<sup>155</sup> At the same time, whilst the UDC persisted in its demands for concessions on internal organisation and the representation of private clinics on planning committees, Debré busied himself attempting to organise a vote of confidence in the government should it employ Article 49.3.<sup>156</sup>

However, the negotiations of an agreement with the UDC were increasingly hampered by the fallout of the financial affairs surrounding the Rocard government.<sup>157</sup> On 22 April, Durieux faced with no majority, delayed any vote on the Bill. At the end of the afternoon, the UDC made known its opposition to the whole of the Bill (Evin having spent the whole day locked in discussions).<sup>158</sup> Barrot acknowledged that the hospital reform suffered from the concurrent resurgence of the alleged scandals and announced that the UDC would not associate itself with any possible vote of confidence if Rocard was to invoke Article 49.3.<sup>159</sup> Faced with little choice but to invoke Article 49.3, Durieux delayed not only the vote, but also the discussion of the internal organisation of public hospitals.<sup>160</sup> With the opposition wedded to the distinction between services and departments, Durieux, taking his opportunity to mark the text, proposed the Durieux amendment, which became known as the *amendement libertaire*. Drawn up by Couty, Vincent, Durieux and Laurent, his *directeur du cabinet*, on a Sunday afternoon, this amendment gave hospitals the possibility to adopt any model of organisation they wished.<sup>161</sup> It was a last ditch attempt to bring the UDC back on board.

However, the UDC still considered the Bill to be too far removed from its concerns, failing to respond to the issues of improved representation for private clinics in regional planning committees, ignoring the managerial autonomy of public hospitals in the statute of EPS, and under-representing nurses in decision-making bodies.<sup>162</sup> With no

majority, Rocard retreated to the use of Article 49.3 on 29 April 1991. The government accepted all previously negotiated amendments despite opposition from the PS.<sup>163</sup> With no vote of confidence raised by the RPR and the UDF, the Bill was considered adopted in its first reading on 30 April 1991.<sup>164</sup> Immediately, the urgency and the centrality of the debate for the opposition dissipated. After a failure to agree common amendments by representatives of the Senate and National Assembly, its second reading in the National Assembly brought no recourse to Article 49.3, because Raymond Barre and three centrists abstained and the government gained the support of independent deputies and of the centrist deputy, Gérard Vignoble.<sup>165</sup> When the Bill returned to the Assembly for its final vote, Rocard had left Matignon and the text had an uneventful passage through the Assembly enjoying the continued support of Vignoble and independent deputies.<sup>166</sup>

## CONCLUSIONS

In evaluating the influence of an pressure group or a profession on policy-making, it is important to adopt a realistic assessment of how much state and public administrative arrangements can ever approximate the optimal point of any single vested interest, rather than balancing out different concerns. The rise of hospital directors to a central position within both the internal management of hospitals and the wider systems of funding and state management controls, gave the *corps* and the SNCH a particularly all-encompassing view of how hospital reform should be undertaken. But, as the grassroots pressure within SNCH demonstrated, hospital directors were no different from any of the other professional groups and union interests in mixing together 'philosophical' arguments for overall system configurations and more directly self-interested pleading for group advantages and concessions. Thus, it was inherently likely that the SNCH would have points of disagreement with the eventual law, because it must necessarily take account of a wider range of interests. The SNCH had also moved on in terms of its professional discourse, pushing ahead the development of new policies and options to which it had to be committed if it was not to lose any agenda-setting capability for the future.

It would be easy to conclude from the SNCH's formal absence from directly influential negotiations with, or demand-setting, to government that the union and the

*corps* were somehow inessential to the hospital reform, and that, in the explicit demands they did formulate (such as EPIC status), the union was unsuccessful. Apparently, the union's influence *qua* union only weighed on the debate over whether hospital directors or hospital doctors presented the *projet médical* and the *projet d'établissement*. Such an interpretation would be fundamentally wrong-headed, however, because the agenda for the 1991 reform was set fundamentally in the 1980s by the development of the union's and the *corps*' internal discourses, and because hospital directors were the key people responsible for securing the surprisingly consensual institutionalization of this discourse into law. The SNCH so much 'owned' the reforms that were implemented by Evin, his *cabinet* and the DH that their formal subscription to more radical reorganization possibilities was effectively side-lined.

The informal influence of the union cadres and the profession's internal cohesion as a key actor in health policy networks both reached an apogee during the hospital reform process, especially with the appointment of Vincent to serve as the head of the DH. With this key agency on-side, the whole reform process successfully recovered ground tracked over back and forth unsuccessfully by apparently much stronger governments of the 1980s. Together with hospital director colleagues in the various *cabinets* and advising parties in the National Assembly, Vincent played a key role in seeing his own ideas bearing fruit, leading one interviewee to conclude: 'The 1991 law was the law of Gérard Vincent.'<sup>167</sup> In particular, the negotiations between Evin and the UDC during the first reading in the National Assembly were led on both sides by hospital directors of the ENSP generation united by common affiliations. So, it was little wonder that the Evin *cabinet* and the DH were able to reorientate measures previously lost to Finance Ministry at Matignon, in particular the inclusion of the possibilities of co-operation for public hospitals.

## ENDNOTES TO CHAPTER SEVEN

1. *Hospitalier-Actualités* (1988), no. 59, p. 8.
2. *Le Quotidien du Médecin*, 19 April and 11 May 1988.
3. A. Stevens (1996), *The Government and Politics of France*, London: Macmillan, 2nd ed., p. 257.
4. R. Elgie (1991), 'La méthode Rocard existe-t-elle?', *Modern and Contemporary France*, no. 44, pp.11-19.
5. For example, Jean-Marie Rausch, Lionel Stoléru, Jean-Pierre Soisson and Michel Durafour.
6. J. Keeler (1993), 'Executive Power and Policy-making Patterns in France: Gauging the impact of Fifth Republic institutions', *West European Politics*, vol. 16, no. 4, pp. 518-544.
7. J-P. Huchon (1993), *Jours Tranquilles à Matignon*, Paris: Grasset, p.31.
8. *Le Nouvel Hospitalier* (1993), no. 22, p. 6.
9. Schwartzenberg resigned over a statement in favour of the legislation of hard drugs. *Le Monde*, 08 July 1988.
10. *Le Quotidien du Médecin*, 19 February 1982.
11. P. Domy, interview, 03 July 1992.
12. F. Delafosse, interview, 02 March 1992; E. Couty, interview, 24 November 1992.
13. *Le Monde*, 20 December 1988.
14. Delafosse, interview, 02 March 1992.
15. This need to negotiate was confirmed by Couty who met with nursing trade unions in May 1988. Interview, 24 November 1992.
16. M. Schachtel and A. Rebours (1989), *Ras la Seringue*, Paris: Lamarre.
17. See, for example, *Le Monde*, 02, 23, 24, 25, 27, February and 02, 06, 09, 15, 22 March 1989.
18. *Le Quotidien du Médecin*, 13 March 1989.
19. *Le Monde*, 08 March 1989.
20. Delafosse, interview, 02 March 1992; D. Tabuteau, interview, 25 November 1992; G. Chodorge, interview, 19 June 1992.
21. Couty, interview, 24 November 1992.
22. *Lettre de Matignon*, no. 286, 23 January 1990, pp. 7-9; see also, D. Clark (1998), 'The modernisation of the French civil service', *Public Administration*, vol. 76, no. 1, pp. 97-116.
23. See R. Elgie's study of the 1989 budget in R. Elgie (1993), *The role of the Prime Minister in France, 1981-1991*, Macmillan: London; P. Hassenteufel (1997), *Les médecins face à l'État*, Paris: Presses de la FNSP, p. 293.
24. *Le Monde*, 13 April 1989.
25. C. Evin (1989), 'Les grandes orientations de la politique de santé 1989-1992', supplement to *La Lettre du 8 Ségur*, Paris, 12 April.
26. *Espace Social Européen*, 13 October 1989.
27. Internal Note to Director of Hospitals, February 1989, p.2
28. Couty met with Peigné one morning a week once the report got under way. Couty, interview, 24 November 1992.
29. The Peigné team proposed increased managerial autonomy for public hospitals with an a posteriori tutelle, government-hospital contracts, harmonisation of public-private funding systems, regional organisation and the renovation of the Health Map. See *Rapport*



