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Abstract

This article asks whether the public administration of health in France fits the general description of French state institutions as autonomous, powerful bureaucracies. Existing sources on the French Ministry of Health indicate that three types of processes have shaped its institutional structure, its official mandate and its actual policy influence since its inception in the 1920s. Faced with the rise of private-practice medicine, the Ministry first emerged as a resource-poor institution, and still remains an endemically weak ministerial portfolio by virtue of institutional path dependence. Since the 1980s, it has then aligned itself on cognitive influences from other ministries, and has been especially sensitive to the pressure exerted by spending ministries to control health expenditure. Finally, in the light of recent health scandals, the creation of several health agencies have contested its effective mandate over public health issues. As a result, the current Ministry struggles to redefine its role in the competitive landscape of French health policy formulation.

(156 words)

Keywords

Ministerial power; Ministry of Health; France; Public health policy.

Introduction

The current academic literature on health policy and politics quasi-systematically lists ministerial health departments¹ in its catalogue of important actors to be taken into account as soon as one becomes involved in the analysis of a particular health or public health policy (see, e.g. Baggott 2007); yet the state of the art does not provide any theory, or method, to measure more precisely the precise role and influence of health ministries within the policy process (Greer, this issue). When qualitative insights exist on given department, they rarely engage into a systematic comparison with other ministerial structures, even though this issue of *Social Policy & Administration* and some recent descriptive reports are now contributing to closing that knowledge gap (Ettelt *et al.* 2007, 2008). The literature also seems to fall short of any quantitative analysis of ministerial health structures, despite the potentialities of established frameworks in the study of bureaucracies (among which bureau-shaping comes first to mind) or of other options such as structural equation modelling, which is currently being applied in comparative political economy² and in other branches of comparative politics.

The dearth of comparative – or comparatively inclined – research on health departments is also observable in the French case, at the remarkable exception of the recent work by Hassenteufel and colleagues on the interventions of “programmatic elites” in health policy in a sample of four West European

¹ The terms ‘ministry’ and ‘department’ are used interchangeably.

² See Hall and Gingerich (2009) for an example of how structural equation modelling can support systematic comparison over small-N sets of national cases.

countries (Hassenteuful *et al.* 2008). In the present article, then, my objective will be to review the literature on the French Ministry of Health, as well as to suggest a possible framework of analysis to gauge its potential influence over health policy formulation. In order to engage with that research question, preliminary insights will be drawn from historical sources on the Ministry of Health, written both by senior civil servants and by academics who have looked into the history of the department over the past thirty years. This body of literature is relatively small, especially if compared to the large amount of historical work that has been produced on other French ministerial administrations.³ It is sufficiently detailed, however, to be reformulated into a concise narrative, from which I will derive some background assumptions that can then be submitted to closer scrutiny through detailed empirical studies of specific French health policies.

The analysis presented in this paper proceeds as follows. The next section sketches a theory of ministerial influence rooted in Joseph White's distinction between technical, institutional and political capacity, which are then linked to the formal attributions and internal morphology of a given department. The rest of the paper applies that framework to the most salient developments experienced by the French Ministry of Health (*Ministère de la Santé*) since its creation in 1920, in order to establish the symbolic rank of the Ministry in the

³ Unlike other departments, the French Ministry of Health does not feature a ministerial committee to work specifically on its history; instead, it currently hosts the *Comité d'histoire de la sécurité sociale*, which is concerned with all aspects of social security policy and has yet to produce an official history of the Ministry.

larger institutional edifice that governs over French health and social policy development. The findings of that analysis suggest that, according to its varying portfolios and chaotic history, the French Ministry of Health has suffered for several decades from poor resources and a weak and unstable architecture; more recent evolutions, however, might have produced a path-breaking change in the capacity of the Ministry to weigh in significantly on several aspects of health policy formulation, even though these changes are still limited and remain subject to further evaluation. In contrast to the generic description of French central state institutions as autonomous, powerful bureaucracies, the public administration of health in France is still hesitant and comparatively less in control of its policy sector than other health departments.

