International Summer School

On the logic of Self-reinforcing Processes in Organizations, Networks, and Markets

Berlin, July 13 – 17, 2009

Lise Monneraud
PhD Student
University of Bordeaux, Sciences Po Bordeaux
CNRS, SPIRIT « Science Politique, Relations Internationales, Territoire »
lmonneraud@yahoo.fr

Self-reinforcing processes within the French health system: multiples forms and factors of path dependence

Introduction

Nowadays, the field of health is characterized by a strong rhetoric of change and modernization in France, underpinned by a twofold purpose: control expenditure and improve the quality and scope of services. This is part of a trans-national movement: the efficiency issue (both economic and technical) appears problematic in all OECD countries. National systems have to deal with an increase of spending, notably linked to population ageing and medical progress. Thus, new management solutions are currently implemented in order to rationalize spending and organisation (for instance the reform of the British NHS since 2001, or the Medicare Prescription Drug**,** Improvement, and Modernization Act enacted in the United States in 2003 which produced a deep overhaul of the historical public health programs). A similar logic is behind the so-called "new governance" reforms in French hospitals and health insurance network launched in 2004[1]. At the same time, governments have to face political pressure to offer high-quality health services to all, given that health has become a real value.

In France, it results in an important production of legal, administrative and professional norms, aiming to reform practices, organizations, financing methods, and so, actors' legal and legitimate missions. Chiefly, reforms focus on two main dimensions of change.

The first one deals with decompartmentalization. Health care professionals implement a collective and multidisciplinary work based on a global approach of the individual. This is implemented mainly through health "networks" connecting different practitioners of the same

[1] Notably Law on the public health policy (August 9, 2004), Law on health insurance (August 13, 2004), Order on health care facilities (September 1, 2005), Order on the simplification of the legal regime of health facilities (May 2, 2005). A new bill is currently under dicussion, called "Hospital, patients, health and territories", aiming to redesign the general patterns of health care supply and regulation.

specialty, for sharing knowledge, or different kinds of practitioners altogether with other professionals such as nurses, physiotherapists and even social workers, in order to meet better patients' multifaceted needs and. In the same logic, new decision-making forums are created which gather several administrations or administrations and professionals or associations, in order to improve shared decisions and programs.
The second movement aims to get closer to users, both physically and symbolically: it gives rise to territorialized or decentralized policies on the one hand and to different channels of participation for users, meant to improve their involvement in public decision-making processes.

Such a normative movement clearly appears in actors' discourse. Health public action is perceived as globally evolving and actors use terms related to "change" or "evolution" when referring to health action in general, notably when dealing with the affirmation of comprehensive care and overall health logics. Such a discourse is also present when actors describe their own activities and missions. For example both hospital managers and practitioners underline a context of change concerning their mutual relationships. The same way, state devolved services agents consider that their relationship with physicians have been changing constantly, towards more understanding and partnership.
In that sense, actors seem fully aware of the need to change practices and organizations, actually internalizing normative evolutions and taking them into account when implementing their daily actions.

Nevertheless, a detailed analysis of dynamics at work in the field, among individual actors and organizations, reveals the difficulty of implementing change, considering practices, prerogatives, hierarchies, or the distribution of powers.
Indeed, actors describe certain inertia in institutions and health public action in general.
This may seem contradictory with what we have just about actors talking about perceived evolutions. However, the contradiction occurring here is only apparent: the analysis of actors discourse reveals a certain mistrust vis-à-vis the permanent reform process and a limited personal involvement in successive reforms because of their quick pace and a strong impression of complexity. So the injunction to change is not systematically producing change, insofar as uncertainty and the limited gains associated to fast regulatory and organizational evolutions can trigger, on the contrary, conservative dynamics.
Actors' discourse reveals fundamental dimensions of health public action that remain unchanged and constitute a well-established and even unchangeable framework. So actors underline how much it is hard to renew daily ways of doing at both the individual and the collective levels. Some underline that the field of health is particularly complex and depends on high technical processes and organizations which take time to be transformed; but some consider that it is precisely the rapid pace of reforms that produce a sort of tension and a tendency to take refuge in the habits.
Self-reinforcing mechanisms and therefore path dependence phenomena are observed. They prevent a deep change in both administrative and professional practices and create a generalized process of reproduction and perpetuation of traditional roles, hierarchies and practice. Not only actors express an impression of constant evolution of norms and standards, but also a strong perception in terms of path dependence and difficulty of change.
In that sense, a kind of double bind appears throughout their spontaneous discourse: change is required, individuals have the feeling that ideas, legal norms and organizations are – or have to be – evolving, but at the same time, practical implementation appears highly constrained by unavoidable self-reinforcing dynamics.
In such a context, we propose to enlighten the processes that prevent or at least limit change in practices and power relationships in the French health system.

Our analysis follows a two-fold question in order to determine where path dependence occurs and where it is rooted, that is to say what are the mechanisms that favour self-reinforcing dynamics. This leads us to structure our findings in two parts.
Firstly we would like to enlighten the forms of the self-reinforcement processes observed in the French health care system. In other words, we aim to show to what extent health public action cognitive frameworks and actors' concrete daily practice are not changing. Mainly, we can observe that established roles and hierarchies are reinvested and even reinforced and that divisions between categories of actors are permanently reaffirmed, contrary to the multidisciplinary/cooperative rhetoric. In a second part we are to consider different dynamics that are at the basis the self-reinforcement of traditional practice and established patterns of action: notably we will underline that the system lacks an actor who could provide impetus for change and drive it; then we will show that individual or organizational actors do not fully play the game of coordination and cooperation; finally we will try to explain how doctors maintain their traditional central role thanks to the position of other actors that take part in health public action but without seeking to have greater power, considering their own role as peripheral.

Method

Our goal is to study change and permanence beyond law texts: from a quantitative point of view, we cannot consider that the numerous regulations that are presented as vectors of evolutions constitute in themselves a real evidence of effective change; qualitatively speaking, the formal rhetoric in terms of reform and evolution that is contained in the texts must be concretely measured. In that sense, we propose to focus on the actual behaviour of local actors that allows us to stress self-reinforcing processes taking place in the French health system.
To this end, we focus on the way they express about what they do. Indeed we consider that field actors' representations and discourse constitute a relevant basis to measure the importance of path dependence phenomena within the health care system. Indeed, those cognitive and discursive frameworks indicate how formal norms are understood and implemented; they also have a performative dimension: talking about the health care system is also constructing it (Austin 1975).

We rely on an empirical investigation launched in the bigger French region, Aquitaine. Chiefly we are relying on direct observations of meetings and working sessions and on a series of about eighty semi-structured interviews undertaken with both hospital and liberal practitioners, hospital managers, members of associations, State devolved services and local authorities agents, as well as local elected officials. The investigation was conducted, between April 2007 and May 2008[2].

The forms of path dependence: where do self-reinforcement processes unfold?

Remaining divisions between categories of actors

Despite the cognitive movement in favour of share decision-making and the development of patterns of multidisciplinary work, historical divisions built between categories of actors and notably between health care providers who have different modes of practice persist in representations and then appear in concrete interactions. Actors' discourse reveals various

[2] Interviews have been launched in French. What is quoted here is an *ex post* translation.

preconceptions that sometimes go to clichés and are in contradiction with actors' reflexive effort. They are related to quasi clan perception and spontaneous expression.
Actors mention "barriers", "very fragmented professional cultures" or even a "fragmented system", without always being able to explain this generalized impression. As a hospital physician says, "everyone has their own philosophy, their ways of doing, and has difficulties to understand other people's ways of doing". The same way a General practitioner (GP) describe the separation between categories of physicians: "we are in parallel worlds, because we do not deal with the same things and because we have little need to meet." actors describe different worlds that coexist without necessarily understanding each other but often constructing a precise image of others and their perceived intentions.
Our interest here is not to wonder whether such representations correspond to a reality or whether actors overstate the actual divisions. Insofar as actors' ideas and feelings exist for them and structure their perception of reality, they will have effects on their ways of doing and building their world. As Thomas said, "If men define situations as real, they are real in their consequences" (Thomas 1928). Thus, our purpose here is to underline how actors actually perpetuate some kind of myths that are founding myths for categories and allow them justifying the differences displayed with others.