- d'Étape, Mission du Dr Peigné sur l'avenir de l'hôpital*, 04 April 1989, pp.29-37; *Le Monde*, 18 May 1989; *Espace Social Européen*, 19 May 1989.
30. *Horizon*, no.32, p.8.
  31. Delafosse, interview, 02 March 1992; Couty, interview, 24 November 1992.
  32. Couty, interview, 24 November 1992.
  33. *Le Quotidien du Médecin*, 23 February 1989.
  34. Chodorge, interview, 19 June 1992.
  35. Chodorge, interview, 19 June 1992.
  36. C. Pigement, interview, 26 November 1992.
  37. *Le Monde*, 20 April 1989.
  38. *Le Quotidien du Médecin*, 21 April 1989.
  39. *Le Quotidien du Médecin*, 03 July 1989.
  40. *Rapport Mengual*, p. 1
  41. Chodorge, interview; 19 June 1992; *Le Quotidien du Médecin*, 03 August 1989.
  42. The Mission was formally constituted on 09 October 1989.
  43. Couty, interview, 24 November 1992.
  44. E. Couty, D. Kerroux, G. Nicholas, F. Peigné and S. Silland (1990), *Conclusions de la concertation menée par la mission d'information, de concertation et de proposition sur son rapport du 5 avril 1990*, Paris: Ministry of Health, Solidarity and Social Protection.
  45. F. Peigné, interview, 23 November 1992.
  46. Couty telephoned and faxed Silland every night. Couty, interview, 24 November 1992.
  47. Evin delivered this speech at the annual Assises nationales de l'Hospitalisation publique, organised by the Fédération Hospitalière de France. For the transcript of the his speech, see *Le nouvel hospitalier* (1990), no.1, pp.6-9.
  48. Couty, interview, 24 November 1992.
  49. This meeting at Matignon was the first inter-ministerial discussions on the hospital reform since April 1989.
  50. E. Couty, D. Kerroux, G. Nicholas, F. Peigné and S. Silland (1990), *Rapport de Mission d'Information, de Concertation et de proposition sur la réforme hospitalière*, Paris: Ministry of Health, Solidarity and Social Protection.
  51. Couty, Kerroux, Nicholas, Peigné and Silland, *Rapport de Mission d'Information*, pp. 24-47.
  52. Couty, Kerroux, Nicholas, Peigné and Silland, *Rapport de Mission d'Information*, pp pp. 14-16
  53. E. Couty, D. Kerroux, G. Nicholas, F. Peigné and S. Silland (1990), *Conclusions de la concertation menée par la mission d'information, de concertation et de proposition sur son rapport du 5 avril 1990*, pp. 6-7.
  54. Peigné, interview, 23 November 1992; Couty, interview, 24 November 1992.
  55. *Le Quotidien du Médecin*, 03 March 1990.
  56. Peigné, interview, 23 November 1992; Couty, interview, 24 November 1992; DH Internal Note, Working Group: Hospital Internal Organisation, 22 June 1989.
  57. J-L. Chassaniol, interview, 16 December 1991 and 27 November 1992.
  58. *Les Echos*, 05 April 1990; *Le Quotidien du Médecin*, 06 April 1990; E. Couty, D. Kerroux, G. Nicholas, F. Peigné and S. Silland (1990), *Rapport de Mission d'Information, de Concertation et de proposition sur la réforme hospitalière*, Paris: Ministry of Health, Solidarity and Social Protection.
  59. Peigné, interview, 23 November 1992.

60. DH Internal Note, Working Group: Hospital Internal Organisation, 19 September 1989.
61. DH Internal Note, Working Group: Hospital Internal Organisation, 19 September 1989.
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## CHAPTER EIGHT

### CHANGES IN NETWORKS AND GOVERNMENT INTERVENTIONS

By the start of the 1990s, the *corps* of hospital directors occupied some of the highest paid posts in the French civil service. Its ENSP training programme mirrored the 27 month cursus of ENA and, one of its own key figures, Vincent, was the first hospital director and the first graduate of the ENSP *assistanat* to become the head of the *Direction des Hôpitaux* (DH). This consolidation of the *corps* took almost 30 years, commencing with the creation of the ENSP programme for hospital directors in the early 1960s. It continued through the affirmation of the managerial functions of hospital directors and the expansion of the *assistanat* generation in the 1970s. And, it culminated in the 1980s with the 1988 revision of the terms and conditions of hospital directors and the SNCH's rise to policy influence behind Vincent and the hospital law of 1991. These two phenomena symbolised the maturity of the *corps* and of the ENSP programme, the full institutionalisation of the *corps* and the union within the policy network, and the passage of its discourse into official policy.

This chapter stands back from the twists and turns of the SNCH's policy and performance throughout the hospital management reforms of the 1980s and early 1990s to examine how the *corps* emerged and came to occupy so critical a position in a crowded policy field, in competition with so many long-established professional interests, inside the national and regional administration of the state, and inside the hospital system at a local level. Policy communities and networks are often treated in a rather static manner, and it is a standard criticism of the policy networks founding literature that it provides little idea of the dynamics of network change, the emergence of new dominant discourses and the creation of new coalitions. The literature's emphasis on stability and incremental change, on the ability of policy networks and communities to damp down cycling of policy changes, and to stabilize the otherwise chaotic and ever-shifting coalitions forecast by rational choice theory - all these are advantages. But how then do policy networks ever get to be fundamentally reconfigured? How do new groups with new ideas emerge and

acquire influence?

The short answer charted in these pages is that major policy changes often are a bit chaotic, with a good deal of tracking back and forward in short term 'wobbles'. In the French context (and in Britain) powerful central government departments often tackle major long-run problems and the need for structural reforms by trying first one thing and then another. But, behind these policy vacillations and often partly failed innovations, there can be a longer-run dynamic of more coherent and consistent change. These strategic shifts can emerge when actors at different levels get 'lucky' by finding coalitional partners with congruent interests, whose combined and complementary efforts can help them achieve a fundamental restructuring of a policy network. Normally central government ministers and departments are severely constrained in their efforts to push through reform in health care systems by the entrenched interests of grassroots professionals, who impose severe 'agency' costs upon the 'principals'.<sup>1</sup> But, once in a lifetime, central policy-makers identify an insurgent group inside health policy networks whose own interests fit more closely with their needs, offering the prospect of radically reducing agency costs if only this group can be built up and its grassroots influence boosted.

In the French public health care system, by the 1980s, hospital directors could form a useful counterweight deep inside public hospitals to the entrenched power of hospital doctors and the medical profession (just as health care managers within the British NHS played a very similar role in more or less the same period). Of course, the emergent *corps* still had a struggle on its hands to establish itself as a coherent professional group, to develop its own internal cohesion, and to prove itself a reliable and influential coalitional partner for central government ministers and departments. The new *corps* could not risk arousing unmanageable antagonisms from other groups in the health care sector or creating more management difficulties than could be solved inside hospitals. For the *corps* and the union leadership of SNCH, as well as for rival groupings of hospital directors, issues of how to steer a course successfully through contradictory threats, pressures and opportunities were never easy. The threat of central government opportunism was always present, of ministers involving the *corps* in their reform efforts, but without pushing through any compensating increases in their professional recognition,

remuneration or policy influence. Equally, there was always a threat that the *corps*' strategic ideas for achieving management reforms in hospitals could be adopted by the central state as a cover for straightforward cutback management policies. Deciding whether the central state could be trusted was made additionally difficult for the SNCH leadership by the constant rotation of ministers, *cabinets*' personnel, lines of communication with Matignon and the Elysée, let alone, changes in partisan control of government. And, all the sometimes subtle and sometimes radical changes in style which accompanied these constant reconfigurations posed additional problems for the union leadership.

So, we should not expect to find, and nor do we see, any simple linear progress story of constantly increasing influence from the hospital directors or from the SNCH. Nor were there constantly improving or 'ever closer' relations between the *corps* and the union on one side and the political hierarchy of ministers, *cabinets* and top departmental officials on the other. The co-operation across these two tiers was instead constructed intermittently and at many levels, in the debate over ideas emphasized in advocacy coalition accounts, but also in the classical interest group politics of salary levels, apprenticeship norms and *corps* privileges. The complexity of the SNCH leaderships' calculations is shown in the internal politics of factions and groupings struggling for organisational and ideological cohesion first, and then for organisational or ideological hegemony within the profession.

The first section of the chapter recaps briefly on the internal changes in the resources and organisation of the *corps* of hospital directors. The second part analyses how the SNCH interacted with other actors and responded to the intervention of politicians in the management of health policy networks. The third section explores some of the wider implications of this case study of long-run network change for the policy networks literature and for models of French policy-making.

## 8.1 CORPS CONSOLIDATION AND PROFESSIONALISATION

The leadership of the *corps* faced four associated tasks if they were to be successful in their attempt to professionalise the *corps*: the formation and mobilisation of an *assistanat* generation, the management of trade union politics, the balancing of pecuniary and policy rewards throughout the *corps*, and finally, the construction of a substantive knowledge base and the development of organisational resources. The perceived significance of these tasks for the leadership of the *corps* was not stable, but waxed and waned over time as the *corps* focused, or was obliged to focus, its attention on different combinations of tasks which were not necessarily compatible with one another. More importantly, these tasks were often eased by the indirect results of state managers' efforts to transform the management of public hospitals, and changes in the social and economic environment. In other words, the *corps* of hospital directors was advantaged as befits an organisational profession which, by definition, is dependent upon state patronage.

### *Overcoming the barriers to group mobilisation*

In the 1970s, ENSP graduates had first to overcome the incentive of directors to free-ride in order to mobilise a collective attempt to achieve self-regulation in their organisation and working practices. These initial collective action difficulties were overcome by defining occupational group identities, building participation in social networks, developing the reputation of political entrepreneurs in the *corps* and securing favourable interventions from the French state. First, the creation of the ENSP programme put in place the institutional framework for the formation of a group identity of a new generation of hospital directors. The ENSP competitive entrance examination, the *concours*, homogenised the entry into the *corps*, imposing selection procedures at which university graduates or, more importantly, graduates of the institutes of political studies flourished. The selective soft incentives associated with the expression of group identity, rather than any pecuniary benefits derived from trade union membership at the *commissions paritaires*, led the most *corps*-oriented graduates of the ENSP to join the SNCH, because their group identity was reflected in the constituency defended by the hospital director trade union. More importantly, the association of *corps* identity with passage through the



ENSP led these ENSP graduates to define the boundaries of their specific identity set in opposition to the established non-ENSP directors within the leadership of the SNCH. The expression of ENSP codes and conventions by *assistanat* directors thus not only provided incentives for *corps*-oriented graduates to enter the SNCH, but also clashed with the organisational culture of the trade union creating a dynamic for change within the trade union leadership.

