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Politiques de Santé: The Territorial Politics of French Health Care Reform

David K. Jones
PhD Candidate, Departments of Political Science and Health Management & Policy
University of Michigan, Ann Arbor

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European Union Centre of Excellence, York University
715 York Research Tower, 4700 Keele Street
Toronto ON M3J 1P3
Tel: 417 736 5695
Fax: 416 650 8069
euce@yorku.ca

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This paper is the first stage of a larger project studying the regional politics of health care in France, particularly since the creation of the Agences Régionales de Santé (ARS) in 2009. Subsequent work will focus more specifically on the ARS, how they function, and how they interact with each of the relevant stakeholders. My goal with this paper was to lay the foundation for fieldwork to be done in the summer of 2010 by placing these reforms within a larger context of French governance.

Abstract

Decentralization has been a major theme of French governance in recent decades, with communes, départments, and régions receiving more and more control over expenditures and decision-making. Health care is a particularly interesting case to study, as it is a policy domain that has experienced a parallel trend of recentralization of control by Parisian ministries. By consolidating power over health policy to administrative bodies at the regional level, the 2009 reform known as "Hôpital, Patients, Santé, et Territoires" raises important questions about the evolution of governance in France. For example, do the new arrangements indicate increased decentralization or are they actually attempts at further recentralization? What are the implications of these regional organizations being disconnected from elected bodies at the regional and local levels? Are sub-national bodies given room for policy experimentation or do the reforms merely adjust which level of government is responsible for implementing the national government's priorities?

This paper lays the foundation to answer such questions by reviewing the relevant literature on decentralization in France. Building on this review, I make predictions about what these reforms mean in the context of French governance in general, and of decentralization in particular. I explore the possibility that these reforms are emblematic of a new phase of the French Fifth Republic marked by both pluralism and greater central control.

1. Introduction

The United States is not the only nation in the midst of intense debates over health care reform. After a long period of discussions, protests, and amendments, legislation known as *Hôpital, Patients, Santés, et Territoires* was passed by the French Parliament in the summer of 2009. More commonly referred to as HPST or, *La Loi Bachelot* after the French Minister of Health Rosalyne Bachelot, these reforms are an important step in a set of larger reforms known as *Hôpital 2012*. One of the most important aspects of HPST is the creation of regional-level bodies known as *Agences Régionales de Santé* which have powers and functions previously performed by seven other bodies at the departmental and regional levels.

That the nation ranked by the World Health Organization as having the best health care system(World Health Organization, 2000) would make such dramatic changes might come as a surprise to some. However, why President Nicholas Sarkozy and the French Government pushed for major reform is not necessarily the

most interesting question. France is facing the same problems of national deficits, rising health care costs, and aging populations experienced by most industrialized nations. The important political questions are why leaders opted for the solutions they did and what these reforms indicate about the nature of governance and inter-governmental relations in France. The important policy questions are whether this reform will work to streamline management, reduce costs, and improve quality of care. Interestingly, the French use the same word, p*olitiques*, to refer to both politics and policies, suggesting that the two are inherently linked. Although it is important to understand both aspects of these reforms, this paper will focus primarily on the political questions.

As the Fifth Republic reached its 50th anniversary in 2008, some theorists and politicians wondered aloud whether its institutions had changed so much that it made sense to start thinking of France as having entered the 6th Republic (Loughlin, 2007).[1]Although such a re-branding does not seem necessary, there has been undeniable evolution in the structure and processes of governing in France. The first 25 years of the 5th Republic saw the buildup of the welfare state through centralized control, whereas the second 25 years witnessed significant decentralization. Le Galès and Pinson describe these two periods and predicted that "the golden age of decentralization may be over" and that the Fifth Republic might have entered a new phase that is "more plural but recentralizing,"(Le Gales and Pinson, 2009).