This approach has obvious limitations that should call for more extensive research. The administrative history of the Ministry itself is covered only in large strokes, and is restricted to the attributes that allow to situate the department in the wider architecture of the French welfare state; several aspects of administrative growth or restructuration, such as detailed budgets and staffing, would require a sharper and more systematic examination of ministerial documentation, as well as substantial archival research across several ministerial departments. With respect to the preliminary nature of the argument exposed in this paper, its data rest principally within the secondary sources reported in its bibliography, although several interviews conducted among

senior civil servants and health policy stakeholders for two other research projects have contributed to triangulate different aspects of my narrative.⁴

A tentative framework of ministerial influence

The analytical framework offered below ties three different elements of ministerial influence together. It starts by delineating the double challenge of ministerial authority and autonomy within the complex architecture of the French welfare state. It then defines three forms of ministerial capacity through which the French Ministry of Health can exert some influence over policy formulation. Finally, it suggests using the formal attributions of the Ministry as a possible proxy for the measurement of technical and institutional capacity within the French Ministry of Health.

Ministerial authority and autonomy in the French welfare state

While a functionalist approach to health care and public health would link the formulation of health policy primarily to the closest executive structure resembling a health department, the governance of health care states effectively spans over a number of ministerial mandates, which are involved in the funding and/or the delivery of health policies. Furthermore, modern health systems are not solely governed through ministerial nexuses but also involve the settlement of complex, unstable arrangements with non-state actors such as health professionals and the biomedical industrial complex, as well as the creation of

⁴ Some of the interview data appear in previous research by the author on health inequalities, and in an ongoing research on national cancer control programmes. Both projects are based upon a comparative analysis of England and France.

regulatory agencies that are required to make independent decisions while operating only at “arm’s length” from governments. As a consequence, health ministries face the common challenge of simultaneously preserving their authority within the general pattern of health governance and securing their autonomy within the overall architecture of government (Greer, this issue).

Both aspects of that challenge might reveal particularly arduous in the French health care state. Health coverage in France relies on a system of statutory insurance that is still strongly reminiscent of the Bismarckian model of welfare, in which expenses rely primarily on reimbursements from health insurance funds that are themselves funded through payroll contributions, as opposed to public taxation in national health systems (Saltman *et al.* 2004). If France has become a somewhat paradoxical Bismarckian system, due to its increasing centralization and reliance on public funding as well as patient co-payments, it remains a health system in which negotiations between health insurance funds, representatives of the medical profession and the state are perceived as crucial to the efficient regulation of health care. Throughout its history, the divisions among doctors’ trade unions (Hassenteufel 1997) and the ambiguous involvement of social partners in the control of sickness funds (Palier 2005: 254-72) have had serious consequences on the cost containment strategies and overall governability of the French health system, leading to stronger state control over health care and public health in the past fifteen years (Hassenteufel and Palier 2007). Yet, for a large fraction of its history, the French health system has been riddled with policy deadlocks and undefeatable veto points that have severely limited the success of state actors in effectively regulating its costs and

evolution.

The overall architecture of executive governments in France also reveals a complex pattern of ministries and ministerial portfolios, with wide variation in the number of departments and frequent changes in their internal geography. The distant vision of the French 'State' as a unified, homogenous machine of government immediately breaks down at a lower distance of scrutiny into a constellation of national administrations that combine internal rivalries with large restructuring efforts currently advocated under the neo-managerialist leitmotiv of "*la réforme de l'État*" (Bezes 2009), with several ministerial departments suffering significant reorganisation, and occasionally suppression. This constant process of departmental reshuffling has led the total number of ministers, junior ministers and ministries to vary remarkably under the Fifth Republic. Further ministerial restructuring, inspired by the desire to signal increased state involvement in a particular matter or by the personal will of prominent ministers eager to signal their influence (Offerlé, 2004: 47), has accentuated the 'variable-sweep' shape of the French state executive wing. Even the powerful Ministry of Finance, which remains an essential stakeholder in most governmental decisions and in virtually all social policy issues, has undergone important alterations in the past decades that have altered the respective influence of its internal bureaus (Siné 2006).

With respect to health policy, the acquisition and preservation of ministerial authority and autonomy in France is thus bound to occur in that dynamic, multi-polar environment of governing institutions that can exercise significant veto power over rulemaking. Measuring the influence of a particular ministerial

structure over policy-making in that environment first requires, then, a stable definition of ministerial leadership (or *capacity*), which are offered here with reference to the recent work of Joseph White (2003, 2009) on the governance of health systems and health care.