Second, participation in social networks forged by directors at the ENSP continually reasserted the boundaries of the common identity set of *assistanat* graduates and reconstructed codes and conventions so that they gained force over time and more specific 'factional' identities could develop their own discourses and values within the overall occupational frame. These factional networks facilitated both the mobilisation of directors and the creation and maintenance of leadership alliances. Social networks developed at the ENSP were behind the emergence of *Grenoble 80* and the Paris modernisers behind Vincent. They provided, through their reassertion of common identity sets, the foundations of the alliances of *Grenoble 80* with Vincent, and ultimately, its cohabitation in the national executive, the *Bureau National* (BN), with rival views, like those of Trazzini. Social ties also eased the entry of Coz into the Vincent faction and his subsequent election as president, which passed control of the leadership of the SNCH to its traditional 'opposition'.

Third, the articulation of the group identity of hospital directors cannot be divorced from the role of political entrepreneurs within the *corps*. Not all directors internalised the *corps* identity. Only the most *corps*-oriented people joined the SNCH and the reformist zeal of the SNCH leadership was always somewhat divorced from the grassroots membership of the trade union. Individual directors such as Vincent, Fischer and Coz were themselves pivotal in the articulation of the group identity of ENSP graduates. They gave birth to social networks and were able to act as brokers between distinct social networks. They then articulated within the health commissions of the SNCH and at annual conferences the discourse of managerialism and the demands for professionalisation. For instance, through his reputation, Vincent embodied the 'modernist' image of the ENSP generation of hospital directors. Significantly, the leadership of key policy entrepreneurs were head directors who successfully negotiated

the promotion bottleneck facing lower-ranked directors, intent mainly on rising through the classes of the *corps*. Over time, this pattern meant that hard incentives were added to the initially soft selective incentive for expressing a *corps* identity.

Yet, this construction of the ENSP group identity was not solely a bottom-up endogenous process whereby ENSP graduates themselves determined the nature of their own group identity. It was equally the product of a top-down exogenous process whereby the group identity of the *corps* was shaped by the external interventions of the French state as it formalised the civil service organisation of the *corps*. The progressive acquisition by hospital directors of the characteristic traits of a *grands corps* depended upon the tacit support of state officials. And, it institutionalised the wider practices of French civil service *corps* within the occupational group. The state expanded the numbers entering the *corps* in the 1970s and pushed through legislation, most notably in 1970, which legitimised the identity of a managerial class of hospital directors. Thus, it was state action which triggered the mobilisation of a group of political entrepreneurs within the *corps* who pieced together a modernising strategy which espoused demands for managerial autonomy. And, the prospect of further consolidation of state patronage for the occupational group was the vital glue, the immediate lure, which tied hospital directors into sustained mobilisation and a long-term effort to upgrade their status and expand the scope of their responsibilities.

### *Managing internal trade union politics*

Once campaigns are established, they can quickly falter if their leaders fail to achieve the original aims, or if, after some success, they extend the aims of the campaign beyond the initial objectives accepted by the grassroots membership.<sup>2</sup> To sustain their professionalisation drive, the ENSP graduates in the leadership of the SNCH thus had to construct a campaign strategy that would unite the different ranks of the union membership behind their modernising discourse. This task was hampered by the trade union orientation of the SNCH, which obliged its leadership to trade-off policy rewards and pecuniary benefits. They were also constrained by the competition of other unions and the 'fixed' demands of their own grassroots membership. The delivery of improvements in employment terms and conditions was not easily associated with the

knowledge orientations of a professionalising organisation - which required the SNCH to function as an arena for debate and the production of knowledge in the *corps*, a lobby for health reform, and a limited regulatory body for hospital directors. This multi-tasking also took place within a trade union which was not solely a union for top hospital directors, but also a catch-all organisation for all ranks of hospital administrative personnel.

The SNCH leadership juggled these roles by campaigning for advances in improvements in pay and conditions, not as the outcome of traditional forms of collective bargaining, but as the outcome of hospital management reforms which elevated the standing of the *corps*. This evolution towards the strategies and tactics of a health policy lobby emerged out of the failure of the Charlotte leadership's 'externalist' strategy, and was epitomised by the modernisers' adherence to the strategy defined at Mâcon by Vincent. Internally, this approach made it legitimate for the moderately modernising leadership to extend the SNCH's knowledge and lobby orientations, as well as responding to the demands of both the supporters of *Grenoble 80* and the Vincent's ambitious modernisers in Paris. Externally, it cemented the SNCH's constituency in relation to its rival trade unions and the *Fédération Hospitalière de France* (FHF). The approach asserted SNCH's occupational trade unionism, political neutrality, and ambition to influence state policy. These commitments and aspirations reinforced the union's competitive advantage over *Force Ouvrière* (FO), with its ties to the FHF, the *Confédération Française et Démocratique du Travail* (CFDT) and the *Confédération Générale du Travail* (CGT). FO, CFDT and the CGT were unable to pursue moves towards the collective upward mobility of hospital directors from within the confines of wider trade union structures. The conservative FHF remained a stout defender of the public hospital service, out of step with the moves towards managerial reform and cost containment.

The pursuit of the Mâcon strategy, once again, owed much to the capacity of political entrepreneurs within the SNCH leadership to drag the rank-and-file membership down the path of professionalisation and health care reform. Particularly with *hôpital-entreprise*, this course advanced the interests of head directors. In practice, the professionalisation of the *corps* pursued by the SNCH was the property of a band of approximately twelve ENSP graduates, revolving around the tandem of Vincent and Paillé

in the early 1980s. At Mâcon, Vincent's reputation throughout the *corps* swung conference delegates behind support for the global budget, which reversed the SNCH's previous positions and forced it into the health policy arena. Vincent's adoption of centrist positions made him the primary bridge-builder between the left and right of the trade union. Working with Paillé, his orchestration of the SNCH's policy agenda relied upon a perpetual process of justification and persuasion by the leadership through conference debates, working groups and the production of substantive knowledge.

The leadership experienced some difficulties of internal cohesion and, in particular, elite-follower relations. Before the 1988 revision of the terms and conditions for hospital directors, the Vincent leadership faced attacks from the leaderships of *Agir et Liberté* and even *Grenoble 80*. Whilst not rejecting the Mâcon strategy, they demanded a more aggressive pursuit of pecuniary benefits by the Vincent leadership (much like the attacks on Charlotte). The Vincent leadership persistently attempted to jump onto the bandwagon of government reform, only to bale out again at a later date as the balance of advantages and costs in being associated with a failed or unpopular reform changed. The conditions attached to the endorsement of the global budget to appease delegates at Mâcon ultimately forced the SNCH leadership to retreat back into the conservative coalition, with its attacks on the global budget proposals mirroring those of the FHF. Likewise, the failure of the Mâcon strategy to deliver pecuniary benefits came to dominate the SNCH's twists and turns throughout the introduction of departments. At this time, the leadership's short-term needs to deliver improved terms and conditions to the grassroots membership overwhelmed the modernisation ethos inherent within the Mâcon strategy. Unable to advance its demands for improved terms and conditions under both the Mauroy and Fabius governments, the union's leaders used its support for departments as a resource in its bargaining strategies with the *Parti Socialiste* (PS) government. With no immediate gains, they withdrew co-operation entirely from the implementation of departments and lobbied against the last-ditch attempts of Terquem to introduce departments before the March 1986 legislative elections.

Thus, the leadership juggled the competing roles of the SNCH through the pursuit of a Mâcon strategy which tied pecuniary benefits to policy rewards. However, its success ultimately depended upon the capacity of the Vincent leadership to deliver the expected

pecuniary benefits to the grassroots membership. The SNCH leadership never fully abandoned the tactics of Charlotte and the tensions within the Mâcon strategy were relieved by the improvements in pay and conditions agreed in 1988.

### *Mobilising resources at the disposal of the corps*

An individual group seeking to gain entry into a policy network from which it has previously been excluded may make some headway because of its bargaining strategies, but its progress will depend much more on increasing the resources at its disposal. Behind the Mâcon strategy, the SNCH increased its hold over the elections to the *commissions paritaires* as FO support declined. The leadership was able to draw upon the rise within the *corps* from 1985 of the *assistanat* graduates and the hold of ENSP graduates over the representative bodies within the *corps*. From 1985, ENSP graduates began to arrive in the First Class of hospital directors, thereby improving the reputation of the *corps*.

Imbued with the organisational values of the French civil service, ENSP graduates reproduced the ideology of the *grands corps* in an attempt to increase the resources at their disposal. They vaunted the traits of expertise and extensive training. And, like the *grands corps* before them, they claimed to monopolise the value-free representation of the public interest, using a legitimising cloak of managerialism. Management was represented as a distinct organisational function with its own separate expertise, which was founded upon a discourse of increases in productivity through freedom to manage.<sup>3</sup>

From the mid-1970s onwards, the *corps* undertook a rapid turnover in its accepted best practices as it constructed its own body of substantive knowledge, particularly within working parties of the SNCH. With the emergence of the ENSP generation in the SNCH from 1976, *assistanat* graduates undertook a prolonged campaign to build up intellectual capital - punctuated by the annual reports at conference in the 1970s, and the publication of both *200 Propositions* in 1985 and the Trazzini report in 1987. These developments within the SNCH were nourished by the grassroots activities of leading individuals within the *corps* and the redefinition of 'best practice' which took place within the professional networks of hospital directors. Individual initiatives were popularised in professional journals, such as *Gestions Hospitalières*, and then mirrored over time in the training programme of the ENSP.