One of the central questions of this paper is to explore whether Le Galès and Pinson are right within the context of health care policy. I will focus on the creation of 26 new regional-level organizations known as *Agences Régionales de Santé* (ARS) which went into effect on April 1, 2010. Because the *Agences Régionales de Santé* are in the very earliest stages of development and still mostly only exist on paper, it is too soon to definitively make such broad claim about shifts in governance; however, this major reform provides a unique opportunity through which to consider the nature of governing in France. At first glance, this seems to be a case in which Le Galès and Pinson's prediction is accurate. The national government appears to be asserting greater control, but within the administrative structure and rhetoric of decentralization.

The next section will focus on the evolution of the French health care system within the context of the three phases proposed by Le Galès and Pinson. I will then briefly discuss a few of the theoretical frameworks used to describe governance in France. In each case, I will discuss whether and how that framework can be extended taking into account my argument about health care reform and the new phase of postdecentralization/ re-centralization.

[1] Some are more aggressive than others, calling for a reassessment of French institutions and even a new constitution. For example, consider Arnaud Montebourg's Convention pour la 6ème République http://www.c6r.org.

2 First Period: Centralization (1958-1981)

Although the first half of the Fifth Republic was a period of centralization, this trend obviously did not begin with the creation of the Fifth Republic in 1958. As the prototypical, textbook example of a unitary state, the roots of central control run deep in France, dating to at least the creation of *Départements* in 1790 and the assignment of *Préfets* to each *Département* in 1800. Throughout most of modern French history, the *Département* has been the only constitutionally recognized sub-national unit of government, with *Préfets* acting as the eyes, ears, and arms of the State. This model is biased against policy diversity, instead focusing on standardization to achieve the higher priority of equality (Loughlin, 2007; Ridley, 1973; Schmidt; 1990).

As was the case in many other nations, the building up of the French welfare state began in earnest during the post-war years. *Sécurité Sociale* was passed in 1945 and became ubiquitous by the early part of the Fifth Republic. Although originally designed only for certain groups of employed citizens, by 1970 *Sécurité Sociale* covered 96% of the French population and was accepted by 89% of French doctors. These percentages have since increased to near universality (Dutton, 2007).

Although progressively more centralized throughout the 1960s and 1970s, I should be clear to distinguish the French model of health care from the British model. The French have no interest in a single-payer system in which the government owns all the health infrastructure and have fought vigorously to maintain their Bismarckian social insurance model with its fee-for-service financing and few explicit constraints on the amount of care patients can receive (Dutton, 2007). Even still, the development of the French health care system during the first 25 years of the Fifth Republic was built on a highly centralized system of governing.

3. Second Period: Decentralization (1982-?)

Decentralization took place during two major periods, 1982-1986 and 2003-2004. Although health policy was not the major focus of these reforms, it is a policy domain that was seriously impacted. As described earlier, it is still an open question as to whether we are still in this second period of the Fifth Republic or if we are now in a new period.

3.1 Act I: 1982-1986

The decentralization reforms that began in 1982 have their roots in the cultural and administrative changes of the 1970s. In some ways these reforms were a dramatic development given that Charles de Gaulle himself was forced to resign the Presidency in 1969 after the failure of constitutional reforms that would have decentralized government power (Schmidt, 1990). On the other hand, a study of expenditures shows that a longterm shift away from a simple hierarchical model "towards the creation of a multi-level governance structure with multiple sources of

power" preceded decentralization legislation, and that this shift was independent of partisan controls (Baumgartner et al., 2009).

Regional level administrative bodies, *Etablissements Publics Régionaux,* were created in 1972 to coordinate various types of policies. Although this development had little impact in most places, it served to mobilize policy networks in areas were traditional regional sentiments were strong, such as Bretagne and Aslace, as well as in areas of economic crisis, such as Nord-pas-de-Calais and Provence-Alpes-Côte d'Azur. Additionally, one of the final acts of the d'Estaing presidency was to give municipalities and departments the ability to determine the rate of their own local taxes, a critical issue if decentralization is to be meaningful (Le Gales and Pinson, 2009).