Ministerial capacity

Assuming that successful leadership stems out of a combination of knowledge, power and will, the capacity of a health department to effectively secure some influence in the policy process can be broken down into three different forms of policy capacities, for which White's definitions of *technical*, *institutional* and *political* capacity have been altered to apply specifically to the generic case of health ministries.⁵

Technical capacity designates the ability of a given health department to identify present and future issues within its ministerial competency, to frame them as – at least partially – solvable policy problems, and to produce recommendations on how to reduce their negative impact on the state of affairs. Technical capacity stands, in short, for the proficiency of a ministerial structure at formulating multiple instances of policy diagnosis within the domain of health care and public health—the “knowledge of how to do something” (White 2009: 371). In the post-war period, the ability to determine health care costs and to advance prescriptive measures that are perceived as efficient measures of cost

⁵ The normative overtone of White's argument concerning the leadership of federal government over health care in the United States (White 2003) has also been stripped off the definitions offered here.

containment should feature prominently in the constitutive elements of technical capacity, which suggests a strong association between the development of technical capacity and the appropriation of health economics within ministerial expertise (Benamouzig 2005).

Institutional capacity underlines the ability of a given health department to support its diagnoses and prescriptions with the appropriate instruments and resources to achieve its policy goals (White 2003: 222). Of the different subcomponents listed by White, several are directly relevant to the case of health ministries, such as the ability of the ministry to secure funding for its initiatives – i.e. to be part of the health care ‘expenditure community.’⁶ Identically, the limits imposed to institutional capacity by procedural restrictions and organizational distance also apply here to some respect. At a lower level of abstraction, however, institutional capacity also defines the ability of a given ministry, in an administrative environment that is frequently subject to change, to protect the existence, mandate, budget and staffing of its existing bureaus, and to expand them when deemed necessary, hence spanning over theories of bureau maximisation and bureau-shaping. The emergence of independent or state agencies has also affected health policy in many countries over the past decades; even if their effects on ministerial capacity can be ambiguous due to the complex politics of state delegation (Thatcher 2003), the central, top-down nature of such agencies symbolises an indirect extension of ministerial territory and, *prima facie*, an enhancement of both technical and institutional capacity.

⁶ The expression is taken from Hecló and Wildavsky (1974).

Last, White defines *political capacity* as the will to overcome veto points and to successfully coerce others into following a particular decision (White 2009: 372). In the applied context of a particular ministry, political capacity will depend on the minister's personal authority, visibility and popularity within and without government, and on his or her personal involvement in forcing the acceptance of ministerial advice and decisions in the policy community affected by them.

That last dimension of ministerial capacity probably escapes in great part any attempt at formal measurement, except if reduced to criteria such as the lifespan of the minister's mandate. Technical and institutional capacity, however, are more readily amenable to examination through the proxies offered by the ministerial *morphology* of a given health department.

Ministerial morphology

Ministerial influence is generally measured through the distribution of material and symbolic resources that occurs inside a particular department (Greer, this issue). Within the literature concerned with ministerial influence, budgets, the critical mass and composition of civil servants, as well as devolved services and connexions with particular social groups are the most common resource-driven proxies of a potential influence in the policy process; all which are generally considered to be effective means of measurement when applied to the French state (Offerlé 2004: 47-8).

The measurement of ministerial influence cannot, however, bypass a preliminary examination of ministerial portfolios (Rose 1987). Previous research in that area shows that the precise boundaries of ministerial departments rest in the hands

of a very restricted number of political decision-makers (Pollitt 1984). This observation implies that the exact delimitation of departmental attributions is perceived both as a highly sensitive area of executive decision-making and as an important condition of success in the attainment of policy goals, especially since ministerial portfolios affect the amount of inter-ministerial coordination – another factor identified as conducive to successful policy innovation (Hall 1983) – that policy-making will require. Correlatively, the creation and destruction of bureaus within a ministry, as well as “the extent to which non-departmental bodies... are utilized to implement public policy,” are also expected to change the expected influence of a department over the policy process (Peters 1985: 111).

The very wide variations in portfolios and bureaus within the French Ministry of Health over its existence largely confirm that the starting point for the analysis of ministerial capacity should reside in the most essential components of its ministerial morphology, that is, in its formal attributions. The following section hence offers to treat the formal contents of ministerial portfolios as an independent variable with (some) explanatory power over the relative influence of the Ministry in the formulation of health policy, since its chaotic emergence in 1920.

