

## Hierarchy, Management and Participation: Issue-related, Regional and Infra-regional Variation in the Hybridisation of Governance Models in Long-Term Care Policy

Hervé Hudebine<sup>1</sup>

### Introduction

As other European countries, France has experienced parallel processes of increased universalisation and of recentralisation of long-term care<sup>2</sup> policies (Theobald, Ozanne, 2016). Tensions affecting these policies not only proceed from potentially contradictory objectives (increased, qualitative and personalised cover in a context of fiscal restraint). They are also related to the fact that LTC governance implemented during the last decade amount to an apparently radical break-up with a history of bottom-up policy making (**section 1**).

The above mentioned recentralisation process has culminated in the 2009 Health, Patients, Hospital and Territories reform, whose main consequence regarding LTC policies is the transfer of a significant amount of planning, regulation and resources allocation powers to new Regional Health Agencies (RHAs). This reform purported to reinforce health democracy while preserving local government (départements) competencies with regard to social care. RHAs answer primarily to central government and national bodies, to which they are bound by performance agreements. However, RHAs were also conceived of as instruments contributing to the implementation of a general review of public policies (2007) aimed at cutting public spending. Considering the contradictory nature of the above mentioned objectives, the ambiguities and imprecisions characterising the new institutional framework set up in 2009 come as no surprise. The aim of this paper is to provide an analytical account of the governance of the tensions arising from the ambiguities and uncertainties contained in the institutional framework of long-term care policies. A key issue was the regional and local legitimisation of an institutional reform aimed at creating efficiency savings, while partially depriving local government and other local stakeholders from their powers or influence on the planning and regulation of LTC policies. A key hypothesis, inspired by the approach developed by Torfing and several other authors (Torfing, Triantafillou, 2013; Torfing et al., 2013), is that the management of the central tensions affecting of LTC policies at the regional and local levels involves varying combinations (or hybridisations) of hierarchical, managerial and participatory governance styles (**section 2**).

The last two sections of this paper are based on an empirical study of the regional and local governance of LTC policies conducted in three French regions. Their aim is to put to the test and to specify the above mentioned hypothesis. To this effect, the third section of this paper focuses the implementation of the 2009 reform until 2016, and on a consequence of the

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<sup>1</sup> Senior lecturer, social policy, Université de Bretagne Occidentale, LABERS, Brest, France.

<sup>2</sup> Long-term care can be defined as “a range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period of time on help with basic activities of daily living, such as bathing, dressing, getting in and out of bed or chair, moving around and using the bathroom. This personal care component is frequently provided in combination with help with basic medical services” (Ranci and Pavolini, 2013).

uncertainties and ambiguities contained in the new institutional framework. Namely, key LTC policies actors at the regional and local levels had to engage into a learning process involving the trial and adaptation of different governance styles combinations. One striking result is that governance styles vary according to the salience of the issues considered in the eyes of national decision makers, while the framing (or metagovernance) participatory governance (health democracy) involves the delimitation of its boundaries in accordance to national priorities and with a focus on non-financial issues (**section 3**).

In addition, the **4<sup>th</sup> section** of this paper aims to demonstrate that, although metagovernance rules apply to all the cases studied, they allow for infra-regional and regional variations in the dynamics of health democracy. It is possible to hypothesise that these variations are related to social, economic, demographic and geographical, local and regional contexts. However; they also proceed from regional policy inheritances, organisational and strategical choices made by key LTC policy actors.

Although one of the regional cases involves a more dialectical process in the shaping of metagovernance rules, the **conclusion** of this paper focuses on the limited inputs and impacts of regional and local participatory forums in the LTC field.

## **1. Central local tension within French social and long-term care policies: from bottom-up policy making to recentralisation?**

### **1.1. A history of bottom-up policy making**

French home, social and long term care policies are characterized by a history of bottom up policy making. This is especially true when considering policies aimed at disabled people. The implementation of the social care component of these policies has been devolved to local government (départements) in 2005. However, this devolution has been preceded by a history of local mobilisations dating back to the 1950s, where families of disabled people would come together, set up projects and request financial help from public authorities at the local (départements – equivalent to county councils) and national levels (Claveranne, 2012). Rather than a capture of public administration bodies by disability organizations, this amounted to a mutual colonization. However, with no expertise of their own, public authorities came to depend on regional centres created by disability organizations as far as data regarding disabled populations and their needs were concerned. In addition, political decision makers and senior civil servants were concerned about the appropriate use of public (and social insurance) money, and the compliance with regulations in disability care homes and settings. As a consequence, the 1975 health and social care laws entrusted the local field services of the department of health and social affairs (directions départementales des affaires sanitaires et sociales) with financial and regulatory powers over care home and settings. Regional commissions aimed at providing an overview of the populations needs and of the existing care and help services were also established. As these commissions lacked effective powers, the control of the health and social care sector in the disability field rested with the regional and (more crucially) with the local field services of the health and social affairs department. Civil servants working in these field services were still dependent on the expertise of the disability organisations. Such an interdependency translated into a propensity to control the sector on

the basis of informal arrangements with disability organisations, in a context where discretionary subsidies from parliament members and ministers, as well as creative accounting offered financial leeway.