The articulation of this substantive knowledge base was wrapped up with wider political discourses as competing factions injected new practices into the SNCH on the back of discreet partisan affiliations. As the Left emerged in the late 1970s, socialist sympathisers within the leadership of *Grenoble 80* promoted wider conceptions of public health and participatory management within public hospitals. This health manifesto inspired by the PS was then confronted by those supporters of the gaullist *Rassemblement pour la République* (RPR), Grenon and Trazzini, who injected the values of the market-inspired *hôpital-entreprise* into SNCH conferences and forums. The dialectic of debate, its framing, was driven by partisan competition. However, ironically, these partisan cleavages occurred in a trade union defined by its political neutrality and were subsumed by the ENSP identity and the primacy of the management function. The rival school of statist and autonomists within the leadership from the mid-1980s, mushroomed alongside largely party political divisions - with *Grenoble 80* remaining somewhat divorced from the autonomist ranks of Trazzini and Grenon. But, these lines of cleavage were cross-cut by the professional cleavages dividing directors in regional teaching hospitals and general hospitals and ENSP social networks.

In addition, members of the *corps* entered the health commissions of the main political parties so that, from 1985 onwards, hospital directors contested the predominance within such commissions of hospital doctors and *énarques*. Couty rose within the PS. Trazzini voiced SNCH concerns in the RPR. Paillé lobbied within the CDS. This reinforcement of the organisational resources of the SNCH was overseen by Vincent and Paillé. The SNCH leadership instructed its members to exploit their traditional ties with mayors. The publication of *200 Propositions* was deliberately timed to mark the electoral campaign of 1986. Paillé's appointment as the trade union's first ever national delegate, augmented its lobbying capacity. Indeed, Paillé was widely seen as a 'political animal' and formed an influential partnership with Vincent at the head of the trade union.

The SNCH leadership thus constructed a professionalising strategy which facilitated its entry into health policy networks. It reinforced this strategy after Mâcon with the rapid turnover of its substantive knowledge, practising entry into a range of political parties, and expanding the SNCH's organisational capacity through the appointment of a national delegate. In fact, the union's inconsistent support for hospital

reforms contrasted with its consistent stress on increasing the knowledge and expertise of the *corps* of hospital directors. Pressures for pecuniary benefits primarily constrained the level of support for government measures, but they did not hinder making the Mâcon strategy more concrete through the development of the union's advocacy and lobbying resources.

Overall, through reducing the costs of collective mobilisation, the SNCH was able to 'revalue' its existing resources, to exploit some previously untapped resources and to change its stock by developing some new resources (see Table 8.1). The emergence of the generation imbued with the ENSP identity facilitated the construction of a collective strategy of upward social mobility. This drive for professionalisation was supported organisationally by the SNCH, which benefitted from the entry of the most *corps*-oriented graduates in the 1970s. These ENSP graduates not only improved the reputational resources of the *corps*, but also worked within the *corps* and the SNCH to assert their own codes and conventions. The Mâcon strategy subsequently eased elite-follower relations by tying pecuniary benefits to the reform of hospital management practices. To this end, the *corps* overhauled its expertise and knowledge base in the 1980s, cementing its organisational networks through the entry of directors into political parties.

**Table 8.1: Bottom-up endogenous resource change in the SNCH**

<b>SNCH and Bottom-Up Endogenous-Led Change</b>			
Revaluation of resources	ENSP identity and Mâcon strategy	Overhaul of knowledge base, entry into parties, arrival of ENSP graduates	Change in stock of resources
	Cost of mobilisation falls	Organisation develops new resources	

Throughout this transition, the SNCH undertook a number of tasks normally associated with separate organisations. The task of managing union politics and alliances

was central to the ENSP graduates' agenda between 1976 and the Mâcon compromise and, then again, in 1989 following Vincent's departure (see Table 8.2). Building a better knowledge base was a consistent concern of the SNCH leadership, but waned in importance after the publication of the Trazzini report and the rally behind the conception of public hospitals as *établissements publics de santé*. Pecuniary benefits and policy gains were both pursued from Mâcon onwards, but the settlement broke down in the mid-1980s as pecuniary benefits dominated over the pursuit of policy rewards. Policy gains then returned to the agenda after the 1988 settlement. The management of these tasks was facilitated by the group identity of the ENSP graduates, the significance of social networks and the role of policy entrepreneurs within the *corps*. However, the construction of a group identity was never a primary objective of the ENSP graduates. This identity was constructed and reconstructed throughout the process of consolidation and professionalisation of the *corps*. Yet, it was cemented externally by the formalisation of the *corps* by the French state. Indeed, the resources at the disposal of groups can be revalued by other actors as they grow in utility or salience or, actors can be *advantaged* whereby they benefit through the actions of another actor or person. So, although the ENSP generation pieced together the modernising strategy within the SNCH, the catalyst for their emergence within the *corps* cannot be divorced from the management of the *corps* by the state.

**Table 8.2: *Corps* consolidation, the changing agenda of the ENSP generation, 1976-1991.**

	Union Politics	Knowledge Base	Pecuniary Benefits	Policy Gains
1976-1982				
1983-1986				
1987-1988				
1989-1991				

Notes: Shaded areas indicate prominence on the agenda of the ENSP generation.



## 8.2 HOW THE STATE MANAGED HEALTH POLICY NETWORKS AND ITS IMPACTS ON THE CORPS

Top politicians can manage health policy networks through a series of network restructuring paths lying between exit and voice in one dimension, and expansion and consolidation on another dimension. In the case of the French public health system, these political interventions were more than sporadic external shocks to existing networks. They were persistent attempts to restructure these networks through the imposition of top-down changes in the regulation and financing of the health policy sub-system, and through fostering bottom-up changes in professional groups and the local management of public hospitals. Ministers' and national departments' costly crusades were triggered by the perception of declining quality in health care. Bureaucratic officials and ministers across government, not only within Health and Social Affairs, but also within Finance, Matignon and the Elysée, recognised declines in the quality of the outcomes produced in hospital management as early as 1976, when concerns over the long-term deficit of the health sickness funds were voiced. Demographic pressures, technological innovation in medical specialisms, changing consumer expectations and perceived 'unlimited' demand added to the problems. In addition, contingent professional changes, not least the growth of a hospital bureaucracy and the fragmentation of medical services, destabilised the historic compromise which had previously governed the French public hospital service. The ward fiefdoms which guaranteed medical autonomy inevitably led to fragmentation and discontent within the ranks of junior doctors.

This section analyses the top-down strategies adopted by politicians and considers how these strategies impacted upon the resources and opportunities open to the SNCH and the *corps* of hospital directors. The first part examines the evolution of the priorities and objectives of ministers from the initial perception of decline in the quality of outcomes. The second part analyses how successive governments employed a series of network restructuring paths to induce change within health policy-making. The final part assesses how far the management of health policy networks consolidated the SNCH's influence and that of the hospital directors' *corps* within health policy-making.

### *Ministers' Shifting Agendas*

Network restructuring was driven by the different values and objectives imported into the management of health policy networks by successive sets of ministers and senior state officials, most notably the 'political' appointees within ministerial cabinets. Upon arrival in office, ministers did not necessarily share the entrenched rules and norms which governed relations within established health policy networks. Rather, they had their own distinct priorities which were formulated outside the network.<sup>4</sup> The concerns to impose cost containment, driven by Barre and then Farge, alienated ministers' traditional partners in the DH, the FHF, the medical elite in the regional teaching hospitals and even the SNCH. These distinct priorities, coupled with the turnover of ministerial chairs, meant that ministers could break the routine of policy network consultation. Ralite and Questiaux relegated to the background concerns over health spending against the advice of senior bureaucrats like Marmot whilst Bérégovoy implemented the global budget. Blighted in the medical community by his communist affiliations, Ralite ignored the established rules of consultation even before he released for consultation the draft decree on departments. Dufoix reneged on the agreement on departments negotiated by Hervé and began private negotiations with the leaders of the *conférences*. Evin arrived in office with the expressed intention of revisiting the debate over departments and revising the system of hospital planning. Durieux, as the conditions of his appointment dictated, intervened in the parliamentary negotiations of the 1991 Hospital Law to stamp his influence over the text. So, ministers and senior state managers were often unpredictable policy actors.

In part, these interventions were designed to manage some short-term crisis or to achieve short-term payoffs for ministers. Farge was appointed by Giscard to cap hospital spending by the presidential elections of 1981. His short-term mandate guided his use of network restructuring strategies, the internalisation of policy-making, and his reluctance to launch the long-term implementation of the global budget. The appointment of Terquem to push forward the introduction of departments, like previous hesitations by Hervé and Dufoix, was another attempt to achieve short-term payoffs. After the hesitations of the Mauroy and Fabius governments, it was supposed to regain the support of left-wing doctors before the March 1986 legislative elections. The origins of the

decision by Evin to rewrite the public hospital legislation lay in discussions with his *cabinet* about the best strategy to manage the 'crisis' that was mushrooming in public hospitals, particularly the discontent of nurses.