Health within the French Ministerial Portfolios

A genetically weak architecture

Prior to the interwar period, public health did correspond to a single ministerial

portfolio in the organisation of the French state. Instead, “public hygiene” involved no less than eight departments in charge of various public health issues within their overall portfolios, spreading over home affairs (Interior), agriculture and trade, education, as well as defence and admiralty (Colomb-Londeix 1981). Following a law passed in February 1902, public health *per se* rested in the hands of bureaucrats assisted by a handful of physicians at the level of municipal authorities. Although mayors had been largely unsuccessful in their limited efforts to impose public health regulations among their electorate (Murard and Zylberman 1996a), this status quo – a ‘territorial’ model of public health grounded at the level of local authorities, and administered at the central level by one directorate at the Ministry of Interior – still had many supporters in the early 1920s (Renard 2000: 188). Its lack of efficiency was only matched by the lack of support for public health among private-practice physicians, who effectively advocated individualised care at the detriment of collective sanitary measures. As a consequence, in the early twentieth century, ‘France [was] the only large industrialised country where hygiene is governed by [non-physicians] and where state administrators have no link with the medical profession’ (Murard and Zylberman 1996b: 15).

Immediately after the First World War, however, massive epidemics of typhus and influenza acted as a focusing event⁷ among the ruling elites and opened a window of opportunity for the creation of such a Ministry, an idea that had been floating in the primeval soup of policy suggestions since 1902 (Bargeton and Ziegler 1971: 26) but had never found enough supporters among French

⁷ As defined by Birkland (1998).

statesmen in the past (Renard 2000). The sense of urgency associated with high casualties from both fighting and disease, as well as the obvious lack of coordination between state services, did not convey, however, to the creation of a strong, single entity with vertical power over disease control. A resource-poor institution since its addition to the state machinery, the capacity of the Ministry will remain endemically weak throughout the French Third Republic.

Two difficulties account for the weak nature of the Ministry in that period. A first obstacle came from critical deficiencies in its institutional capacity. In 1920, the department was meant to emerge through a complex operation of ‘organ transplant’ that aimed at transferring bureaus from several long-established departments into a new ministerial structure (Ziegler 1980: 17). Unsurprisingly enough, this move was met with considerable resistance within other state services, and was criticized as having effectively failed by several parliamentary reports after the creation of the Ministry by the French executive. From its inception to the outbreak of the Second World War, the Ministry struggled to regroup more than a couple of directorates (Friot 1993) and did not manage to secure substantial budgetary or staff resources.⁸ On top of that, the creation of the Ministry was not matched with a specific devolved administration, as public health doctors remained under the control of local authorities. In its first fifteen years of existence, critics from within the French Parliament and beyond were therefore right to view the Ministry as little more than a “paper organization,”

⁸ After ten years of existence, only 10 additional employees had been added to the initial staff of 137 in 1920. The Ministry had only 232 employees when the Second World War broke out (Murard and Zylberman 1996b: 14-5; see also Colomb-Londeix 1981).

governing over public health with almost no administrative thrust to pursue its missions (Renard 2000: 184-5; Murard and Zylberman 2003: 21).

A second difficulty at the central level resided in the large mandate carried by the Ministry, which was made responsible for public health but also, as was the case in Britain (Ziegler 1980: 15), for poverty alleviation and early forms of welfare assistance. Its creation therefore not only drew on missions and resources that had previously belonged to the Ministry of Work (Bargeton and Ziegler 1971; Renard 2000), but also lacked any technical focus, embracing instead a larger mandate that combined health and social services into a vague and, later on, hardly defensible area of competency. As a result, the newly formed *Ministère de l'Hygiène sociale, de l'assistance publique et de la prévoyance* was further attacked in Parliament for being a weakly defined hybrid entity, which unconvincingly combined a small number of bureaus reluctantly extracted from other departments into a weakly staffed ministry responsible for a wide range of policies. In that context, and in spite of the strong rationale for state public health intervention that persisted in the interwar period and led to effective advances in budgets and infrastructures, the Ministry failed to appeal to skilled and high-profile civil servants (Murard and Zylberman 1996b: 102; Murard and Zylberman 2003), with high levels of personnel turnover both in terms of ministerial appointments and of leading civil service offices (Renard 2000: 206). In the absence of either symbolic or material means to conjure an authoritative claim of legitimacy in public health issues, it remained a genetically weak source of technical capacity in that policy area.