Although decentralization largely transcended partisan ideology, the growing power of the *Partie Socialiste* in the late 1970s and the early 1980s played an important role. After doing extremely well in the1977 municipal elections, socialist leaders became frustrated by Prefects stunting the advancement of their agenda.(Le Gales and Pinson, 2009) It is not surprising therefore, that leading socialists advocated decentralization reforms as part of the 1981 presidential campaign. Although previous generations of leaders had forgotten campaign promises of decentralization once they were in control, the socialists followed through and swiftly began passing major decentralization reforms
(Loughlin, 2007).

It is important to note that decentralization did not result from one single piece of legislation but was the cumulative effect of over 40 laws and more than 300 decrees passed between 1982 and 1986. Although the implications of these reforms are too numerous to discuss in detail, it is important for my analysis to highlight three. First, regions were recognized as a sub-national unit of government for the first time. Rather than strengthening the hierarchal model, this change greatly confused it. Instead of being legally situated between the departments and the State, regions were given equivalent legal status as the departments. To confuse matters further, the legal status of the more than 36,000 municipalities were elevated to the same legal status as departments and regions.

Second, the spreading of power in this way had the effect of significantly reducing the role of the Prefect. In fact, many powers traditionally exercised by the Prefects were specifically transferred to the *Conseils Générals* and the *Conseils Régionales*, the legislative bodies of the departments and regions. Third, the regional councils created in 1982 became fully elected bodies in 1986. Although this was an important development, the historically low turnout of the March 2010 regional elections indicates confusion and apathy among the French over the role of this level of government.

Like most other policy domains, the management of health care was significantly affected by this period of decentralization. Departmental and regional leaders were given greater autonomy and flexibility in setting budgets and local policies. However, the impact of decentralization in France is somewhat atypical and diminished compared to the impact in other countries because the powers are devolved to administrative agencies and not elected bodies (Sandier et. al., 2004). This is an important distinction which minimizes the importance of the regionally

elected officials while elevating the status of administrative bodies, at least in terms of actual policymaking powers.

3.2 Act II: 2002-2004

After a period in which the Prefects were given greater authority relative to the regions, and it seemed that the pendulum might be shifting back towards centralization, Prime Minister Jean-Pierre Raffarin introduced a series of three bills and a constitutional amendment which he described as the second act of decentralization. His proposed change to the constitution was to say that "France is an undivided, lay, democratic, social *and decentralized Republic*." Chirac insisted it instead read "France is an undivided, lay, democratic and social Republic. *Its organization is decentralized*," (emphasis added). Phrasing it this way did not challenge the hierarchal control of the state, ensuring that France would remain a unitary state and not drift towards federalism (Loughlin, 2007).

The Constitution as amended now recognizes four levels of local authority: commune, department, region, and those with special status, such as inter-communal bodies. As significant as this amendment is, it is a mostly symbolic change that has had little impact as it essentially just codified the complicated multi-actor system that already existed (Loughlin, 2007). French citizens deal with as many as seven layers of government, including the communes, inter-communal organizations, pays, department, region, nation-state, and the European Unions (Cole, 2008). At any one point in time, there are an estimated 557,000 elected politicians serving in the 36,000 municipalities, 100 departments, 26 regions, as well as in the Parliament composed of the National Assembly and the Senate.

In addition to updating the constitutional status of the different levels of government, Act II of decentralization enhanced the ability of sub-national units to experiment from national policy. However, this is far from the level of innovation that is possible in countries with federalist backgrounds such as the United States or Canada, as any major variation requires prior approval from Paris. Even if approval is granted, this experimentation is only allowed for a certain period of time, at which point it is reviewed. If found likely to be of broader benefit, then this policy change is implemented throughout the rest of the country. If not, then the innovation is discontinued (Loughlin, 2007). To do otherwise would be to potentially institutionalize inequity, a highly un- French notion (at least in theory).