Ministers were also side-tracked by the desire to accommodate the demands of party clienteles. The primarily top-down emergence of the global budget contrasts with the bottom-up emergence of departments, which built upon the client groups of the French socialist party and the gaullist RPR. Political parties are not homogenous organisations, but are coalitions of interests embedded within networks of organisational interests and groups. These clienteles are sources of initiatives which do not fit within the rules and behaviour of the established policy community because they are intra-party processes and can have atypical dynamics. Where political parties have formal ties with interest groups or are 'captured' by a group, politicians are likely to engage in network structuring if their clienteles are closed out of the decision-making process. Such network restructuring is particularly likely to occur when partisan cleavages structure a fragmented professional group universe, as in the case of the differential support of hospital doctors for parties of the right. The PS's few connections with hospital doctors, and its prolonged absence from office, acted as a source of dynamism within the policy subsector, paving the way for network restructuring strategies. In 1981, it brought into office individuals from *Santé et Socialisme* and elevated Peigné and his supporters. However, these groups lost such privileged access once the RPR and the giscardian *Union pour la Démocratie Française* (UDF) returned to office and the Chirac government reinstated individuals from the *conférence* within ministerial cabinets. This inconclusive differential support promoted Evin to draw hospital directors into the ranks of decision-makers as he sought to create an alliance of modernisers.

However, ministers also took short-term actions which appeared to go against their chances of re-election. Debré was ignored by the Chirac government. Dufoix sought a negotiated compromise with the *conférence*, ignorant of Peigné's demands. The formulation of the global budget, by its very nature, provided only diffuse gains for potential beneficiaries outside the national state, whilst the costs to individuals were direct and its effects were highly visible and traceable to government leaders.

Health and Social Affairs ministers were also unable to insulate themselves from

the broader policy concerns, particularly economic concerns, of senior core executive actors - expressed in interventions from the Finance Ministry, the Matignon and the Elysée, who possessed a broader concern with policy dilemmas than health policy network actors. Senior core executive actors parachuted into health like-minded individuals with externally-defined agendas to control costs. Barre and Giscard imposed Farge. Mitterrand and Mauroy imposed Bérégoovoy, who assembled a team of advisers led by the financial manager, Naouri. However, the Elysée and Matignon intervened only sporadically in the implementation of departments, advancing the interests of doctors at various stages. Evin came up against the DB as the 1991 Hospital Law became embroiled with internal PS battles and battles between the competing bureaucratic interests of ministries.

However, ministers did not simply inject short-term concerns into the network restructuring of health policy networks. Neither should they be classified as non-strategic actors. There was policy learning by ministers and *cabinets*, as Evin and Couty demonstrated in the formulation of the 1991 Hospital Law, an organisational reform which did not resurrect the spectre of departments. Indeed, the introduction of departments was never a priority of Matignon and the Elysée under the PS, and from 1987, the introduction of departments was a 'settled' issue. Likewise, although the launch of the global budget stuttered throughout the 1970s, the permanency of stringent controls on hospital spending was not questioned from the mid-1980s. Such policy learning supports conceptions of adaptive interventionism by ministers rather than knee-jerk reaction in non-strategic directions. Ministers might not be dictated to by the norms of behaviour within policy networks, but there is a departmental history or conception of ideas to guide their actions. Reforms such as departments and reform of the private sector had been suggested and discussed long-before the arrival of the French Socialists in office. Most importantly, in health policy subsystems, both different governments and grassroots participants shared an interest in defining a workable compromise to regulate the delivery of services and allocation of resources.

### ***The tools of network management***

With the imposition of top-down controls on financial aggregates, the Barre government began to lay the foundations of a rival policy network. It assembled a loose linking of

*Inspecteurs des Finances* within the ministerial divisions of health and social security and the administrative leadership of the health sickness funds, the *Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés* (CNAMTS). This community of actors was committed to centralised budgetary controls, sharing a strategic perception of the requirements of hospital management reform which owed much to their common *corps* socialisation and interests. This loose network was not a formal policy community, but rather a first step towards 'exit'. It internalised policy formulation in the hands of ministers and state managers, divorcing financial reform from any external partners. More importantly, the imposition of top-down controls on financial aggregates created difficulties for most of the traditional partners of the DH, because the Barre government opted out of the DH's established relations with the regional teaching hospital elite and the FHF. Farge and his colleagues simply made arbitrary controls on public hospital spending against what they interpreted to be the interests of a set of pro-spending local cartels involving mayors, doctors and hospital directors alike.

In the formulation of the global budget, three key state managers (Naouri, Kervasdoué and Marmot) dominated the formulation of a replacement for the patient-day rate. Intermittent interventions by hospital doctors were disregarded by this trio, particularly as the representative organisations of medical professionals were distracted by the threats posed to the state-profession compromise by the abolition of private pay beds and the introduction of departments. In fact, hospital doctors deliberately divorced themselves from debates surrounding the introduction of the global budget, believing themselves to lack the requisite expertise to intervene in its formulation. However, even where expertise was recognised, the issue of legitimacy was exploited by state managers to isolate the CNAMTS: it was labelled by the *Inspecteurs des Finances*, and the hospital directors for that matter, as a private organisation which was unrepresentative of the public interest. The introduction of the global budget with only concessions to changing managerial and organisational practices in public hospitals consolidated the capacity of state managers to 'exit' in the short-term from the established policy networks. It did gain some hold over global hospital spending, although such a crude cap on expenditures did little to advance the redistribution of budgets between hospitals and 'froze' the then existing distribution of services between public hospitals. The failure of other groups to

buy into cost containment meant that moves towards management change were lacking and the initial phase was simply to cap spending.

This strategy of top-down internalisation of policy formulation was not mirrored in the pursuit of organisational change in public hospitals. The interventions of the communist Jack Ralite, and, for that matter, his very appointment, broke the rules of consultation between the state and the medical profession and questioned the boundaries of the state-profession compromise, thereby triggering the mobilisation of hospital doctor trade unions. It tied the Mauroy and Fabius governments into a series of consolidations and expansions of the membership of policy networks as they strived to broker agreements within the medical community. Uncertain of the support of hospital doctors, Hervé oscillated between answering the demands of the modernising Peigné, the alleged left-winger Derenne and the conservative trade unions and the *conférences*. Dufoix subsequently reversed these overtures to Peigné and his supporters and attempted to re-establish privileged relations with the *conférences*. With the *conférences* ultimately renegeing on their agreement with Dufoix, the Fabius government appointed Terquem to push through departmentalisation on the back of Peigné and Gatelmand; he failed to do so because the issue was already dead and just waiting for the re-election of the Right.

The PS's failure to broker a compromise between the competing factions of the medical profession was confirmed by the Chirac government, which allied itself firmly with the leaders of the *conférence* for regional and teaching hospitals. After the crisis of relations between the PS and hospital doctors, the Chirac government, through its appointment of Pellerin as advisor to Barzach, awarded the traditional medical elite privileged access to the hospital policy-making process. Barzach's 1987 legislation mirrored the policy proposals of the *conférence* as the right-wing government, eager to trade with the *conférence*, stood out against the influence of both the left-leaning pro-department doctors, in particular, Peigné, and the radical conservative wing of the elite *mandarins* led by Debré.

Behind the ruptures of the opening and closing of access to different groups within the medical profession, politicians persistently sought to construct and advantage the resources of the more managerialist sections within the medical profession. Even the Chirac government's settlement endorsed a compromise acceptable to the *conférence* and

not its vocal supporters behind Debré, leaving decisions to reorganise services in the hands of doctors themselves, but acknowledging the principle of limited performance measurement (hampered in practice by the scarce resources at the disposal of the Health Ministry) and the obligation to attribute more responsibilities to junior doctors. More importantly, at key stages of the moves towards departmentalisation, the PS responded to the demands of the INMH, bringing Peigné into the core of decision-makers, because he had access to the Elysée. Government backing of Peigné, who came out in favour of departmentalisation, fragmented his support within his federation and forced the rupture between the INMH and other trade unions.

Politicians' backing for Peigné continued under the Rocard government where he was brought into the policy-making process surrounding the 1991 Hospital Law by Evin, who tied him to the government's proposals - commissioning him to report on the future of the public hospital service and appointing him to the Couty Commission. His involvement within the Couty Commission brought together an emerging advocacy coalition within hospital personnel. The PS encouraged the managerialist INMH to break off from more conservative trade unions, who mobilised collectively by the late 1980s in the *Coordination*. Thus, the PS continued the Barrist attempts to construct an alternative policy network within the hospital management policy sub-system. It sought to create a 'partner' to negotiate with the financial 'community' of state managers who had invaded the management of hospital spending.

The reinforcement of potential allies was encouraged by the state's involvement in the production of substantive knowledge and promotion of methods of managerial innovation. Ralite commissioned reports on hospital reorganisation, as did Bérégovoy who also commissioned reports on regional health planning. This process was continued under Barzach, who commissioned Trazzini to write a report on the possibilities of introducing *hôpital-entreprise*. These reports played an important role in the popularisation of change and practices within the medical profession and amongst hospital directors. Nowhere was this more apparent than during the formulation of the 1991 Hospital Law when Evin commissioned a series of reports to inform hospital reform and the Couty Commission, following the *méthode Rocard*, engaged in a period of grassroots consultation and the popularisation of new practices. So, politicians sought influence by managing the

construction of new practices and effecting changes in the substantive knowledge base for grassroots management.

Successive ministers also repeatedly exploited top-down controls on financial aggregates to foster changes in the accepted working practices of public hospitals. Although a relatively blunt instrument for state managers, the imposition of ever more stringent *taux directeurs*, particularly after the short-lived expansionism of 1981 and 1982, became not simply a means of limiting the deficit of the health sickness funds, but also a means of facilitating cultural change within the local management of public hospitals. The replacement of the inflationary patient-day rate with the global budget removed control of financial aggregates from hospital directors and doctors, but devolved responsibility for cutback management. Bérégovoy popularised the principle of the redeployment of existing sources, which posited that public hospitals were not to receive additional finance, but instead to raise resources through efficiency gains. This transformation of the budgetary rules and procedures acted as a catalyst for the redefinition of the established best practices within hospital management.