First, the remaining perceived division between professionals and administrations has to be mentioned.
Physicians express their reluctance vis-à-vis public authorities' regulatory intervention which is often considered as a threat for their autonomy or their interests. Thus a devolved service agent considers that relationships with physicians are "not simple", given that "they have certain distrust related to institutional procedures". One of his colleagues asserts that private practitioners have "a great horror of administrative things".
But administrative actors themselves have general representations of physicians who are often criticized for their alleged tendency to spend public money or for their corporatism and their propensity to defend strictly categorical interests through conservative medical unions.
Such oppositions between practitioners and supervisory authorities are staged during meetings in which every one plays his role and embodies his category and its claiming. But beyond that, actors discourse reveals a lack of mutual knowledge coupled with a misunderstanding of respective ways of doing. Chiefly, private practitioners criticize administrations for not consulting them enough before initiating projects that actually fail because they are not adapted to their ways of working. For example, for a hospital practitioner, Health insurance "has created financial mess, because of prevention policies that were irrelevant because they were badly done. All this because they never wanted to work with practitioners and because they wanted to work alone in their corner in order to be sure to be right".
Physicians also describe the way health insurance offices communicate with them by sending multiple letters, which is not suitable for their daily conditions of work. They admit that they do not always pay much attention to those letters but they all underline that the latter represent additional workload.

A second kind of categorisation appears strongly between "public" and private, that is to say, between public hospitals and private clinics that share the supply of hospital care in France. Practitioners belonging to both categories mention "two different spheres", "strong divisions". Many actors of both the medical and the management staff of public hospitals underline the mercantile aspect of the activities of clinics which are not constrained by public service obligations. They also underline that the management of their own hospitals are far more difficult insofar as they must take responsibility of activities the least profitable, notably taking care of new patients twenty four hours a day, dealing with most serious diseases

requiring complex procedures or managing social problems, while private clinics can select the most interesting and profitable medical cases.

In the private sector, highly remunerative procedures are performed and practitioners are attracted thanks to prospects of wages higher than in the public sector, so that public hospital physician considers that in the private sector "they spent a lot of money to make a lot of money".

Reversely, public hospitals are criticized precisely for having a weak management, mainly linked to the tradition of the global endowment provided to each hospital which was independent of the actual activity[3]. Private clinic are presented then as symbols of good governance allowing to develop technical activities and to generate profits.

Such a cultural opposition between public and private organizations is reflected in another form of antagonism, opposing private practitioners working in a medical office and hospital practitioners who are employees of their hospital[4].

This opposition dates from the turn of the twentieth century. It is rooted in what Brémond calls the "narcissistic injury" of the private practitioners (Brémond 1999): indeed, the latter traditionally reproached university professors of medicine for keeping them away from the academic medicine developed within hospitals. The contradiction of hospital medicine with the liberal foundations of the French medical profession and the progressive affirmation of its excellence, have reinforced this scission (Hassenteufel 1997).

Once again the images of two social worlds culturally separated and irreconcilable are dominating in actors' descriptions. For instance they mention "two worlds ignoring each other", "well-rooted cultures", "parallel worlds that do have neither the same constraints nor the same goals".

A private GP insist on the fact that "we do not exercise the same profession. We do not deal with the same problems", while a hospital practitioner considers that "we do not have the same job! Admittedly we both treat patients, but it is not the same work. We do not do it the same way". One of his counterparts also says, about his meetings with private practitioners, "I don't know to deal with those people! I really don't know. We are not in the same world: what makes me happy is having a paper accepted in a journal, being a researcher, or make a good diagnosis. This is great. But for them, it is making money. We are not the same! So when I come to see them, I must let them speak for a long time before I know how I'm going to say things".

Even if this description is a caricature, we cannot ignore that hospital and private practitioners have to deal with very different environments, mainly linked to their mode of remuneration (salary versus fee for each service), the different technical tools available to them, their type of practice (alone or within a medical team), etc. But beyond those material variables, their divisions are rooted in mutual representations and constructed images of each other. As summed up by a hospital practitioner, "the health care system is actually segmented. Because do not work in the same places, because there are organizational barriers. But there are also barriers in our heads. So there are both an organizational constraint and a constraint in terms of images we have".

Not only do actors highlight differences that are constitutive of their professional identity, but they criticize the other category, underlying individualistic and utilitarian dimensions of its goals and reversely claiming the noble aspect of their own choice of practice. Private

[3] This global endowment has been replaced by activity-based pricing for both clinics and public hospitals. It has been applied progressively. Today it concerns all procedures, but public hospitals still get specific funding due to their public service activities (emergency care, research and academic missions, etc.)

[4] Note here that some hospital physicians can also develop a private activity within their hospital, parallel to their public consultations. For such an activity, those physicians can benefit from the equipment of the hospital but they are not paid by the latter.

practitioners are reproached for increasing medical activities in order to increase their wages, and in return they accuse of looking for “interesting” patients, in order to publish in academic journals and so advance their carriers. Thus, the categorical division revolves around the issue of the patients’ interest that each intends – and claims – to put in the foreground.

Besides, in a context where hospitals still embody excellence and medical progress, private practitioners often stress the contempt shown by hospital ones which is, for them, a cause of division. This impression of being disdained makes them reluctant to involve in projects in which they would work directly with hospital practitioners, such a health networks. Indeed, they justify their lack of enthusiasm for those forms of institutionalization of the cooperation between the two worlds by the fact that they might be dispossessed from their patients and above all from their authority, arguing that hospital practitioners do not try to work with them but rather to teach them how to work better.

We have to add another kind of division is perpetuated in the health system which is not linked to statuses that determine different environments for professional practice. A last compartmentalization process clearly appears in field actors’ representations, crossing those we have just mentioned, that is to say the one between GPs and medical specialists, regardless their place of work.

This cognitive and technical differentiation between GPs and medical specialists was born of the division between hospital and private medicine, given that medical specialisation first developed in hospitals.

Medical specialists constitute knowledge communities based on an identical education, but also communities of interest. The material and ideological division between GPs and medical specialists derives from the development of segmentation between medical specialties: indeed the formers’ practice has long had a negative definition (those who do not have any specialization) and was quite devalued, scientifically and economically speaking (Arliaud 1987).

GPs interviewed spontaneously address this issue of the need for them to institutionalize their own union representation and to revalue their role and specificities: “there has always been a contradiction, or an opposition between medical specialists and GPs. GPs used to be the good little soldier who obeyed to everyone. Until the day a GP union emerged. And we’ve struggled for the role of generalist practitioners to be specifically identified, not some sort of sub-doctor who knows nothing but should still do everything”; “for the last twenty years we have attempted to develop concepts and criteria to define the function of a GP in our health care system”; “GPs have claimed to be defended equally with other medical specialities. That is why we had to create our own union”.

GPs have continued until today to affirm their identity, and especially a social role based on a close relationship with patients, far beyond that of treating organs. Actors’ representations show that this categorization is reproduced and I still a base for socialization and construction of identity. GPs underline the unique capacity to get closer to the lived of their patients, replacing ills and symptoms in their social, familial and affective dimensions, so taking distance from medical scientific categories.

In such conditions, even if most actors relay the discourse in terms of cross-cutting practice, a real partnership between various professionals beyond categories and professional cultures appears difficult to achieve.

The Aquitaine case finally shows that despite multidisciplinary care or cooperation rhetoric field actors remain compartmentalized regarding both interests and ideas.

Self-reinforcement of established roles and hierarchies

The rhetoric of global care and the official discourse in favour of users' empowerment are meant to redesign both the forms of professional practices and the balance of power in the French health care system. But in spite of this double affirmation in legal texts and in cognitive frameworks defining the values of legitimate health public action, established roles and hierarchies remain because they are constantly reinvested.
We would like to address here two main self-reinforcement dynamics. Each of them affects one of the two movements we identified as representing the directions of change at work in the French health system, that is to say decompartmentalization and the necessity to get closer to users.