Health policy was affected during this period of decentralization, as greater competencies were devolved to the departments. In some ways it is ironic that a reform which specifically recognizes the constitutional status of regions would so greatly favor departments over regions. However, as seems to be the case with health care, regional leaders were not lobbying for increased competencies, but were actually arguing against further responsibilities in some cases. Whereas departments had the administrative bureaucracy and infrastructure to handle responsibility in welfare policy, this was only possible in a limited sense at the regional level (Cole, 2008).

4. Third Period: Post-Decentralization (?)

Almost immediately after taking office in 2007, President Nicholas Sarkozy ordered a general auditing of French public administration. Although much of the rhetoric coming out of this process focused on empowering sub-national units, there was also a focus on strengthening the role of the Prefect, particularly with regards to regional administration.[2] This tension between the rhetoric of decentralization and the preferred institutional design of recentralization is epitomized in the recent health reform debates and brings to mind Le Galès and Pinson's predictions about a new phase of the Fifth Republic.

Although the creation of *Les Agences Régionales de Santé* (ARS) is generally framed as devolving power to the regional level, the fact that each of the 26 regional directors are named directly by the *Conseil de Ministres* (Prime Minister's Cabinet) and report directly to the Minister of Health has raised more than a few eyebrows among medical professionals, patient advocates, health insurers, and opposing politicians. ARS directors will have a significant degree of control over regional health budgets and delivery of services, with few checks on their power besides the central government and the limits of their own political capital. The ARS directors will also be responsible for overseeing newly empowered hospital directors who themselves are named by the *Conseil de Ministres*. The chain of command will now be remarkably clear and close between the Minister of Health and individual hospitals.

The consolidation of power to centrally chosen officials has led many to describe the directors of these new regional bodies as "*Préfets sanitaires*," (*Préfets* over health),[3] implying that their allegiances and interests are with the state and not with the regions and departments, or perhaps even not with the health care system. In many ways, ARS directors do resemble *Préfets* such as in the fact that directors can be moved at will by national leaders and that none of the incoming directors seem to have strong ties to their newly assigned regions. The concern over ARS directors becoming agents of the state reminiscent of pre-1982 *Préfets* is particularly interesting given that the *Préfets* themselves have actually now been given a significant role of presiding over a C*onseil de Surveillance* (Supervisory Council) for the ARS. Although it is unclear at this point exactly how powerful this council will be, it seems that the prominent position of the *Préfet* is to serve as an additional check by the State on the directors' autonomy.

Do these reforms, important as they are, signify the ushering in of a new period in the history of the Fifth Republic? I have argued in this section that this seems to be the case as far as we can tell from the new model of management used in recent health care reform. Of course, determining whether the Fifth Republic has truly entered a new phase would require a broader assessment of many issues and policy domains, an analysis which is beyond the scope of this paper. There are a few

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[2] See for example this summary of President Sarkozy's agenda: http://www.gouvernement.fr/premierministre/une-reforme-de-l-etat-sans-precedent

[3] The amount of sarcasm and derision associated with this term seems to vary depending on where on the political spectrum the speaker falls.

reasons to suspect that health care might be different from other areas given the large number of stakeholders invested in the eventual shape of the health care system. These include medical professionals, employers, employees, insurers, and users of the health care system (which should include the entire French citizenry). At the same time, given the consistency in rhetoric used when discussing this and other issues (such as empowering sub-national leaders but simultaneously empowering Prefects), I suspect we will find that health care might not actually be that atypical.

5. Theoretical Frameworks

In an effort to further investigate the evolution of the Fifth Republic, this section will focus on four of the theoretical frameworks that have been used to study governing, government, and governance in France. I discuss the degree to which my analysis can be situated within each approach. The goal with this section is not necessarily to use these frameworks to make conclusions, but to lay the foundation for further analysis by suggesting which frameworks might or might not be useful.

5.1 Agency vs. Choice

The choice model and agency model, or principal-agent model, is one way of representing the tension inherent in local-periphery relations (Loughlin, 2007). The main distinction is essentially the central question of fiscal federalism, which level of government is better able to most effectively, efficiently, and equitably deliver social goods. On the one hand, the choice model is built on the assumption that optimal results are more likely to be achieved when goods are delivered at the local level and tailored to local needs. On the other hand, the agency model assumes that although goods may be delivered locally, they are most effective when done so as agents of the central authority.