Whilst these top-down controls increased 'stress' in the system, politicians also introduced new institutional mechanisms to guide implementation structures and decision-making processes. The global budget introduced cost centres, *centres de responsabilités*, and the move towards departments tried to institute new managerial responsibilities for head doctors as well as new practices of accountability. The return to services was not without its constraints on hospital doctors, since the Chirac government enshrined the penalisation of poor management (see above). It reduced the tenure of head doctors to five years, with their re-appointment dependent upon satisfactory reports on their management and their future plans for development. In fact, the outcome power of hospital doctors led the state to foster the growth of hospital director-hospital doctor tandems as the strategic apex of public hospitals. The tandem of chair of the hospital medical commission and hospital director was progressively elevated in importance, while the influence of the Mayor and the Board of Trustees was typically reduced. This reinforcement of a reconfigured strategic apex was coupled with attempts to both fill in the middle-line of clinical managers, and to redefine collective medical responsibility (as seen in the introduction of departments and the remodelling of the hospital medical



commission). Consecutive reforms extended the consultative powers of the hospital medical commission to develop an overt decision-making role within the running of public hospitals. The 1991 Hospital Law gave it the role of preparing the *projet médical* upon which the director based the *projet d'établissement* which itself was presented jointly by the director and the chair of the hospital medical commission (after a hard fought parliamentary battle on this provision).

The planning ethos of the 1991 legislation also saw politicians attempting to introduce a variant of managed competition as a mechanism to allocate resources within the hospital management system. With the right of patients to choose the care of their choice enshrined within legislation, hospitals were now obliged to produce development plans which after submission to regional health boards, would be judged both alongside other proposals and alongside the regional priorities for health care provision. This mild competitive tendering or bidding process sat alongside attempts to devolve managerial decisions down to hospital directors, free to manage at the grassroots. Its encouragement of entrepreneurial innovation fostered change in the balance of professional groups, weakening the influence of both hospital doctors and local Mayors. Despite its claims to promote managerial autonomy, the legislation enhanced the intervention of regional health boards, thereby reducing the local capacity to determine the overall pattern of service delivery. With the health sickness funds, the CNAMTS, quasi-excluded from negotiations, the managerial network was boosted by this legislation - which sought to foster the development of a *cadre* of regional health inspectors, nurse managers and the tandem of hospital directors and chairs of hospital medical commissions.

### ***Hospital directors and network management***

Throughout the introduction of the global budget and departments, the SNCH did not possess the necessary reputational resources to forge privileged relations with the PS government, or the Barthe government before it. This weakness stemmed from the perception held by ministers and bureaucrats that the *corps* lacked outcome power. Crystallizing the views of the financial community at the end of the 1970s, Farge did not consider hospital directors to have the necessary resources to counter the influence of the medical profession within public hospitals - an attitude shared by Bérégovoy, Naouri,

Kervasdoué and Hervé. These perceptions were reinforced by the competition between the *Inspection des Finances* and the *corps* of hospital directors. The dominance of the *Inspection des Finances* within the central administration ensured that hospital directors' aspirations were relegated as part of its territorial battles with the rival *corps*.

Throughout the failure to implement departments, the SNCH was crowded out of the policy arena by the fragmented hospital doctor trade union movement and its well-established *conférences*. At no time did the SNCH leadership intervene so as to either stand against the challenge of the likes of Debré in defence of departments or try to act as a policy broker between the competing coalitions surrounding departmentalisation. Within the trade union, Vincent was not fully committed to the introduction of departments against the wishes of the medical profession. Instead, improvements in pay and conditions came to dominate the SNCH's responses to the attempts by Hervé and Dufoix to broker a compromise with hospital doctors. The beliefs of state managers and ministers that the SNCH lacked outcome power was thus reinforced by the internal contradictions and mixed messages sent by the hospital director trade union - a weakness which blighted the trade union leadership's influence during the formulation of the global budget and the introduction of departments.

This said, ministers and state managers did sponsor the development of the *corps* and facilitate the development of organisational resources by the SNCH leadership. The successive steps in the formalisation of the *corps* of hospital directors, such as the 1984 reinforcement of the authority of directors, were matched by informal inducements for change as ministers tried to use 'voice' options to change the working practices of hospital doctors and directors. Supported openly by Kervasdoué, Bérégovoy publicly derided the managerial qualities of hospital directors, cajoling them to espouse new practices. The utility of such interventions was limited. Whilst Bérégovoy engaged in a war of attrition with public hospital directors, he lobbied Mitterrand to create a *Conseil Général des Hôpitaux* so that he could remove allegedly incompetent directors from their posts. With Bérégovoy's support, Kervasdoué introduced the HEC training programme for senior directors, which spread private management techniques down through the *corps*. However, such direct interventions in the internal management of the *corps* were restricted, as the outcry surrounding both Bérégovoy's and Barzach's interventions in

the appointment of directors demonstrates.

In fact, the policy failures of the SNCH in the early 1980s stand in marked contrast to their successful negotiation of improved terms and conditions under Barzach. The Chirac government isolated itself from the SNCH's attempts to exert policy influence in the 1987 legislation, but it recognised its trade union objectives of pecuniary rewards for its grassroots membership. After the dissatisfaction of Rayroles and the PS, these rewards upgraded the *corps*, making the posts of hospital directors some of the highest paid posts in the civil service. Ironically, these statutory improvements came when the SNCH had neither representation within ministerial *cabinets* nor access to the closed arena of policy formulation. Instead, the SNCH forged ties with the RPR whilst in opposition, exemplified by the discourse of *hôpital-entreprise* and its popularisation by Trazzini and Grenon. Yet, the SNCH leadership initially backed the influence of Debré which waned after the 1986 legislative elections. The union leadership thus relied upon Vincent's network and his ties with Bérard to gain privileged access to Matignon. However, Matignon revised the terms and conditions of the *corps* without the SNCH exercising its influence over the direction of the hospital policy programme of the Chirac government, and without the SNCH forming an integral part of its support coalition within the hospital policy subsystem. The SNCH seemed to benefit primarily from the emergence of a fashionable managerialist stance and new attempts made by the state to cement a managerialist coalition and acquire a potential corporatist partner.

The SNCH was gaining credibility through helping push ahead substantive knowledge, much of which was sponsored by the French state. The SNCH leadership participated in this experience of policy innovation, presenting itself as 'leaders' in the market for new ideas. The union manipulated its discourse in response to the evolving concerns of politicians as it attempted to maximise the salience of its own resources. Vincent endorsed *hôpital-entreprise* because it gained favourable responses in the media and articulated the evolution of managerialist practices from managers as controllers to managers as leaders, motivating teams working in looser systems of formal control. However, despite adopting a more autonomist managerial discourse under Coz, the SNCH sat firmly at the head of a dominant advocacy coalition which proposed regional planned markets as the most efficient response to the demands of cost containment. The

planned competition of the 1991 Hospital Law mirrored the discourse of the SNCH under Vincent and that of the *200 Propositions*.

The *corps* swept into pivotal positions within the decision-making process surrounding the 1991 legislation, as Evin brought together a network of modernisers. This elevation of the SNCH was facilitated by its identification with the issue of regional planning and the failure of the Left to cement clientelistic networks with Peigné and the modernisers within hospital doctor trade unions. Although the French state sought to force changes within the INMH, with Peigné absent through his involvement in the Couty Commission, his replacement, Stanislas Johannet, resigned because of his frustration with grassroots hostility to managerial change and demands for improvements in pay and conditions. In addition, throughout the formulation of the 1991 Hospital Law, hospital doctors tended to contest issues about medical organisation within public hospitals rather than the backbone of the reform, which was its renovation of hospital planning.

The SNCH benefitted from the short-term crisis experienced by Evin and his desire to ward off further discontent in public hospitals after the nurses' strikes. These benefits were amplified by Coz's personal relationship with Evin, the weakness of the Rocard government's parliamentary majority, and the contingent responses of ministers to hospital reform. With Vincent and his team at the DH, Couty and Chodorge in the *cabinet* and Coz at the head of the SNCH, a network of ENSP graduates assembled behind the Minister for Solidarity, Health and Social Protection. This network was subsequently advantaged by the institutional framework and priorities of the Rocard government. As the Bill floundered in the National Assembly, hospital directors including Paillé were able to come to prominence in negotiating the legislation's passage through the Assembly. The organisational networks constructed by the SNCH appeared to have reaped their full benefit as the 1991 Hospital Law became 'the law of Gérard Vincent.'<sup>5</sup>

Behind the long sequence of bottom-up and top-down contingent changes lay, nonetheless, the assertion of the *corps* within a rising advocacy coalition, and the sponsorship of the *corps* by successive governments. Thus, the SNCH gained its highpoint in terms of policy influence in 1990 and 1991 whilst its trade union objectives were attained in 1988. With the implementation of the *200 Propositions*, the cycle which started with the emergence of the ENSP generation was complete. This emergence of the SNCH

occurred as the previously established partners of the Health Ministry were relegated to second tier actors. Over time, the *Inspection des Finances*, and the INMH were encouraged to 'invade' areas previously monopolised by the FHF and elite hospital doctors. Although the SNCH was a nodal actor which straddled the issues of planning and finance as well as internal hospital organisation, it was crowded out in the 1980s by the *grands corps* and hospital doctors. Its changing alliance strategies were only tacit alliances then, and the union suffered from its weak outcome power. However, the *corps* continued to benefit from state sponsorship and the emergence of a managerialist advocacy coalition. These external factors then combined with the work of the union leadership in promoting ideas as well as grassroots changes in the *corps* and the organisational networks of the trade union to give much more influence to hospital directors when Evin sought to solve short-term unrest in public hospitals through the rewriting of the 1970 Hospital Law.