Finally, the political capacity of the Ministry was residual since its

creation. Contrarily to the British Ministry of Health created by Lloyd George in 1919, the one officialised in France by Alexandre Millerand was met by a defiant parliamentary majority and by a highly sceptical public opinion that had already expressed its dissent with previous forms of state-led *hygiénisme* (Murard and Zylberman 1996a). The legal creation of the Ministry itself was characterized by a certain degree of improvisation, with the appointment of Jules-Louis Breton as its first minister occurring one week before the effective creation of the Ministry itself, through a decree of 27 January 1920 (Renard 2000: 181). Strong criticism in both houses of Parliament and in civil society at large were not systematically met with strong standpoints from within the Ministry or from the executive during its two first decades of existence. Instead, the symbolic rank of the Ministry in the governance of public health was rendered even more marginal by the strong presence of private actors assuming effective leadership over policy formulation and development in that area: in the late 1930s, the extensive network of consultative bodies built around the Ministry, with over 1200 members working in 28 commissions, failed to advantage public health over private health care and were unable to compete with the policies advocated by private actors, such as the Rockefeller Foundation, in organisations external to the central state (Murard and Zylberman 1996b: 17-8, 109-20).

The combination of these limitations to technical, institutional and political capacity contributed to making the French Ministry of Health a weak, dominated departmental structure both within the French executive and within the field of public health in general. Its weakness was characteristic enough for the Ministry to completely vanish from ministerial portfolios in 1924, at a time when the

French government was pressured to make state intervention look more parsimonious, at least on paper (Renard 2000: 201). While public health was not suppressed from governmental missions, but simply integrated within the larger edifice of the Ministry of Work, the symbolic value of having a specific Ministry of Health was low enough in 1924 to rule it out of ministerial mappings without suffering from any substantial political backlash; symmetrically, the re-emergence of the Ministry in 1930 occurred mostly for symbolic reasons, without any significant positive effect on the resources or power of the Ministry overall.

In the late 1920s and early 1930s, as strong organized interests were emerging in private health care and through the expansion of Bismarckian social insurances to sickness,⁹ even the supporters of an autonomous ministerial structure to govern over public health in France were arguing for its limited authority over the growing, autonomous power of the medical profession (Renard 2000: 188). During its first period of existence, then, not only had the Ministry failed to establish a passable level of autonomy in the general architecture of government; it had also failed to acquire the resources and mandate that would have borne its authority among devolved and professional interests in its policy community. By the early 1930s, the window of opportunity opened after the Great War had closed without consecrating the creation of an influential ministry in the health care and public health arenas. Instead, as the more general objective of *protection sociale* (welfare) gained in importance as a

⁹ See Hassenteufel (1997: 97-101) on the advent of *médecine libérale* and Renard (1995: 38-45) on the institutionalization of *assurances sociales* during that period.

core mission of the French state, the Ministry of Work rapidly became the locus of state involvement in the government of social insurances (Renard 2000: 304), relegating the Ministry of Health to a lower, dominated status in the French state apparatus. This trend was still observable after the Second World War, by virtue of institutional path dependence that perpetuated the endemically weak nature of the health ministerial portfolio.

Path dependency after the Second World War

In the immediate aftermath of the Second World War, the reorganisation in the balance of power between state and society over social security issues through the advent of *Sécurité sociale* did not significantly correct the genetic weakness of the French Ministry of Health. While its existence was not radically put into question, its mandate did not expand to the regulation of health care beyond public health. Instead, the Bismarckian, statutory nature of the French welfare state confirmed the Ministry of Work as the mere ‘centre of gravity’ for corporatist bargaining over social benefits between the state, medical trade unions and sickness funds—a pattern in which the role of the Ministry of Health was clearly ‘subaltern’ (Renard 2000: 204), as the pricing and funding of health care rested in the hands of non-state actor coalitions. Contrarily to countries where public authorities became the main budgetary provider for health care through national health services, the French state was not endorsed with that mandate (Palier 2005, ch. 1), and its political capacity was characterised less by government than by arbitration between the powerful interests of the health care arena. Subsequently, ministerial understaffing persisted and direct

ministerial expenditure remained low and marginally important in the state budget: between 1926 and 1966, health weighted between 1 per cent and 3 per cent of overall state spending.¹⁰