This framework fits nicely within my characterization of the three periods of the Fifth Republic. Although Mabbett and Bolderson found that very few countries could accurately be described by the Principal-Agent model (Mabbett and Bolderson, 1998), I would argue that pre-1982 France should be one of them. The shift from centralization to decentralization could in this case be described as a shift from the dominance of the agency model to the dominance of the choice model. If we think of these models as situated on either side of a spectrum rather than as all or nothing, then we can think about the new phase of increased centralization within a more plural state as somewhere in between, but moving further from choice and closer to agency (Loughlin, 2007).

5.2 Cross-Regulation _ Mutual Interdependence

The main weakness of the agency and choice models is that it oversimplifies interactions between the center and the periphery. In 1983, even before the effects of decentralization reform would have been felt, Dupuy and Thoenig proposed a more nuanced model of *régulation croisée* (cross-regulation) which among other

things takes into account the roles of actors outside the single hierarchy (Dupuy and Thoenig, 1983).

Loughlin updates Dupuy and Thoenig with what he calls the mutual interdependence model (Loughlin, 2007). The central point is that instead of there being one single hierarchy through which center-periphery relations take place, there are actually two parallel, occasionally intersecting, unequal and mutual dependent hierarchies. He places local notables, departmental councilors, and mayors in the first hierarchy and ministers, prefects, and local administrators in the second, more powerful hierarchy.

Looked at through this lens, the consolidation of power over territorial health policymaking to regional directors appointed and managed by the central government indicates a decrease in the salience of the mutual interdependence model in France. The first half of his parallel hierarchies is essentially eliminated from the picture. The model is still useful, however, as it pushes us to consider actors outside the main hierarchy of the Ministry, ARS directors, and hospital directors, as well as to explore how these hierarchies intersect. To some degree, it is too early know what this parallel hierarchy should be, as the reform is still so new that institutions have barely been or are still being put in place.

5.3 Governance

Although more inclusive than the agency and choice models, the cross-regulation and mutual interdependence models are still somewhat restrictive. They only allow us to think in terms of hierarchies, when the reality is that many important interactions take place outside of a formal hierarchy. The concept of governance attempts to get at this very issue. As summarized by Cole, "The challenge is to understand how and when sectors, actors, levels, institutions, or interests matter and how best the relationships between them in the context of French politics should be conceptualized,"(Cole, 2008). In this context, I prefer to think of governance as an attitude or frame of mind than as a specific framework. It represents a commitment to seeking out all relevant factors and developing ways to take them into account.

In the case of health care in the post-decentralized phase of the Fifth Republic, we know who most of the relevant actors are. In addition to the bureaucrats and politicians at the ministerial level, directors of the new regional health organizations, members of the regional health organization's supervisory council and bureaucracy, and newly empowered hospital administrators, we need to consider the roles and interactions associated with doctors, nurses, other medical professionals, insurers, employers, employees, pharmaceutical companies, patient advocates, etc. By definition, governance in this sense challenges us to move beyond what is described on paper. Unfortunately, the agencies may be too new to fully unravel all of these dynamics and relationships. Even still, this commitment to incorporating all actors and interactions will be important for researchers who study the development and practices of the ARS.

5.4 Three Types of Decentralization

In the same book, Cole provides another useful framework for understanding center-periphery relations. He discusses three prisms through which to view decentralization. First, steering at a distance is reminiscent of the principal-agent model discussed earlier. In addition to allowing the State greater control over policy implementation, it gives the state the option of blame avoidance – passing off to lower levels of government responsibilities and functions it sees as political harmful. Both types of steering at a distance can be seen in recent years with regards to social policy. An internal memo circulated throughout the Prime Minister's office during the debate about Act II of decentralization specifically advocated devolving competencies in an area deemed to be "technically and socially the most difficult," (Cole, 2008). The high degree of ministerial control over both the ARS directors and the hospital directors almost seems to be a textbook example of steering at a distance as described by Cole.