### **CONCLUSIONS: INTERPRETING THE SHIFTS IN FRENCH HEALTH POLICY NETWORKS**

By stressing the longer-term favourable shifts brought about by the complex courtship dance of the hospital directors *corps* on one side, and of national politicians and state agencies on the other, the previous two sections return us squarely to the broader issues of interpretation raised in Chapter One. Like any other conscientious empirical research in public policy, this study has thrown up results which are susceptible of interpretation at a number of explanatory or analytic levels and in a number of different ways.<sup>6</sup> Thus, conventional pluralists might draw comfort from the complexity and detailing of the story told in Chapters Two to Seven, arguing that it illustrates the haphazard process of individual politicians and changing coalitions of interest groups interacting in a series of rushed decisions and processes, seeking always in an incremental way to push through marginal changes from the status quo while maximizing levels of agreement. They could illustrate their account with the many instances of stops and starts, changes of direction, neglect of opportunities and misperceptions of interests by different actors. In their view, the hospital directors might be seen as a pivotal group in a finely balanced interest group sub-sector, who played a clever tactical hand, maintaining good relations with a wide range of interests, cultivating their political contacts to achieve 'insider' status, exploiting

opportunities that came along, and shrewdly investing in building up the interest group's internal resources for the future.

On the other hand, neo-Marxist authors could plausibly point to the central state's attitudes on public hospitals being fundamentally set by broad-scale external shifts in the political economy, especially internationalisation, marketisation, technological development and decentralisation.<sup>7</sup> In their view, the relentless push for achieving financial cutbacks, rationing resource allocations for public hospitals and curbing the bargaining power of their workforces, were the long-run constants behind the French state's shifting exploration of different 'solutions' to immediate crises or conflicting interest group pressures. The hospital directors were just another techno-bureaucratic occupational group, with no more claim than the next group along to become recognised as a *grands corps* profession. They nonetheless got lucky, because they offered the state apparatus a means of implementing retrenchment and the enforcement of economic rationalization in public health care under the guise of a socially neutral managerialism.

The evidence presented here does not rule out either of these models decisively. The vagaries of the political process and the shifting short-term configurations of interest groups were terribly important in how the particular sequence of attempted reforms panned out, but, in itself, this fact does not invalidate a long-run neo-Marxist account. Equally, important though they were, the factors stressed by pluralists (such as the cycle of month-by-month and week-to-week fluctuations in the political fortunes of elected politicians and their advisors and governments) were clearly not all there was to the evolution of French public health policy networks. The long-run trend beneath the wobbles is an important 'fact' in itself that needs more of an explanation than just that the SNCH or the *corps* played their cards right (in such a crowded and competitive interest group space) or just happened to get lucky in attracting central state assistance.

By contrast, a general neo-pluralist approach seems to best fit the kind of analysis set out here. It focuses directly on corporatist links and exchanges between state and organized interests. It takes seriously the role of professionalism, the development of ideas, and the creation of overarching 'advocacy coalitions' in shifting the terms and terrain of public policy debates. It stresses the genuine and ineradicable difficulties confronted by top policy-makers in making decisions with relatively poor information and

foresight possible, and often confronting 'wicked' problems under conditions of severe constraints. In Majone's important insight, the solution is a division of labour.<sup>8</sup> The key locus of development for new ideas is in policy communities and networks, with insurgent or consolidating groups (like the SNCH and the hospital directors' *corps*) as a key source of dynamism and change within networks. The key locus of selection of policy ideas is the political arena, for here a shifting cast of politicians and their assistant entrepreneurs and advisors scan for new ways of addressing intractable problems that fit with the politicians' own needs and orientations. Attractive solutions are those which seem to promise low transactions costs<sup>9</sup> by proposing as an agent institutions or groups whose interests are more congruent with legislators' interests than others; by allocating risks to social actors who can best insure against them; and by offering the prospect of a relatively long-lived and well-accepted solution, that will not simply be reversed in a few years' time by a new and different majority coalition of legislators or a differently-structured set of top policy elites. In this world, actors whose solutions seem to work (like the SNCH and the wider *corps*) can command a higher price for their involvement in coalitions or networks. And, governments who pick up on such solutions will achieve some of their objectives, stabilizing (if not actually solving) their problems in some dimensions.

## ENDNOTES TO CHAPTER EIGHT

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## RESEARCH METHODS APPENDIX

This study focuses upon the emergence of hospital directors as a new and influential actor in French health policy debates. The first half of the study provides a detailed analysis of the bottom-up changes inside the *corps* of hospital directors and its major trade union, the *Syndicat National des Cadres Hospitaliers* (SNCH). The second half of the study examines the process of hospital management reform in the 1980s, and the involvement of hospital directors in successive policy initiatives. It examines three case studies of hospital reform: the introduction of the global budget in 1983, the failed introduction of departments in the mid-1980s and the renovation of hospital planning in 1991. These case studies are both sufficiently similar and distinct to draw comparative lessons about the campaigns of hospital directors. They cover different functional tasks and patterns of policy-making as well as varying levels of success for hospital directors in advancing their demands for pecuniary gains and the long-term goal of professionalisation. In addition, the timescale of more than ten years allows full analysis of the complex dynamics of policy networks. Indeed, the sequencing of case studies facilitates the drawing of conclusions as to the patterns of change and the capacity for 'learning' by the actors involved.

The fieldwork for the research involved an initial period of almost twelve months research in France from October 1991 to September 1992. This first period of fieldwork involved study at both the *Université de Paris-I* within the health policy unit led by Michelle Fardeau and the *Centre de Gestion* at the *Ecole Polytechnic* supervised by Gérard de Pourville. Whilst at the *Université de Paris-I*, I attended the first semester of the course in public hospital management for students preparing the entrance examination for the hospital director training programme at the *Ecole Nationale de la Santé Publique*. Equally, I visited Monika Steffen and Bruno Jobert at the *Institut des Etudes Politiques de Grenoble*. This initial period of research was supplemented by essentially two further shorter visits to France in November 1992 and May 1993. These two later visits were dedicated to the completion of further rounds of interviews with elite policy actors.

The internal evolution and changing policy commitments of the SNCH were documented by a systematic and detailed survey of *Hospitalier-Actualités*, its monthly

information newsletter for the members of the SNCH, and its quarterly journal *L'Hospitalier*, which later became *Le nouvel hospitalier*. These publications are the voice of the SNCH leadership and grassroots members. They contain regular minutes of the meetings of its national executive and editorials from the leadership as well as policy declarations, conference proceedings and open forums for debate within the *corps*. I undertook the survey of these SNCH publications at its national office at *Hôtel-Dieu* in Paris with the assistance of the national delegate, Michel Pallot, and his administrative staff. Upon repeated visits to these offices, I gained full access to the archives of the hospital director trade union.

To support this archival research at the headquarters of the SNCH, I undertook further surveys of the medical press, the national press and official publications in order to plot the changing stances and reactions to government reforms of the multiple public hospital lobbies. The survey of the medical press focused primarily upon the leading daily newspaper for doctors, *Le Quotidien du Médecin*, and its archives in Paris which cover the full period of this study. Similarly, I surveyed leading national papers, in particular, *Le Monde*, using here at the press cuttings services at the *Institut des Etudes Politiques* in Paris. These two surveys were supplemented by a further survey at press cuttings library at the *Ecole Nationale de la Santé Publique* (ENSP) in Rennes and an examination of the *Revue Hospitalière de France* and the circulars of the *Fédération Hospitalière de France* at its head offices in Paris.

Finally, I completed my analysis of documentation and records with an examination of official publications and internal government reports. For the case study of the formulation of the 1991 Hospital Law, I was granted access by Mr. Gérard Vincent, the then Director of Hospitals, and his technical advisor, Mr. Jean-Luc Chassaniol, to the full library resources and official papers of the *Direction des Hôpitaux* (DH) throughout the formulation of the 1991 Hospital Law. I was thus able to analyse both the personal memos and internal notes of the DH and the whole of its communication with the ministerial cabinet of Claude Evin, the Minister of Solidarity, Health and Social Protection, fellow administrative divisions within central government, and its consultation with external groups. I also gained access to the minutes of all the interministerial negotiations surrounding the formulation of the 1991 Hospital Law.

Alongside this analysis of diverse sources of documentation, I also undertook during fieldwork in France an extensive series of in-depth interviews with central figures in the SNCH over the period of 1976 to 1991 and with politicians, elite bureaucrats and group leaderships involved in the decision-making processes of the three selected case studies. Overall, I undertook a total of 62 interviews over a period of approximately 18 months (see below). The interviews, apart from a few exceptions, were all taped and lasted on average between one and two hours, although the longest involved four hours of conversations with Pierre Rayroles, the hospital director and former technical advisor to Edmond Hervé, Junior Minister for Health from 1983 to 1986. Indeed, most interviews involved, in addition to the formal and taped discussions, a series of more informal conversations and time spent meeting with hospital staff and colleagues of the interviewee. The interviews took place across France and I visited hospitals as far north as Compiègne and as far south as Bordeaux. This geographical spread was necessary to gain an appreciation of the different working environments of hospital directors and because the management structures of the *Assistance Publique* in Paris is unrepresentative of other public hospitals in France. Thus I visited all categories of public hospitals, including, not only hospitals in the *Assistance Publique*, but also the *Hospices Civils de Lyon*, the regional hospital at Bordeaux and the general hospitals at Blois and Orléans.