The weak political capacity of the Ministry also stemmed from the allocation of ministerial portfolios in the post-war period. With the birth of *Sécurité sociale*, a choice in governmental architecture had to be made between entrusting the Ministry of Work or the Ministry of Health with the regulation of social insurances, insofar as social insurances were statutory rights and yet aimed at covering the whole French population. This choice was made in 1944, when the first provisional government created a Ministry of Work and Social Security and a separate Ministry of Public Hygiene, leading to the handling of social welfare policy by the department that represented the traditional bargains between the state and the working class instead of public hygiene (Marrot 1995: 17). Several attempts were made to merge both departments into a single one, as had been the case during the suppression of the Ministry of Health, from 1924 to 1930. Three attempts to create a single Ministry of Social Affairs occurred until the late 1960s, lasting from one month in 1947 to three years from 1966 to 1969 (Bargeton and Ziegler 1971: 82-86).¹¹ Until the end of the 1960s, and outside of these short periods where the whole spectrum of social policy lied with a single department, the reshuffling of ministerial mandates was more favourable to the

¹⁰ Figures appear in Murard and Zylberman (1996b: 26) and in the *Tableaux statistiques Santé et Sécurité Sociale* published by La Documentation Française.

¹¹ Further attempts to create large “social ministries” were undertaken in the 1970s, 1980s and 1990s.

handling of social security negotiations by the Ministry of Work rather than by the Ministry of Health, making the latter a weak player in the crucial bargaining processes that accounted for the provision of health coverage and health care in the population (Friot 1993: 146, 155).

Whereas the importance of the Ministry in health policy formulation was limited with respect to the government of social health insurance, its expertise in health affairs nevertheless grew significantly. Its pre-war network of consultative commissions had effectively prefigured this trend of increasing state knowledge in population trends of morbidity and mortality, which led to the creation of the *Institut National d'Hygiène* (INH) in 1941, which became the *Institut National de la Santé et de la Recherche Médicale* (INSERM) in 1964; this increase in technical capacity did not, however, translate into an increase in institutional capacity: as Berlivet (2008: 472-473) has remarked, 'the chronic difficulties experienced by the Ministry of Health in terms of staffing, funding, and finally legitimacy made French government officials dependent on the INH's (and later INSERM's) expertise,' which gradually shifted from the investigation of public hygiene to the support of biomedical research.¹² Instead of developing an important technical capacity over population health, then, and in coherence to hierarchies in the medical field that privilege specialised clinicians over public health practitioners, the effective locus of ministerial expertise in health care has concentrated on the

¹² The reorientation of INSERM towards clinical research has not only deprived the Ministry of Health of an authoritative source of expertise on various aspects of public health, it also meant that research initiatives to understand populational health matters were sparse and sometimes even met with adversity (Abenhaïm 2003: 85).

regulation of hospital care, which forms the backbone of the French *appareil sanitaire* (Friot 1993: 155).

As a consequence of both its lack of control over *Sécurité sociale* and its specialization in hospital regulation, the French Ministry of Health developed as a technical rather than a political actor (Bargeton and Ziegler 1981), and did not act as a prime mover or veto point over important aspects of health policy formulation in the post-war decades. The distribution of ministerial portfolios and pattern of ministerial bureaus in the period from the mid-1940s to the late 1960s indeed indicate that the Ministry remained a weak influence over the *government* of the health care state, even though it had broken its initial path of quasi-complete powerlessness within the state machinery. Some of the stigma associated to low political capacity has remained over time: the Ministry of Health has always enjoyed a low symbolic rank among ministries throughout the Fifth Republic, sometimes to the point of being denied formal ministerial status (Greer and Briatte 2009: 102-3), its budget was still low in the mid-1990s (Marrot 1995: 13), and accusations of understaffing were pervasive in the anecdotal evidence provided by high civil servants until a very recent period.