Professional and political actors tend to show their concern for some rights of citizens (effective or potential patients and users) that have to be protected, in the individual medical relationship but also when it comes to managing hospitals or the whole health care system. Those rights represent the basis of a movement of implementation of a so-called "Health democracy", progressively built and affirmed from the 1990's and explicitly enshrined with the Law of March 4, 2002 on patients' rights and the quality of the health system. Health democracy has a double meaning: affirm patients' and more widely citizens' rights concerning health care and provide them effective participation channels in health care procedures and at the level of the global health system. The active role is enshrined in the name of two intertwined questions, that is to say defending citizens-users' rights and improving quality of care.
The shapes of users' participation entailed by the recent legislation follow three levels of the health decision-making. First patients have been progressively given the ability to rebalance their relationship with expert professionals by being active in the course of their illness and managers of their treatments. Properly informed, they build a contractual relationship with their doctors, based on mutual respect. In that sense health care takes the form of a true collaboration.
On the basis of this first step of recognition from the individual point of view, users (including patients but also citizens as they are potential or effective users for their own care or their relatives') have become legitimate to take part in the management of hospitals, representing an alternative view – even a potential counter powers – vis-à-vis managerial and medical specialists. Patients, but also family representatives, as well as association members are able to intervene in hospitals' policies through various forums recently created or that already existed but used to be far more closed.
Furthermore, the Law has set various institutional spaces in which users can take part in the definition of health policies, at the national and local levels. At the national level, users sit in different bodies: the High Council for Public Health (*Haut Conseil de Santé Publique*) the National Institute for prevention and health education (*Institut national de prévention et d'éducation pour la santé*), or the National Health Conference (*Conférence nationale de santé*), which is an advisory body responsible for advising and making proposals on government programs and plans, or in order to improve the French health system. This body is reproduced in each region, with the Regional Health Conferences which contribute to the definition and evaluation of regional public health objectives and control the implementation of regional plans.
In such conditions, the democratic dynamic of evolution of the health system seems to be affirmed. However the role of citizens/users remains problematic: despite different organizational reforms and professionals' changing attitudes, they still have an inferiority position in their individual relationships with practitioners and within health decision-making forums vis-à-vis expert actors.

Professionals recognize the rise of users' voice at various levels of decision-making, but their discourse does not allow attesting that a model of "heath democracy", in which civil society would have a strong role in decision-making processes, is fully implemented

Several professionals describe a mid-stream situation in which behaviours do not keep pace of reforms automatically: "Users' place in regulation is evolving very quickly, and in the right direction. For instance, the access to medical records has been an undeniable step forward. So, regulation has evolved… But concerning relationships with the medical team, it's much slower" (hospital manager); "For a few years there has been rhetoric on health democracy. There has been real progress; it is a very good thing. But it is long in coming, because this is not usual in France. So, it might take time". (Devolved service agent)

Indeed, all professionals are not equally sensitive to the democratic discourse and some have difficulties to determine the right place to provide to their patients. Others even feel that users' voice challenge their authority. Thus, a hospital practitioner talking about making patients involve in their care project asserts that "for me it's perfectly normal. But some practitioners consider that there is no discussion to have. Not everyone has acquired this idea. That's probably why laws were made". As one of his counterparts says, the relationship between caregivers and patients has only evolved "for the ones who really want to make it evolve".

We also have to moderate observations about users' role within hospitals, keeping in mind that the actual scope of reforms remains unequal from one hospital to another, from one management and medical team to another. Observing professionals' practice and their discourse, we could say that it is in midstream: users have broken into various decision-making forums; yet their role turns out to be much reduced for both technical reasons and power reasons. Very often they appear more as spectators or alibis in a decision-making that remains controlled by professionals.

Many hospital managers, as well as practitioners sitting in hospital decision-making bodies, underline that even if users are able to intervene during meetings and working groups, they do not have a decisive role. Very often they do not dare defend their specific positions in forums gathering mostly expert professionals, either because they do not master their professional language or because they do not understand highly complicated technical or financial issues. So their role is often reduced to observation, or information relays to other users. In a word they attend debates but they do not participate in discussions. In that sense, users' representative cannot be considered as complete representatives: they sit on behalf of a larger group of individuals, yet they do not speak on their behalf, they do not fulfil their mission of expression of their claims and beliefs.

Hospital managers' words are significant, describing a users' role that seems stripped of its most active dimension: "I have never seen a meeting of the Board of Directors during which the orientation would move the slightest centimetre because of the intervention of a users' representative. They do not understand because it is very complicated, or they do not dare to speak. For instance, when there is a debate over a budget, it is very hard for patients to imagine concrete effects; even for us it's difficult!"; "Within the institution, users have a formal place, they come, and if they want to talk they are listened to. We are not against them. But they do not make a difference. It is more an alibi. Even for us, it is difficult to understand our organizations. So for them it is worse, even if there are training sessions for patients' representatives, even if guides are published, for example about complaints and claims in hospitals which provide key for us to work better together."

A similar finding appears regarding the level of regional health planning. Chiefly, several testimonials of actors sitting at a Regional Health Conference show that great expectations in terms of democratic debate and impact of civil society on health decision-making are not met.

Devolved service agents recognize that their ways of doing do not change, the Regional conference being a formal meeting where there is little if any debate: “It is only promises… actually it is very institutional. For a moment we thought that is would be decisive, but it is not”; “People are invited, but there are mostly professionals. And when someone mounts the rostrum, everybody knows what he is going to say! It is an institutional discourse. It is so general! When the regional health conference takes place, we go and we explain what we do, but we do not change our priorities strictly speaking”; “It cannot shatter anything! Theoretically there are associations’ and users’ representatives, but it is institutional. It is not completely useless, but it is not that that makes things change”.

Members of the Conference from civil society also explain that their ability of influence over institutional health planning is very limited. Indeed, they quickly realized that professionals intended to retain control over health policies and would not tolerate that users question their priorities or their local strategies. Users’ representatives describe meeting during which what they were expected to do was to listen to professionals and endorse their decisions, without asking puzzling questions. This correspond to what Lascoumes (Lascoumes 1996) has observed concerning the intervention of users in areas with a strong technical dimension. He observes that users rarely produce information or develop the terms of the debate. They are rather asked to decide on issues that have already been built on the basis of views or in formations considered as unchangeable.

Indeed, they once asked devolved services agents “what's the point of doing that?”, and “what means have been used?” concerning concrete public health local actions: those naive questions immediately triggered protest and defiance. Those agents actually considered users’ questionings as a way to challenge their expertise: “I immediately saw that we could not speak too frankly! It’s not possible. If we say ‘it is unacceptable! You must present things and we are going to propose you a model with what we want’, everything would be over! Over! None of them would accept!”; “They reaction was ‘You're not there to judge us’! Admittedly, we are here to advice. So the first day, no one had understood the rules of the game. They presented their things and then we asked them questions. But they told us that we were not there to judge. But what does that mean?! So the second time everyone had understood. […] our opinion necessarily goes in the same direction. If someone begins to ask questions about what they do they will get angry. So we have changed the way we do. It is an amazing experience”.

Reversely some devolved services agents actually show through their discourses that they were not prepared to take into account users’ questions. Consciously or not they actually did everything to restrict the impact of the voice of users’ representatives. They affirm that they had to explain to the member of the conference that “they did not decide”, insofar as this prerogative was exclusively for technical services: “They cannot make proposals concerning the implementation. They have to give their opinion on what we have proposed in terms of planning”; “It is clear, through their interventions that they do not always understand their role. For example they asked us for a progress report on the implementation of public health programs, with the means, etc. But we told them that it was not their role! We told them ‘you must intervene at the level of the program as a whole. You must evaluate the program, but not the progress of each action’.”

In such conditions it seems that both medical and management professionals talk on behalf of users rather than let them talk.

The second self-reinforcement dynamic we would like to tackle is the perpetuation of the power relations traditionally established between two major ways to define the health action, that is to say individual curative care and public health.

The narrow conception focused on curative care which is the basis of the French model is in a crisis. Most analysts and professionals recognize that it has to be completed by a more comprehensive vision of care, including prevention, therapeutic education, and even social care. Such a wide conception of health action is inspired by the definition promoted by the World Health Organisation (WHO), which defines health as "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Such an enlargement of the frames of action is included in a larger movement that affect public policies in general and especially social public policies, that is to say a tendency to get out of narrow sector frameworks to build cross-cutting actions.

Meanwhile, the French traditional model of health public action based on the individual curative approach is dealing with tensions regarding its efficiency in preserving the health of populations. France is one of the developed countries where life expectancy is longer but the level of premature mortality remains high[5]. Thus, some talk about a "French paradox": the neither the performance nor the technical dimensions of our health care system are questioned, but it seems that this supply fails to unsure health for all.