Second, territorial capacity-building strengthens participatory modes of governing by building on and encouraging local expertise. It focuses on "multi-actor arenas engaged in multi-level and multi-sectoral dynamics,"(Cole, 2008). To some degree this is a version of the choice model that takes into account the whole range of interactions that shape center-periphery relations. Although this is arguably a useful way to explain the delivery of health care during the 80s and 90s, it seems less applicable now for all the reasons that steering from a distance seems particularly applicable.

The third model, identity construction, is the least helpful in terms of understanding the evolution of health policy. Cole calls this the weakest perspective anyway, suggesting that it relies on mobilization around identity politics that just is not present in France outside of a few areas such as Brittany, Alsace, Normandy, and Corsica and has not clear connection to health policy (Cole, 2008).

5.5 Summary

The purpose of this section was to superimpose my analysis of the three phases of health care in the Fifth Republic on to commonly used frameworks to identify which approach might be most useful for further analyzing intergovernmental relations in French health policy. It seems that steering at a distance might be the best way to conceptualize my argument about the beginnings of a new phase of post-decentralization. It is an approach which favors centralization, but allows room for a past, present, and future that includes various degrees of decentralization. This is an important consideration, as I am not arguing that the new phase of the Fifth Republic is a complete reprise of the first phase. The path dependent nature of most political institutions would not make such a reoccurrence likely even if it were desirable.

6. Conclusion

The history of the Fifth Republic has been marked by two distinct phases: 1) the buildup of the welfare state through centralization, and 2) the empowerment of local actors through decentralization. I have argued in this paper that 2009's health reform suggests that Le Galès and Pinson seem to be right in the case of health policy, that the Republic has entered a new phase notable for its re-centralization balanced by its acceptance of plurality. This is particularly evident in the creation of new regional health organizations with a strong leader directly named by the *Conseil de Ministres* (Prime Minister's Cabinet) and overseen by the Minister of Health. Although much of the rhetoric surrounding health reform has invoked decentralization, it actually serves to greatly empower the central government's ability to manage and implement its policies. In Cole's terms, it can now better "steer from the center,"(Cole, 2008). Ironically, one of the few checks provided on the ARS director's authority is the newly re-empowered prefect. Thus, the supposed *Préfets Sanitaires* face both vertical and horizontal oversight from Paris.

Throughout this paper I have mentioned a couple of caveats and limitations that bear repeating here. The first being that these reforms are so recent that many of the organizations and relationships they create are still in the process of actually being formed. As a result, it is impossible to know *a priori* which roles, actors, sectors, and interactions will emerge as the most influential. An important next step for researchers will be to track the development of these organizations and determine the degree to which they differ from their design. In particular, it will be interesting to follow the role of the Prefect as presiding over the supervisory council; the degree of autonomy experienced by ARS directors; and the interactions between Ministers, ARS directors, and hospital administrators at both public and private institutions.

The second limitation is that I have focused almost exclusively on health policy. To determine whether the Republic has really entered a new phase, it will be important to track the development of other policy domains. If decentralization is holding or increasing in these cases, then we know that health care is unique and not necessarily indicative of larger trends in governance. If the trends found in health policy appear consistent with larger trends in governance, a closer look at the application of the various theoretical models I discussed would be warranted. Although I have provided a brief introduction to these frameworks in order to show the ways in which my argument fits, or in which the models could be extended to include my argument, this exercise would need to be done in a formalized and more rigorous way that was beyond the scope of this paper.

Even though I find it unnecessary to start talking about the ushering in of a Sixth Republic, it is clear that the institutions and modes of governance found in France have shifted dramatically during the last 52 years. An important question that this paper raises is whether the health policymaking as really been re-centralized, and if this consolidation of re-centralized power will be unique to health care or felt more broadly.

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