The late strengthening of health care and public health regulation

Important changes have strengthened the political capacity of the Ministry of Health in the recent decades. Early changes in the configuration of the Ministry can be traced to the 1970s, subsequently to increases in the staffing of social

affairs ministries.¹³ In that period, the administration of the French *Sécurité sociale* became a political priority due to its persistent and increasing deficits (Palier 2005, ch. 4), and also started to become professionally more attractive to high civil servants. Prior to that, 'the social policy sector was further representative of 'spending ministries' in that it was seen by civil servants themselves as an ordinary sector, not one of the 'elite' specializations that promised brilliant careers... specialization in the social welfare sector was long considered a professional dead end' (Genieys and Smyrl 2008: 78). Finally, an important change of ministerial portfolios occurred after 1970, when *Sécurité sociale* became a joint responsibility of the Ministry of Work and the Ministry of Health (Friot 1993: 153). Regarding the latter, the most remarkable evolutions in terms of ministerial capacity over health policy formulation are observable in the 1990s, through the strengthening of both health care and public health regulation within the Ministry and its agencies.

The fiscal strain that affected mature welfare states from the mid-1970s was just as salient in health care as it was in other branches of social security, and in parallel to the development of an expert knowledge of cost containment through health economics (Serré 2002; Benamouzig 2005), ministerial 'welfare elites' within the Ministry also started to incorporate the cognitive principles of dealing with permanent austerity in health affairs, aligning themselves with the policy paradigm advocated by 'expenditure elites' at the Ministry of Finance (Genieys

¹³ See Bargeton and Ziegler (1981) and Charbonneau (1977), both cited by Friot (1993: 150).

That trend was short-lived, though, due to drastic cuts in ministerial personnel following public sector reforms in the 1980s (Marrot 1995: 107; Tabuteau 2003; Bezes 2009).

2005). Intergenerational ties and professional longevity in health affairs among the senior civil service, along with the creation of statistics and research bureaus (Marrot 1995: 47-8), enabled the development of a technical capacity on cost containment in health care within the Ministry, as its bureaucratic elites 'gradually rallied around the notion that it was imperative for any new social welfare policy to be constructed so as to preserve a central role for the state, even while also taking into account the new financial constraints' (Genieys and Smyrl 2008: 81). The presence among these elites of a shared belief in favour of controlling health expenditure led the Ministry to craft its own rationale and expertise for programming health care reform, hence allowing its *Direction de la Sécurité Sociale* to compete with other departmental influences (most prominently of which the *Direction du Budget* at the Ministry of Finance) on that issue, rendering it into a possibly determinant source of influence over policy formulation in the recent period (Hassenteufel 1999; Genieys and Smyrl 2008). The most recent configuration of ministerial power shows, however, that the Ministry has not acquired a definite leadership over the fiscal regulation of health care, and that other actors within the core executive are still leading the most substantial aspects of health system reform in France (Hassenteufel 2009: 375).

In the very recent years, this increase in technical capacity over health reform has been supported by substantial organisational changes to the institutional landscape of social health insurance, with the creation in 2004 of a national union of sickness funds (UNCAM) that discards the traditional bargaining model of *Sécurité sociale* between social partners to the profit of tighter regulation by

state elites (Ettelt *et al.* 2007; Barbier and Théret 2009: 78 *et passim*). This ‘state agency’ model (Hassenteufel and Palier 2007: 592), which also led to the creation of a top-level agency with competence over cost containment issues,¹⁴ has been pervasive in French health policy in the recent years, and has led to higher state involvement in all aspects of health affairs, especially since a 2004 reform that has led to two important pieces of legislation on health care and public health (Tabuteau 2006, 2009).

Changes in the institutional capacity of the state have not been limited to health care, as public health agencies have proliferated at a remarkable pace since the creation of a High Committee of Public Health in 1991 and a national public health network in 1992 (later superseded by the National Institute of Health Surveillance [INVS] in 1998; see Buton 2006). During that period, the role of public health policy fiascos, most prominently of which the spectacular failure of health safety in the French blood transfusion system (Steffen 1999), has had a determinant role in creating the sense of alertness and urgency that has presided over the creation of several administrative bodies to monitor and regulate particular aspects of public health policy.¹⁵ Retrospective accounts from academics and higher civil servants both frequently underline the structural

¹⁴ ANAES (National Agency for Accreditation and Evaluation in Health), which became part of HAS (High Authority on Health) in 2004. Comparable agencies have been created in all health systems where managerialist reforms have been successfully passed in health care, a move consistent with European-level policy developments. France also seems to have been influenced by the example set by US federal agencies (Tabuteau 2003: 39).