Premature mortality can only be reduced by increasing the effort in terms of screening, information and prevention on risks linked to individual and collective behaviours, that is to say addressing upstream health determinants.

Furthermore, health inequalities have not disappeared: in addition to economic and geographic inequalities in access to care, social inequalities persist (Leclerc 2000). Indeed, less well-off populations have poorer health because they experience harder living conditions but also because they do not even have the same appreciation of their health status and needs, that is to say they pay less attention to symptoms and do not share the "somatic culture" of people better off (Boltanski 1971). In that sense a model nearly exclusively based on technical medicine is not able to guarantee the health status of all individual because it leaves aside the more fragile part of the population. Once again, the health status of different social levels of populations can only be improve through the development of awareness and health behaviours based on information campaigns, coupled with cross-cutting policies addressing health care replacing it in personal and social trajectories of individuals.

The health system must then melt high quality curative care and public health programs including health education and health promotion to be effective. This requirement are concretely included in the French health system, notably through the development of thematic public health plans receiving substantial funding, a better institutionalization of public health planning[6], and the establishment of health networks gathering physicians, paramedics and social workers.

However, those advances do not mean a global evolution based on the affirmation of a new paradigm of public action, from a biomedical to a public health model (Borraz, Loncle-Moriceau, 2000). Actors' concrete experiences show that curative technical care remains dominant and therefore practitioners keep their central role in the health system.

Several actors – even physician themselves – underline that the culture of technical care remains, at the expense of public health: "I'm not sure that, in France, we have a real public health policy. Even if we do not smoke anymore or if we fight against alcoholism limiting advertisement. We do not have a public health culture, contrary to other countries" (Hospital practitioners); "public health represents an infinite field… but the opposite of our traditions". Some hospitals practitioners even consider that the return of prevention in legal texts and campaigns is "rather a display than a real intention or a political will", or that "it is just

[5] The premature deaths are those occurring before 65 years

[6] Notably a Public Health Regional Group was set in each region in order to gather all actors involved in public health activities and to gather funds in order to rationalize this sector and to give an institutional unique form to disparate actions.

someone at the Ministry, who says that he's going to do this or that; but it is not put into practice". Others actors merely note that the concrete implementation is limited: public health logics "remain very marginal", because legal texts have evolved but "the practice takes place with much more difficulty" (health network coordinator); hospital physicians "do not have such a perspective, such a horizon" (hospital manager).

This generalized impression also emerges in several recent public reports that point this lack of real public health impulsion in France (Inspection générale des affaires sociales 2003 ; Larcher 2007; Bur 2008).

Actors identify several types of cultural and organizational factors that prevent from the real advent of public health.

Some mention the specific case of political history which was marked the development of a strong hygienist movement at the end of the 19th century. This movement meant to reform individuals behaviours in healthier behaviours, by the imposition of standards of food, work and construction safety and the development of urban sanitation or vaccination campaigns. It was enshrined in 1904 with the first public health Law and produced an important progress of health conditions, especially in urban areas[7]. However the hygienist movement was also criticized for being over-prescriptive and for representing a new way of social control, rooted in a moral drift focusing on culpabilization and even criminalisation. Struggling for health determinants would then also be a restriction on freedoms insofar as people are told how to behave in any social situation. This kind of negative conception of public health prescription is still observable today, especially regarding banning smoking in public places.

This "hygienist spectrum", as a devolved service agent calls it, has deeply influence the French history of health public action and favoured the legitimate development of a curative individual medicine based on free choice.

Besides, some actors stress that health care professionals who have a central position in health issues are not very sensitive to public health logics, because the latter represent a peripheral part of their medical studies. Several physicians underline a "hyperspecialization" or a "very fragmented training" based on the organs considered as objects of science which unable to have a comprehensive understanding of the patient. Significantly, being asked whether public health logics were becoming more important in mentalities, a medical professor answers: "obviously not! Because medical studies are based on the ill man or the ill woman. There are no courses in psychology, epidemiology; prevention is not considered as something important, except during the first years. Ten years later it's a bit too far! Reversely, it's all about diagnosis, therapeutics, pathologies… it's a culture".

Such weakness of the institutionalisation of public health logics in the medical profession is particularly important given the social weight of physicians when it comes to solving health public problems. Indeed actors emphasize on the central position of doctors who embody the superiority of curative technical health care and so, participate in the self-reinforcement of the traditional biomedical model. Some insist on the "medical power" at work, asserting that "curative care is the noble dimension of health", or that "the curative side is valued", or noting an "over-valuation of the medical procedures".

In such conditions, prevention and health education programs are still conceived and designed through the prism of curative care, as devices to support and deepen the medical processes. This limits their imposition as a new paradigm of health public action. For instance the coordinator of a health network dedicated to addictions considers that public health preventive and social logics do not fully develop in those networks because physicians are the linchpins of their creation or implementation: "it takes time to get started to move. Precisely because practitioners have a strong role in networks, so that they keep the same

[7] Note that the next one was only voted in 2004.

vision focused on curative care. Even prevention keeps this care dimension. It is rather secondary prevention than upstream prevention, on larger dimensions of health."
In that sense, the General Inspectorate of Social Affairs speaks, in its report, of a situation "à la française" in which prevention and health promotion have not fully enter the French health system because they emerged recently and because the French "doctrine" of action remains "committed to a conception implicitly inspired of the biomedical model" (Inspection générale des affaires sociales 2003).
In addition to these cultural cognitive factors – and perhaps because of them – some organizational factors also participate in the self-reinforcement of the biomedical model. Indeed, public health suffers from a lack of clear division of powers. Many actors State bodies, health insurances offices, health care facilities but also local authorities, are able and legitimate to finance actions, without any full coordination. Despite the creation in 2004 of Public health regional groups which are meant to rationalize the choice of projects and prevent duplication of local actions, there is still a profusion of legitimate roles and actions creates unclear responsibilities and leads to a field of action poorly structured.
For instance a physician working in the a state devolved service underlines this structural inequality between public health approaches and the biomedical model which is far more clearly organized regarding responsibilities and financing channels: "I think things have to be structured. Because otherwise, everything is everywhere. I like working on health care issues because they are structured. Prevention is very interesting but it is not structured. There is a lot of rhetoric about it but sometimes, concretely, it is hard to account for. I think prevention suffers a lot of this lack of structuring." The same way, for the Head of an association dedicated to prevention and health education that the balance between curative care and prevention always leans on the side of the former "because people know what they are talking about, there are well-identified professionals, it is more framed", health promotion or comprehensive care being much more difficult to apprehend.
Multiple health reforms intent to affirm the importance of users' voice and the necessity to make a greater place to public health procedures in the system. But what happens in the field is much more mitigated: professionals remain dominant in the decision-making; especially health care practitioners keep their central role, so that preventive logics still have a secondary position, considering power relations and funding.

The concrete observation of what is at work in the French health care system allows highlighting several path dependence phenomena, despite a lot of reforms that are expected to lead to change concerning patterns of practices and power relationships. Established categorizations and hierarchies are reaffirmed and even reinforced.
The second step of the analysis consists in trying to understand the processes that trigger such path dependence tendencies. Indeed, several dynamics that make change more difficult must be taken into account to understand self-reinforcing mechanisms affecting French health public action.

The roots of self-reinforcing processes: what dynamics promote the perpetuation of traditional practices and patterns of interaction?

Path dependence mechanisms have their roots in structural dynamics that unfold in the French health system. We would like to examine three decisive ones that prevent the real achievement of change in health policies.

A problematic leadership

The central State which is responsible for the production of norms and planning fails to provide – or embody – a real management of public action. Local actors, even those belonging to local State services, stress the awkward position of the latter that are not able to do themselves but also fail to make others do effectively.
So the State (central administrations and local state devolved state services) appears unable to exercise real control and leadership over other heterogeneous actors, in a configuration where leadership is fundamentally shared since other forms of power are legitimate. Thus the system lacks an actor who could provide impetus for change and drive it.