I selected the interviews on the basis of three categories of actors, although, obviously, certain individuals such as Gérard Vincent, the 'leader' of the ENSP generation, president of the SNCH from 1982 to 1990 and then the Director of Hospitals fall into more than one category. The first category which I selected was that of elite decision-makers such as ministers, members of their *cabinets* and leading bureaucrats in ministerial services. This category also included the leading personalities of hospital doctor trade unions and public hospital lobbies such as the FHF and the consultative bodies for hospital doctors. These actors were identified by press reports, official publications and other interviewees who recognised the significance of certain actors. The second category was that of hospital directors who had been leading activists within the SNCH throughout the period under study, in particular, those directors involved in the factional politics of the 1970s and the 1980s. These directors were identified by a survey of the membership of the BN from 1976 to 1991 and by the conference proceedings and interventions

detailed in the SNCH journal, *L'Hospitalier*. The final category selected was that of a cross-section of hospital directors throughout the different classes of the *corps*. I identified the interviewees in this category through breakdowns of the graduations of hospital directors from the ENSP and the listings of directors in the *Bottin Administratif*. It included not only head directors, but a cross-section of assistant directors in Paris and as far afield as Grenoble and Saint-Etienne.

### LIST OF INTERVIEWS

I provide below a list of the interviews undertaken. This list provides the full name of the individuals involved, the date on which the interview took place and the significant responsibilities exercised by these individuals during the period covered by this study.

In alphabetical order with relevant responsibilities when interviewed.

1. Christian Anastasy, Hospital Director and former Technical Advisor to François Delafosse at the *Direction des Hôpitaux*, 03 February 1992.
2. Georges Andreu, Head of Blood Transfusion Service at Hôtel-Dieu (Assistance Publique), 04 December 1991.
3. Patrice Barberousse, Hospital Director and Technical Advisor to Gérard Vincent, Director of Hospitals at the *Direction des Hôpitaux*, 13 May 1993.
4. Guy Berger, Director of the *Cabinet* of Michèle Barzach, Junior Minister for Health, 04 February 1992.
5. Marc Buisson, Head Director at the Specialised Hospital of Poissy, 23 March 1992.
6. Marie-Christine Burmier, Director of Financial Services at the General Hospital of Versailles, 25 March 1992.
7. Philippe Cadène, General Delegate of the *Fédération Hospitalière de France*, 11 May 1993.
8. Michel Calmon, Assistant to the General Delegate, Philippe Cadène, at the *Fédération Hospitalière de France*, 22 April 1992.
9. Maurice Campillo, Assistant to the General Delegate, Philippe Cadène, at the *Fédération Hospitalière de France*, 28 April 1992.

10. Robert Cappe, Head Director at the General Hospital of St. Germain-en-Laye, 04 March 1992.
11. Bernard Campens, Head Director of the General Hospital of Corbeil, 19 February 1992.
12. Marie-Thérèse Chaplain, Technical Advisor at the *Direction Générale de la Santé*, 09 December 1991.
13. Jean-Luc Chassaniol, Hospital Director, Technical Advisor to Gérard Vincent, Director of Hospitals at the *Direction des Hôpitaux*, 16 December 1991 and 27 November 1992.
14. Gilbert Chodorge, Hospital Director at the General Hospital of Orsay and Technical Advisor to Claude Evin, Minister of Solidarity, Health and Social Protection, 19 June 1992.
15. Jean Choussat, Director of Hospitals, General Director of *Assistance Publique de Paris* and Director of the Budget, 24 January 1991.
16. Dominique Coudreau, Director of the CNAMTS, 26 November 1992 and 14 May 1993.
17. Edouard Couty, Head Director, Technical Advisor to Claude Evin, Minister of Solidarity, Health and Social Protection, and Leader of the Couty Commission, 24 November 1992.
18. Jacques Coz, Head Director, leader of *Grenoble 80*, member of the National Executive of the SNCH and president of the SNCH, 11 May 1993.
19. Marie-Madeleine Dautel, Technical Advisor at the *Direction des Hôpitaux*, 24 January 1992.
20. Jean de Kervasdoué, Director of Hospitals, 18 February 1992.
21. Prof. Bernard Debré, founder of *Solidarité Médicale*, 20 July 1992.
22. François Delafosse, Director of Hospitals, 04 February and 02 March 1992.
23. Philippe Domy, Head Director at the General Hospital of Compiègne and Member of the *conférence des directeurs des CHG*, 03 July 1992.
24. Claude Ducreux, Hospital Doctor and Leader of the *Coordination Syndicale des Médecins, Biologistes et Pharmaciens des Hôpitaux Publics*, 05 May 1992.
25. Jean Farge, Minister of Social Security, 15 May 1993.

26. Madame Gay, Assistant Hospital Director at the St. Cyr General Hospital at Villeneuve-sur-Lot, 26 June 1992.
27. Loïc Geffroy, Hospital Director and Advisor to the President of the CNAMTS, 18 May 1993.
28. Marie-Françoise Gonner, Assistant Hospital Director at the Regional Hospital of Grenoble, 21 February 1992.
29. Jean-Pierre Gusching, Head Director at the General Hospital of Blois and National Delegate for Hospital Directors in the SNCH, 16 March 1992.
30. Alain Halbout, Head Director at the Regional Hospital of Rouen and President of SNCH, 17 March 1992.
31. Charles Henri-Filipi, Director of the Cabinet of Georgina Dufoix, Minister of Social Affairs, 07 July 1992.
32. Edmond Hervé, Junior Minister for Health, 24 February 1992.
33. Prof. Jean-François Lacronique, Assistant Director to Jean Choussat at Direction Générale de la Santé et des Hôpitaux, 10 February 1992.
34. Jacques Latrille, Director of the Cabinet of Jack Ralite, Minister of Health, 23 June 1992.
35. Joseph Le Behec, Head Director at the General Hospital of Créteil, 28 February 1992.
36. Robert Le Berre, Assistant General Director at the Regional Hospital of Saint-Etienne, 13 March 1992.
37. Pierre Le Mauff, Head Director at the Regional Hospital of Bordeaux, 23 June 1992.
38. Patrice Legrand, Technical Advisor at CNAMTS under Dominique Coudreau, 17 May 1993.
39. Alain Lepère, Head Director at Cochin Hospital in Paris and President of the *Syndicat National des Cadres Hospitaliers-Force Ouvrière* (FO), 16 June 1992.
40. Jean Marmot, Head of the *Direction de la Sécurité Sociale*, 14 February 1992.
41. Jean-Charles Naouri, Director of the Cabinet of Pierre Bérégovoy, Minister of Social Affairs, 12 May 1993.
42. Roland Ollivier, Head Director, member of *Grenoble 80* and member of the National Executive of the SNCH, 30 June 1992.

43. Louis Omnès, Head Director at the Laënnec Hospital in Paris, 26 February 1992.
44. Dominique Paillé, National Delegate of the SNCH and General Secretary of *Union du Centre* (UDC), 18 March 1992.
45. Christian Paire, Head Director and member of the National Executive of the SNCH, 06 July 1992.
46. Thérèse Pierre, Hospital Director at the Sainte-Anne Hospital in Paris, 02 July 1992.
47. Claude Pigement, member of *Santé et Socialisme* and Health Policy Delegate for the *Parti Socialiste*, 26 November 1992.
48. Prof. Francis Peigné, leader of *Intersyndicale Nationale des Médecins Hospitaliers* (INMH) and member of Couty Commission, 23 November, 1992.
49. Prof. Denys Pellerin, Vice-President of the *Conférence nationale des Présidents des CMEs des CHUs* and Technical Advisor to Michèle Barzach, Junior Minister for Health, 25 November 1992.
50. Pierre Rayroles, Head Director and Technical Advisor to Edmond Hervé, Junior Minister of Health, 27 February 1992.
51. Gaston Rimareix, Director of Cabinet to Edmond Hervé, Junior Minister of Health, 06 February 1992.
52. Prof. Jean-Yves Rochet, Head Doctor at *Hospices Civiles de Lyon* and President of the *Conférence nationale des Présidents des CMEs des CHU*, 23 April 1992.
53. Louis Rolland, Head Director and member of the National Executive of the SNCH, 01 July 1992.
54. Gérard Sacco, Head of Hospital Director Training Programme at the ENSP, 06 March 1992.
55. Didier Tabuteau, Director of the Cabinet of Claude Evin, Minister of Solidarity, Health and Social Protection, 25 November 1992.
56. Prof. Georges Tchobroutsky, Head Doctor at Hôtel-Dieu Hospital (Assistance Publique), 02 December 1991.
57. Jean Terquem, Advisor to François Mitterrand and Specialist Advisor on departmentalisation to Georgina Dufoix, Minister of Social Affairs, 25 June 1992.
58. Christine Thayer, Technical Advisor at the *Direction des Hôpitaux*, 17 May 1993.

59. Michel Tirel, Assistant General Director at Regional Hospital of Rennes, 06 March 1992.

60. Maurice Toullalan, Head Director at the General Hospital of Argenteuil, 03 March 1992.

61. Gérard Vincent, Head Director, President of the SNCH and Director of Hospitals, 17 May 1993.

62. Etienne Weill, Hospital Doctor and Leading Activist in the *Syndicat National des Médecins Practiciens Hospitaliers* (SNMPH).



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