¹⁵ Examples include food safety, blood transfusion, pharmaceuticals and medical goods, and health promotion; see Besançon and Benamouzig (2005).

deficiencies of the French public health regime in that period, in the joint context of the AIDS epidemic the blood contamination scandal,¹⁶ and which were recently rediscovered following the 2003 heat wave (Abenhaim 2003).

The effect of agencies on ministerial power is open to question, insofar as agencies can either weaken or strengthen the positions of state bureaucracies in policy-making. In that respect, health agencies in France might have contributed to the fragmentation of the public health policy community (Tabuteau 2003) and/or to the weakening of the position of central bureaucracies in the regulatory state (Kervasdoué 1999: 85).¹⁷ On the other hand, independent or arm's length bodies have another effect on both decision-making and policy implementation: their central, top-down nature symbolize an indirect extension of ministerial territory, and like other forms of regulatory agencies in Western polities, they increase ministerial commitment in a given policy area by forcing future office-holders into policy activism on a given issue (Gilardi 2008).

¹⁶ See, *inter alia*, Marrot (1995), Setbon (1993) and especially Morelle (1996) for an influential account of the "defeat of public health" in France at that time. His narrative indicates that, in the early 1980s, the ministerial *Direction Générale de la Santé* lacked all means of expertise to face both crises. Ironically enough, the government formed by Jacques Chirac in 1986 did not originally include a Minister of Health (Greer and Briatte 2009: 103). This lack of attention to public health at both the state and administrative levels had devastating political consequences: blood contamination led to judicial sentences and public criticism of the French state's failure in public health, a reaction extensively covered by the media and with substantial societal implications (Lacour 2008; Fillion 2009).

¹⁷ The effect of health agencies on state bureaucracies is considered in more detail by Besançon and Benamouzig (2005) and Gimbert (2006, ch. 3); see also Marrot (1995: 161-2).

Through the creation of agencies, then, the renewed commitment of the French state to public health has challenged its exceptionally weak involvement in public health policy, which has substantially decreased in the second part of the twentieth century (Ramsey 1994: 92) and even more so in the early twenty-first century, with the adoption of a wide-ranging public health law in 2004 (Bergeron, forthcoming) followed by several national public health programmes (Németh 2009).

Conclusion

A historical overview of the *Ministère de la Santé* shows that ministerial power over health policy in France was born in a squalid institutional environment, “weak both in design and structure” (Murard and Zylberman 1996b: 128) and with only limited resources to coerce other stakeholders in the health care and public health policy communities. Its departmental power has remained remarkably stable, and even though the Ministry has successfully developed some technical capacity in its domain of competency, its leadership in the constellation of actors concerned with health policy-making is still subject to high competition from other sources of influence in health affairs, either public (other ministries), parapublic (health agencies) or private (doctors and health insurers). Instead of going through a “golden age” and then through a time of decay, the influence of the Ministry over policy formulation in health affairs has been constantly disputed since its creation; in the early 1990s, it remained a weak administration of high technical capacity but low institutional power, with its total budget and staff representing less than 0.5 per cent of state social

spending (Marrot 1995: 15). Until that period, the French Ministry of Health should not be considered a strong policy player by default, but rather the opposite: its institutional legacy indicates it has been an endemically weak and subordinated participant in the policy process for several decades of its existence.

A cursory comparative assessment of ministerial power in health policy shows that this balance of power can be much more advantageous to state power, as is the case in Britain. In the late nineteenth and early twentieth centuries, important legislative efforts as well as the longstanding support of the British medical profession to public health regulations, and the creation of powerful health departments (in the interwar period and then by a decisive parliamentary act in September 1918) come in stark contrast to the inefficient regulation of public health by local authorities, the adversity of physicians to the principles of public hygiene, and to the chaotic start of central state regulation over health affairs in France (Murard and Zylberman 1996b).

A comparison of both departments on a longer time frame shows that these characteristics are persistent: the directive regime progressively set by the Department of Health in Britain over the NHS (Greer 2005) has no match in France, where power remains scattered among multiple stakeholders. Structural differences between ministerial power in both countries have remained largely stable over their period of existence, and only in the very recent period does the French Ministry of Health seem to have gained some effective leadership over the definition of public health legislation, at the price of offensive bargaining against entrenched and vested interests in that field of state action

(Bergeron, forthcoming). As of today, the current Ministry still struggles to redefine its role in the competitive landscape of French health policy formulation.

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