State services position as conveners and regulators that do not implement public action themselves but supervise and monitor specialised field actors who are meant to do, harmonizing local interventions. In that sense, the State would tend to develop a sponsor-provider relationship with local actors.
However its real position, as it is observed and relayed through actors' discourse, turns out to be much more problematic, insofar as it fails to establish either a hierarchical relationship or an agency relationship with local operators. Because of a lack of adequate human and financial resources, the State cannot require local actors to cooperate and unilaterally decide to delegate them public interventions. As a devolved service agent says, "the threat of the hammer that may fall doesn't work anymore. Especially with the limited means we have… we only have limited incentive effects. We must not delude ourselves!
But reversely, the State does not act in the manner of the "principal" who builds a contractual relationship allowing him to guarantee the services of an "agent", whether a professional, an association or a local authority. Indeed, the agency relationship based a contract which that allows the sharing of risks, while reducing the opportunistic behaviour of the agent through incentives and calls for competition procedures. But in the case of local health public action, the State cannot afford to provide real incentives. So it is in a paradoxical situation in which it produces formal planning without having the means to ensure that its decision will be effective, whether through constraints or incentives. In such conditions, as the Head of a Health insurance office says, "there is no continuum between State policies and implementation. There is no monitoring. And there are inconsistencies. Because there are no sufficient means, not agents for that…"
Several state devolved services agents underline the difficulty to complete their daily tasks which consist in convincing partners to involve in public action while fitting in the priorities set by the State: "we must like partnership, we must be diplomatic and this is not easy"; "when working with health insurance offices, local authorities, if after a while they realize that we want to impose things that are in a DGS[8] circular without listening to them and without taking into account their willingness, it will go wrong very soon". Thus those agents describe the strategies they use to convince field actors to involve, showing the latter that an activity perfectly fits in their legitimate missions or that their own local interests coincide with those of the State.
Field actors describe a configuration in which supervisory administrations persist in issuing norms and directives whereas they have no real capacity for action or general management. In that sense, partnership approaches are seen primarily as a form of disengagement, an admission of the powerlessness of State administrations. So, local authorities' agents often have the impression that State services do not really seek to build a partnership but rather to get additional funds for their projects.
Heterogeneous actors are all extremely critical in this respect: according to a hospital manager, "the State is dysfunctional in its positioning" given that it poduces norms but it

[8] *Direction Générale de la santé*, Health General Department, the main health central administration

doesn't provide the means for them to be enforced; for the head of a municipal department "we experience public policies in which, paradoxically, the State orders, or at least it strongly steers interactions, and at the same time, it is pulling out. The State says 'you must do this but I won't give you the money to do it'. This is a great issue."

In such a context, relationships the most problematic are those with health care professionals, insofar as the latter have an expertise and above all a freedom in their exercice that puts them easily out of the reach of the state guidelines or at least makes them able to circumvent them (Hassenteufel 1997). Some devolved services or Health insurance agents confess their impotence, admitting the strong legitimacy of practitioners. For instance, "our health system is based primarily on private physicians. it is certainly thanks to them that we have a good system. It would be suicidal for the State to oppose practitioners violently. That's why we spare them. When they want one more euro for their consultations we accept without asking too much in return".

Field actors including physicians themselves regret this lack of authority of supervisory bodies towards professionals that can ignore recommandations. A State that cannot force them to follow cannot actually drive change because of professionals' diversion or circumvention of enacted regulations. As a hospital physician says, "anyone who does not want to do will not do because there is no sanction". For one of his counterparts, "some doctors consider that they are beyond, or above the rules of the administration! This is irresponsable! And the administration does not have enought punch to punish those people..."

Even when practitioners involve in the implementation of reforms and align with the objectives of the State, the latter appears unable to control the extent to which they are involved and how they effectively use the envelopes they are given for their projects. For several practitioners, this leads to irrational evaluation.

What appears is a State that displays a willingness to control but that is not able to pursue its mission to supervise public action.

But this structural weakness of the leadership is also due to its dual aspect, split between the State and Health Insurance.

The State does not appear as a leadership because it does not embody autohirty alone: actors' discourse reveal a blurred leadership, shared with Health insurance that keeps a key role in the decision-making power, as it is the main funder of the health system.

In spite of a theoretical sharing of jurisdictions between State services – responsible for public health policies and hospital planning – and Health insurance offices – in charge of the financing of the system and regulation of private health care – fields of responsabilities constantly overlap. With its joint organization historically based on managers and trade unions' representatives, Health insurance remains an independant actor with a strong symblical authority – and legitimacy.

Field actors consider that their daily work is is severely comlpicated by the existence of two competing figures of leadership that both claim to control public action. A hospital manager says that "State and Health insurance could define better the scope of their responabilities; it would be better for us". One of his counterparts also regrets that "they have not agreed yet about who does what, and who rules what precisely".

Another hospital manager explains that "the problem is the relatioship between State and Health insurance. Health insurance has a power of knowledge and expertise stonger than the State's. They also have greater technical capacities. But meanwhile they are are subject to increasing State control. So we do not know who controls who. This is one of the contradictions in the system. The State has great ambitions and great powers but it is unable to exercice them. So it must appeal to Health insurance while controling the latter. But who does what? We do not really know."

Even Health insurance agents consider this dual leadership as a stumbling block regarding the global steering of the health system. For example the health of a local office wonders whether "this dichotomy between the State and Health insurance, which is a historical split, is relevant today". He mentions several issues suffering from "a confusion of responsibilities ", which creates a "mixture of wills" preventing efficient decision-making". Even the Head of the regional main Health insurance office stresses the difficulty to deal with such an "undergone but also wanted sharing of streering responsabilities" which leads to a dilution of authority.

The misuse of cooperation forums

Another structural dynamic that promoted self-reinforcing processes within the French health system lies in the tendancy to divert cooperation forums to institutional uses.
State services have developed their partnerships and common funding with health insurance, notably to support health care innovative networks or to promote good practice. Public health Regional Groups have been created in every region in 2004: they are to gather all actors involved in public health policies, that is to say Social security, patients or users associations, local elected officials, or sector administrations in charge of various issues such as Education, environment or Road safety, more or less linked to health. The great innovation here is that those groups not only gather stakeholders to discuss, but they also gather funds, in order to unify and rationalise public investments in public health. Moreover, participative bodies have been created which tend to redefine old accountability arrangements. Among those bodies, we can cite Regional Health Conferences that are composed of 50 to 300 members representing welfare administrations, public and private health care professionals, local authorities, associations and lobbies, etc. Such consultation forums are to analyse evolutions of local needs, to set regional health priorities and to make propositions in order to improve the global health status of the populations.
But in a context of co-presence of several highly legitimate institutions whose skills can overlap and even compete, we are witnessing an instrumentalization of those forums aimed at winning, so at satisfying institutional interests. Bureaucracies – that is to say highly institutionalized bureaucrticaly structured organizations – taking part in health public action try to promote and impose their own intervention instruments, that is to say their preexisting solutions within forums yet displayed as partnership bodies, in order to maintain their fields of power and their established positions. In a word, organizational actors do not fully play the game of coordination and cooperation. The implementation of arenas that were set for collegial decisions and new solutions boils down to the continuation of established institutional interests.
State devolved services, Health insurance offices and local authorities that have representatives sitting in cooperation forums maintly work on controling the terms and conditions of interaction in order to keep their own freedom of action, parallel to the collective decision-making, or in order to develop or consolidate their leadership within health public action. This tendency correpond to what Freidberg called "autonomization of political exchange" (Friedberg 1993). For this author, this process occurs when partnerships between actors are implemented only in the name of power and influence for the stakeholders. The negotiation about the exchange rules' between partners becomes by-itself the regulating principle of cooperation. The purpose of the partnership is no longer to find solutions to social issues but to assure its own perpetuation. So the "partenership" forum becomes an issue and a tool for bureaucratic power, an area where there are power struggles and the *status quo ante* is strengthened.
Organizations represented in the new forums pursue their own institutional interests in what is designated as a partnership. Each more or less directly seeks to value its own actions or

priorities and finally do dominate other stakehorlders. So the space of exchange is instrumentalized, according to institutional rivalries.
A physician involved in several prevention projects evokes “institutional dynamics that are very damaging”. Another considers that, in the light of his own experience, “institutions are in self-centered logics and all programs are made based on what serves institutions”; so, policies are seen as “centered on the narcissism of the institution, in order to convince that things are done well and to say so”, so that they can be far from what the populatins concretely need.
Admitedly everyone displays a will to work with others, to build altogether, but the main goal is to bring their partners to adhere to their own categories of action, or to join their causes. Thus, institutions do not fully seek to produce collective cooperative intervention but rather to gather others behind their own intervention as they are used to conduct it. As a practitioners says, “institutionally, everybody talks about networking, but everybody wants to do their own network, ordering others how they should do and saying “we know and we are goin to explain to you’.”
Besides, bureaucracies represented in collective partnership forums seek to control the patterns and the content of concrete actions that are promoted and financed through those forums. They use them as spaces of promotion of their own fields of intervention and as new ways to develop their own projects and instruments. As a local authority agent says, “everyone is selling his product”.
We observe the establishment of a power struggle within partnership arenas which governs their functioning and determines the forme of what is finally decided.
Several actors show how a group of professionals seek to orient decision criteria at work in a Departemental House for disabled people in order to favour its traditional public[9]; others describe how categories of actors represented at the Health regional conference stick to their prerogatives and try to promote their own ways of doing displayed as the only way to guarantee the general interest. But it is the case of the Public health Regional Group (GRSP) that illustrates the most the processes of instrumentalization of partenership forums.
State devolved service agents’ representations are the most revealing of this tendency of misusing the GRSP for bureaucratic purposes, given that those actors are its key workers.
Here the power struggle is first about the ability to continue to promote and finance one’s own actions parallel to those that are collectively selected in the framework of the GRSP, even for similar topics. The case of Health insurance is particularly relevant in this regard: Health insurance offices are key members of the GRSP but they keep on financing public health actions unilaterally, notably through a specific fund, the National Fund for Health Prevention, Education and Information[10] which still exist and is not included in the collective envelope of the GRSP. The same way, local authorities that are represented in the Group conserve their old channels of aid allocation and support for projects, which allows them to maintain the display of actions directly linked to their level of authority.
But the power struggle also deals with the capacity for an organization to lead its parnters, once within the GRSP, to involve in themes and projects which it has unilaterally elevated as public health priorities. The objective here is to perpetuate partenerships those organizations have alreaddy built and to impose their field of action making them eligible for additional financial support.
Actors belonging to these organizations, especially devolved services agents who are meant to carry out the implementation of the GRSP, explicitely mention those processes of instrumentalization of collective forums, so that the “autonomization of political exchange”

[9] MDPH, Maison départementale des personnes handicapée. This colletive body was set in 2005 in each department, in order to gather social, medical and psychological workers to identify and allocate aids to handicaped people.
[10] FNPEIS Fond National pour la prévention, l’éducation et l’information en santé

observed by Friedberg appears as a generalized tendency which is not specific to a particular organization: “Health insurance has been implementing things for twenty years and they want to keep on financing them, so they say that we should make it a priority for the GRSP”; “nowadays in the GRSP the General council of Gironde values actions that it has always made, such as Aids or tuberculosis prevention. They value what they were already doing before; “what the regional council wants is to finance prevention and health education actions in highschools[11]. So they put money in the GRSP but they want it to go to highschools. But they don’t want us to tell them what to implement: they define actions themselves. They don’t want to hear about our ideas or the suggestions of Health insurance. The Regional council is a local authority, with elected officials who want to put in people's heads that it is the Regional council who has helped them. So a new collective legal body won’t change anything”.

So, actors describe processes of pervertion of a collective partnership arena because all stakeholders conceive it as a vector of perpetuation and reinforcement of preexisting ways of doing, based on unchanged instruments. So we do not observe dynamics of collective deconstructon/redefinition of public problems but rather a thinly veiled continuation of old segmented logics of intervention: “the GRSP lacks ambition. In theory it's very beautiful. But concretely, regarding the functioning of institutions, it is not a leading thing. This is not something that can make things move forward. Because within such a Group there are big blocs, such as the State, Health insurance, local authorities, and their interests are not always the same. Everyone wants his own priorities to be taken into account. So what happens is a juxtaposition of priorities! But there is nothing that is not consensual. Or it could not work! It is necessarily consensual. The Head of the Drass[12] takes the policy of Health insurance, the policy of State devolved services and tries to make everyone happy. We can consider that it limits double funding, but basically there is no change.”

Finally those processes of misuse of partnership arenas reveal a deficit of institutionnalization, in the sens of cognitive proximity and institutional identification generating real appropriation and mutual recognition. In the case of health local public action bureaucratization does not mean institutionalization: traditional organizations – that are also institutions – are not replaced by new ones; they remain the concrete framework of decision-making bt also the cognitive framework of of belonging and identification.

We rely here on the design proposed by Talbot who considers institutions as “a common idea in action serving a purpose” (Talbot 2008) fundamentally creating a form of proximity. An institution would be a “cognitif device” for coordination but also a way to solve conflicts arising from the heterogeneity of actors, regarding their preferences, their ressources or their skills. On the contrary, the analysis of the local health public action reveals decision-making spaces that do not allow the harmonization of practices or interests, nor even ensure the consistency of actors’ roles. As partnership forums are implemented to meet the Law and not local actors’ choices, they are used for utilitarian purposes by the latter and they do not produce a proper institutional identity. Typifications and representations remains linked to actors’ home organizations, and new partnership forums “do not constitute the frame of reference on their practices nor the horizon of their calculations” (Taiclet 2007). Admittedly all stakeholders share the same space of choice, notably because new collective frameworks are legally stabilized; yet the space of sense is not shared. In that sense we can consider that cooperative forums are not real institutions leading to a real reduction of uncertainty.

The perpetuation of physicians’ image of centrality

[11] According to the decentralization Laws, Regional councils are reponsible for high school policies

[12] Drass : Direction régionale des affaires sanitaires et sociales. It corresponds to the regional level of state devolved services. It is in charge of the secretariat of the GRSP.

Path dependence dynamics affecting the French health system lie in a last process, namely the self-reinforcement of the undisputed central position of physicians. This phenomenon is rooted in two convergent tendencies: on the one hand, physicians themselves integrate new objectives to their activities correponding to public health concerns, which allows them to renew their legitimacy; on the other, no actor really intends to take doctors' central position, other stakeholders taking and displaying subsidiary positions.

First, physicians integrate new objectives in their own practice in order to be in touch with the paradigm of global health and comprehensive care. In that sense they integrate public health decisions and priorities in their own curative activities. In other worlds, their professional interests converge with political values currently at work in the field of health we have alreaddy mentioned. So they restore their legitimacy and centrality in the health system because they cannot be reproached for not taking into account the movement of "change" affecting health public action frameworks and defining what is a legitimate enterprise.
Such a process is not due to all physicians but only some of them who appear as "promoters".
Those we call promoters are locally influential practitioners who give first impetus to new models, through their willingness to restructure their practice. Those promoters are not, strictly speaking, reformers, insofar as their efforts are not governed by a desire to reform the health system as a whole. They do not seek to defend a new health model: they rather act at the heart of the historically established system and ultimately in the interests of this system.
Promoters can be hospital doctors as well as private practitioners. They can be founders or coordinators of health networks, but also instigators of multidisciplinary structures and creators of professional associations aiming to share knowledge and coordinate practices.
Their objective when constructing projects is above all an evolution of patterns and procedures of care, in the interests of their patients but also for themselves.
So their argument is dual: on the one hand they emphasize their desire to improve patients care, notably integrating prevention or multidiscipinary approaches to their traditional ways of doing; on the other it is not care but conditions of care that are tackled, or in other words practitioners' conditions of working and living.
Nevertheless, those repertoires of legitimization can merge, given that professionals underline that helping and curing users can only be achieved by helping health care professionals who work on users' health. Reversely, the implementation of better medical care, regarding quality and simplification, constitutes a support for practitioners and reduces his daily professional pressure.
So categorical interests, and even personal interests meet a general interest which is common to all health care professionals and citizens.
In that sense, the evolution of health public action is based on a double convergence of interests: categorical and personal interests on the one hand, promoters working for better conditions of medical practice, through their thinking and their implementation of projects; professional and general interests on the other, given that the reorganization of practice leads to an incremental evolution of health public action that may benefit users.
Eventually, promoters are practitioners who engage, at their level, in a process of redefining the frameworks within which they practice. So they participate in the evolution of a system in which they are historically at the centre.

Besides, this centrality is reinforced by the position adopted by other actors who do not belong to the medical profession. Indeed those actors maintain a subsidiary role, defined with respect to practitioners' activities, despite the opportunities given by the enlarge definition of "health".

Insofar as health is considered as a global well-being, determined by physical, mental, but also social and environmental determinants, many competences can be – and have to be – mobilized to achieve health goals. Various skills and legal attributions appear necessary to complete the technical action of historically specialized actors such as practitioners, hospitals, health administrations, or pharmaceutical companies. Health being considered as a cross-cutting policy issue, many actors can build legitimacy lines and contribute to health public action by proposing new modes and designs of intervention, inspired by their own central – and official – competence.

In this context, various local actors take part in health action by reinterpreting their own attributions and giving to their legal or symbolical missions a sanitary dimension. In other words, they rebuild existing programs and they redefine their logics of action, so that health becomes a "treatable" issue for actors that do not possess the explicit sanitary competence (Lascoumes 1994). As the borders of health and health public action are constantly moving, it is also true for actors that can legitimately participate. Thus, various actors take part in health public action, especially local authorities, associations and sector administrations in charge of issues such as Education, or Road safety.

But such a movement does not mean a real changing of the French traditional model and its balance of power. Indeed, the heterogeneous actors legitimated to break into health policies voluntarily adopt a peripheral role. They do not consider themselves as embodying an alternative model, a new pattern of health common law that would contradict the biomedical one. Rather, they adopt a position of support, of crutch for practitioners. They act as "facilitators", as subsidiary actors who can help improving the performance of the existing well-established system based on medical authority. In that sense, they favour the persistence of old divisions of roles and powers, insofar as historical leaders are not replaced. Finally those actors do not really try to move beyond the traditional biomedical individual model of health intervention, precisely to be legitimate and define they own identity vis-à-vis this model.

The curative individual model is still conceived as the common law, backed by a kind of natural authority of doctors who determine the framework in which objects and public actions are thought. Thus, local authorities' agents and elected officials display their concern for health considered as an important theme, they demonstrate their involvement in health local projects, but they do not show up as leading health actors. They involvement is more conceived as support to other actors which does not lead to a research of centrality in health public definition of problems and action. In that sense they contribute to the reinforcement of the traditional model, admittedly amended but still legitimate.

This role of "facilitator" is important however, given the multiplicity of actors taking part in health public action. It is precisely because actors are multiple and non-systematically cooperative that facilitators become major actors. This positioning turns out to be a specific form of legitimization for non-central actors. Some of them specialize in this activity of support, to assist physicians in the fulfilment of their central health action, or to remedy its possible shortcomings. So the centre of gravity of health action remains health care professionals.

The role of facilitator must be considered through two aspects: at a first level, facilitating the action of other actors means supplementing it, notably filling the gaps regarding certain populations socially or geographically isolated; at a second level we can observe a kid of specialization of the role of the facilitator who becomes a coordinator and a debate moderator. Here the position of support, of crutch, is further upstream: the facilitator doesn't help his partners when carrying out their actions but works to build the very conditions for collective action by bringing together diverse actors. So the facilitator plays as an essential part of local cooperation.

The first aspect of the figure of facilitator is to promote the proper performance of common law devices, that is to say, to facilitate their implementation conditions or their access by users while displaying a peripheral role.
This positioning is characteristic of the different levels of local authorities.
The Head of the Departmental House for Health (*Maison départementale de la santé*), a unique body created by the General Council of Gironde considers that "our job is to re-sent people to their doctors, clearly. Our job is not to retain people; it is to ensure that their relationship with their doctor is appropriate for them". This actor describes several times the raison d'être of such an initiative: "the idea is that common law devices can be efficiently used by the population and useful to them"; "we are not there to replace anyone, but rather to assist, to develop things where something is missing. We are always complementary to the health care system".
The same way, the director of a municipal service in the town of Bordeaux where a Local health council (*Conseil local de santé*) has been set, considers that "the direct improvement of the health status in our city is not the objective of the Local health council. This is determined elsewhere. It is above all the actions of physicians that will improve the health status". While this agent explains the contributions and the local impact of the Council, he keeps on considering that only health care professionals are determining actors. The latter are considered as central, de facto but quite legitimately. Thus, he considers that municipal actors are not "boxing in the same category".
Another municipal agent also defines the activity of the municipal level as "try to fill the gaps". "I think we must be very modest", he adds, considering that his level only "does little things".
Thus municipalities are considered as complementary actors who facilitate the work of others and support them when accomplishing their health missions. Some agents describe them as tools or forums for coordination. Their role is to clarify who are the actors involved and their tasks and to favour "mutual knowledge", in order to help users to navigate in the system and to facilitate practitioners' daily activities. Fir instance the city of Bordeaux has organized multi professional meetings" or published a "professional directory" distributed especially to local GPs.
The Regional council agents display a similar withdrawn position and stress the humility of their involvement in health public action. An agent of the service devoted to "youth" and implementing several project dealing with health promotion and education asserts that his service "does little" and "is a discreet partner" with a "tiny" budget. In such conditions for other agents, "we are rather more looking for how we can try to work with, to compensate for certain things, to put a little money on two or three things"; "we do not have super ambitious project in health. So there is no question of stealing others their jurisdiction; the idea is rather to bring a little something more, expertise, a little money, etc."
The Regional council also has a Territorial development service that is supporting local projects for the maintenance of medical supply in rural areas. Here again a director insist on the "modest" and "experimental" dimensions of the intervention of his institution which "is not first in line". Another agent also considers that the Regional council "has simply sought to have a complementary view". He underlines several times the vocation of facilitator of the regional institution, meant to "intervene in support, in complementary fields".
Finally to illustrate this first dimension of the position of facilitator, we can mention the creation of local networks by social workers and project executives working for local authorities. The central objective of such network is to help professionals who already practice in a local territory, which is also a way to enhance the attractiveness of this territory.

Chiefly it is the case for the “health and social network of Haute Gironde” created in 2001 in order to “assist physicians, professionals in the health, social or education sectors, to help them in their daily practice ». For the coordinator of the network, “it is not to replace what already exists, but to supplement, to provide a response to demands or needs that are not answered through common law devices”. In that sense, the network implements different tools to facilitate users' access to those common law devices (transportation assistance, aid for the purchase of a health insurance, etc.). But the network also aims at creating « a tool for professionals themselves », which boils down to the creation of a host structure providing listening and guidance meant to “help health care professionals when they are confronted with a situation of social vulnerability and psychological”. Here, the reinforcement of traditional biomedical missions lies in providing support to professionals who daily ensure and embody them, precisely in order to maintain their activities in rural difficult territories.

Besides, the role of facilitator has a second dimension, more positive given that it is not just a simple support to missions performed by other actors but rather a specific task in public action. What we want to underline here is the coordinator/moderator role of some facilitators who manage to gather heterogeneous partners, to introduce a debate, and to bring out constructive proposals. Here the position of facilitator corresponds to a specific legitimating pattern, insofar as without his at least partly disinterested coordination activity collective mobilizations could not take place.

This role is largely emphasized by actors because beyond a support provided to others it constitutes a specific mission from which they derive certain legitimacy and even a certain power, given that they are vectors, or mediators, for other actors to be able to discuss. The facilitator historically does not have the explicit power to resolve health problems himself, he establish himself as a third party who has a key role in the consistent coordination of local actors and in their involvement for innovative solutions. This is not a well-institutionalized juridical defined role, but rather a strategic attitude directly built by facilitators themselves with his technical and symbolic resources.

This unifying and coordinating role appears particularly in the case of some local authorities, notably cities.

Municipalities are able to mobilize and federate local energies beyond sector logics and categories of actors, so that they become key actors whose power lies in their crucial networking and linking intervention. As a mediation body, the municipal level of authority turns out to be a legitimate and relevant actor in health intervention. It is designated by agents as a “unifier”, a “political intermediary”, the only one capable of “putting around the table” actors who do not necessarily share objectives and interests. Indeed, only the municipal institution – particularly the municipal elected officials – may legitimately bring together diverse partners, institutions, professionals but also citizens around a common local issue, that is to say, implement and publicize a large-scale cooperation.

But this local mission of coordination also appears considering the Regional council.

Significantly, the regional elected official in charge of public services and health issues explains that “I’m to bring together public health officials in Aquitaine, to make a link between those people in order to initiate a policy”. Concretely, “I have created a working group gathering all responsible actors. Yes, I have established a dialogue”. Like municipal agents, this elected official emphasizes the importance of his mediating position without which this dialogue could not have taken place: “some actors did not even know each other. The road is so long! I mean, some institutions would not know each other and they met here, at the Aquitaine Regional council”. He considers that this role is “particularly interesting and motivating because we create a link between institutions and we provide another perspective on health issues.” The regional institution adopts a position of interface between all levels of

elected officials, health care professionals and health planning administrations in which lie the value and the legitimacy of its intervention.

Conclusions

To conclude, our findings lead to a series of concluding points, both methodological and empirical, which constitute lines for further of researches.

Our case study shows how it is interesting to cross cognitive analysis and interest/choice analysis: in the French health care system, real evolutions are constrained by field actors' special interests but also by well-rooted habits that derive more from interiorized categories and patterns of action. In that sense a policy analysis based only on values on the one hand or interests on the other would miss and important dimension of path dependence mechanisms. It seems more interesting to combine the variables of interests, ideas and institutions to highlight the complex forms of self-reinforcing dynamics (Hall 1997, Palier 2005): indeed, this allows addressing the multiple dimensions of public action, by using the heterogeneous tools provided by the literature. Indeed, considering only cognitive frameworks could have led us to overemphasize the rhetoric of change noticeable in actors discourse, neglecting their power strategies; reversely, focusing on actors interests would have deterred us from tackling the issue of the institutional frameworks structuring health public action.

Besides, considering our empirical findings, the relation between continuity and change takes a particular resonance.

What emerges from the observation of plural self-reinforcing mechanisms is that evolutions do not come from the margin of the French health system but from within, from its very centre. Change does not systematically occur because of the investment – and even struggle – of peripheral actors who achieve in imposing their views and then, in implementing a new paradigm of legitimate public action. Traditional central actors themselves make their practice evolve, so that the system does not completely remain identical. Thus the case of the French health system allows to underline the two-fold dimensions of the concept of path dependence, that is to say, not only a mere reproduction of similar processes and patters of action but also an incremental form of change, rooted in past policies, consisting in adapting traditional models without questioning bluntly the balance and the political compromises that have been set before (Fouilleux 2002). In the light of the case of the French health system, we should consider self-reinforcing processes not only in terms of locks-ins and institutional inertia, but also taking into account a sort of change in continuity characterized by both perpetuations and incremental evolutions.

Our findings on self-reinforcement processes finally appeal to consider, reversely, what can be the factors that enable change. In a context where perpetuation of institutional divisions and traditional hierarchies prevent any global evolution based on a generalized movement of all stakeholders, cognitive and practical change appears possible only when certain situated conditions are met. Chiefly it is based on a specific form of personal commitment, i.e. self-giving and dedication to a collective cause recognized as such by others. Situated mobilizations for change depend on the personal involvement of isolated individualities, especially those coming from the central category of practitioners: some who fit in the traditional model and even embody it and who are comfortable with institutional mechanisms, can reform practice from within. Their purpose is not explicitly to reform the health system as a whole but to improve local practice. Anyway they happen to be key figures for change because their situated efforts to initiate innovative projects and to create institutional links or local partnerships, thanks to their personal networks or their reputation gradually form the basis of a more general awareness. They actually concretely show that it is possible to go

beyond professional and institutional divisions in order to improve working conditions and services provided to users.

References

ARLIAUD M. (1987) *Les médecins*, Paris: La Découverte

AUSTIN J. L. (1975) *How to Do Things With Words*, Harvard University Press

BATE P. (2000) "Changing the culture of a hospital: from hierarchy to network community", *Public Administration*, vol. 78 (1): 465-512

BOAS T. C. (2007) "Conceptualizing Continuity and Change: The Composite-Standard Model of Path Dependence", *Journal of Theoretical Politics*, 19, 1: 33-54

BOLTANSKI L. 1971. Les usages sociaux du corps. *Les Annales*, 26,1: 205-233

BORRAZ O., LONCLE-MORICEAU P. (2000) "Permanences et recompositions du secteur sanitaire", *Revue Française de Sociologie*, 41, 1: 37-70

BREMOND M. (1999) "Les syndicats de médecins contre l'organisation de la protection sociale, tout contre", *Pouvoirs*, 89: 119-134

BUCHER R., STRAUSS A. (1961) "Professions in Process", *American Journal of Sociology*, 66(4), 325-334

BUR Y. (2008) *Rapport d'information en conclusion des travaux de la mission sur les Agences régionales de santé*, National Assembly, Febrary 6 2008

BUSE K. and al. (2005) *Making health policy*, Milton Keynes: Open University Press

LARCHER G. (2007) Commission de concertation relative aux mission de l'hôpital, *Etat des lieux réalisé par la commission de concertation relative aux missions de l'hôpital, présidée par M. Gérard Larcher* December 14 2007

LASCOUMES P. (1994) *L'écopouvoir. Environnement et politique*. Paris: La Découverte

ESPER C. (2005) *La nouvelle gouvernance hospitalière : réel dynamisme ou évolution imposée? A propos des ordonnances des 2 mai et 1er septembre 2005*, Paris : Editions Dalloz

FOUILLEUX E. (2002) "Propositions pour une approche dynamique des processus d'inertie et de changement dans les politiques publiques. L'exemple de la PAC", in Fontaine J., Hassenteufel P., eds., *To change or not to change. Les changements de l'action publique à l'épreuve du terrain*, 2002, Rennes, Presses Universitaires de Rennes: 255-279

FRIEDBERG E. (1993) *Le pouvoir et la règle*. *Dynamiques de l'action organisée*, Paris : Seuil

HALL P. A. (1997) “The Role of Interests, Institutions, and Ideas in the Comparative Political Economy of the Industrialized Nations”, in Lichbach M., Zuckerman A., eds., *Comparative Politics. Rationality, Culture, and Structure*, Cambridge: Cambridge University Press: 174-207

HANF K., SCHARF F. W., eds. (1978) *Interorganizational policy making. Limits to coordination and central control*, London: Sage publications

HASSENTEUFEL P. (1997) *Les médecins face à l’État. Une comparaison européenne*, Paris: Presses de Sciences Po

IMMERGUT E. (1992) *Health Politics. Interests and Institutions in Western Europe*, New York: Cambridge University Press

INSPECTION GENERALE DES AFFAIRES SOCIALES (2003) *Santé, pour une politique de prévention durable*, annual report, Paris: La Documentation française

LASCOUMES P. (1996) “La précaution comme anticipation des risques résiduels et hybridation de la responsabilité”, *L’Année sociologique*, 46, 2: 359-382

LECLERC A., ed. (2000) *Les inégalités sociales de santé*, Paris: La Découverte

LORIOL M. (2002) *L’impossible politique de santé publique en France*, Toulouse: Erès

MORELLE A. (1996) *La défaite de la santé publique*, Paris: Flammarion

OSBORNE D., GAEBLER T. (1993) *Reinventing Government: How the Entrepreneurial Spirit Is Transforming the Public Sector*, New York: Plume Book

PALIER B. (2005) “Les ‘trois I’ et l’analyse de l’Etat en action”, Revue Française de Science Politique, 55, 1 : 7-32

PIERSON P. (2000) “Increasing Returns, Path Dependence and the Study of Politics”, *American Political Science Review*, vol. 94, 2: 251-267

SCHWEYER F.-X., ed. (2004) *Normes et valeurs dans le champ de la santé*, Rennes: École Nationale de la Santé Publique

SÉGAS S. (2007) “L’élu animateur : savoirs de la “bonne gouvernance” territoriale et légitimation d’un nouvel ordre politique local”, in Pasquier R., Simoulin V., Weisbein J., eds., *La gouvernance territoriale. Pratiques, discours et théories*, Paris: LGDJ: 191-208

TAICLET A.-F. (2007) “Le développement économique au regard des hypothèses de la gouvernance territoriale”, in Pasquier R., Simoulin V., Weisbein J., eds., *La gouvernance territoriale. Pratiques, discours et théories*, Paris: LGDJ: 109-127

TALBOT D. Talbot (2008) “Les institutions créatrices de proximités”, *Revue d’Economie Régionale et Urbaine*, n°3: 289-310

THOMAS W. I., THOMAS D. (1928) *The Child in America: Behavior Problems and Programs*, New York: Knopf