Due to weaker local social mobilisations, the governance of the elderly care sector was historically more centralized. Local elected officials would nevertheless traditionally bypass the prefects and local field services of the state to reach powerful politicians combining local and national mandates (or ministerial positions) in order to speed up application processes or to obtain discretionary subsidies (Argoud, 1998). In any case, and as opposed to the disability sector, such a configuration did not typically allow for innovation and original initiatives. Whereas the financial and implementation processes could be accelerated, they had to comply with guidelines set up in national plans. The only few exceptions were local innovative projects, whose advocates benefited from a support within the health and social affairs administration at the national level (Guillemard, 1986). Although the 1982 decentralization only affected the field services of the state competencies with regard to social care and interventions (as opposed to health and old age insurance funding), such a reform meant that competencies regarding significant aspects of local elderly policies were transferred from field services of the state and the prefects to local government (namely the newly elected presidents of the “départements”). However, this new configuration accelerated the development of elderly care and help services, first in a quantitative manner and then in a qualitative (and innovative) manner from the mid-80s to the mid-90s (Argoud, 1998). Again, such a development rested on informal arrangements similar to those observed in the disability sector (as field services of the state were still entrusted with control powers over the funding and regulation of the health aspects of those services on behalf of sickness insurance). However, this time, informal arrangements involved local government and field services jointly processing funding applications and overseeing elderly care home and services when these services were jointly funded by the départements and sickness insurance. Similar causes producing similar effects, the above mentioned arrangement meant that gaining a view of the elderly population care needs and of the services supply at a regional level was not possible. While such a local, bottom up, elderly care policy style proved inflationary; imbalances in the regional distribution of elderly care home and services were also noticeable (Bauduret, 2013).

## **12. Parallel attempts at consolidating decentralisation and reasserting central control at the beginning of the 2000s**

By the end of the 90s, the consequences of the above mentioned arrangements and policy styles were proving less and less sustainable. During the first half the 2000s, several reforms or specific measures were enacted in order to tackle financial, planning and governance issues related to local elderly and then disability policies. However, one cannot help noticing schizophrenic tendencies in this reform agenda. Part of the measures taken translated into further decentralization, while others clearly reinforced the control powers of national authorities and agencies, albeit in a neo-managerial fashion, which contrasted quite sharply with the historically hierarchized French administrative model.

First, a series of laws and measures tended to reinforce the départements prerogatives in the social, home and long-term care sector. After several experiments and disappointing attempts,

the départements were definitely entrusted with the distribution of personal autonomy benefits (allocation personnalisée d'autonomie) aimed at the elderly (although field services continued to oversee services when sickness insurance funds were needed to provide long-term care). The 2002 social care and user rights law also included a measure reinforcing the départements competencies in the social, home and long-term care sector as the local plans whose elaboration they supervise became legally binding. The 2003 constitutional reform and the 2004 law aimed at clarifying and reinforcing decentralization by solving a difficult and vexed issue, namely the entanglement of competencies between the regional, local and municipal levels of government. Although the 2003 and 2004 laws are recorded in French administrative and political history as failures (Lafore, 2013), they amounted to a symbolic reaffirmation of local governments' competencies. The départements were billed as leaders ("chefs de file") of local social policies, but were entrusted with preciously little additional (legal) powers. Meanwhile, they were reminded that their power had to be exercised while being mindful of the competencies of other public and social stakeholders. In addition, successive public finances reforms were to narrow their budgetary autonomy and make them increasingly dependent on national government transfers. Finally the 2005 disability rights law transferred the powers regarding the implementation of disability policy (except for its healthcare components) to the départements.

In parallel with the enactment and the implementation of the above mentioned reforms, the issue of the sustainability of social and long-term care policies was gaining prominence as the take-up rate of the new personal autonomy benefit was greater than expected. From 2002 onwards, several laws and measures were clearly aimed at rebalancing the distribution of these services while ensuring that their cost remain within financial targets set at the national level. While giving a legally binding status to local social care plans, the 2002 law also set up regional committees made up of representatives of the various stakeholders (field services of the state, local government, voluntary and professional organisations, and service providers)<sup>3</sup>. Their remit was to gain a regional view of the populations needs and the existing service supply, but also to select services creation, extension or adaptation projects, so as to counteract the imbalances and inflationary tendencies produced by the informal arrangements prevailing at the local level. As these committees lacked the inducement and will to engage in the rationing of social care services (they tended to produce "wish lists to father Christmas"<sup>4</sup>), the policy response would come under the guise of the Independent Living Support Fund (Caisse Nationale de Solidarité pour l'Autonomie - CNSA) whose creation was sparked by the summer 2003 heat wave crisis. Just as the French Senate was intended to introduce amendments aimed at reducing the cost of the personal autonomy allowance for the départements, the increase of the mortality rate among the elderly during the heat wave acted as a reminder of the necessity to maintain, if not increase, the level of services for this population. Even though the initial governmental response was to blame families and closed ones for their lack of support, several inquiries were launched and the creation of the ILSF decided (Frinault, 2009).

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<sup>3</sup> Comités Régionaux d'Organisation Sociale et Médico-Sociale.

<sup>4</sup> Member on a Regional Health and Autonomy Agency interviewed in 2016.

This “fund” is misnamed, as it is, in fact and in purpose, a national agency whose resources stem from the collection of the contributions paid by employees working unpaid one day a year on the one hand and, on the other, from the proportion of the national sickness insurance fund that is devoted to long-term care. The setting up of the ILSF amounts in effect to a curtailing of the départements decision making powers in the field of elderly (and then, in 2005, the field of disability) policies in two respects. First, this Independent Living Support Fund is contracted by central government to rebalance the distribution of long-term care and autonomy services, while ensuring they keep within national budgetary targets. Such a change means that, when services aimed at the elderly and the disabled involve sickness insurance funding, the départements in effect lose their decision powers, whatever their priorities and budgets may be. Secondly, the ILSF is assigned the task to encourage and support innovative services and practices at the local level, which means that départements have to abide by the ILSF terms of references if they wish to receive additional resources. In other words, such a policy instrument enables the ILSF to steer the départements innovative policies while remaining at a distance, which contrasts with “old fashioned” centralized policies but is no less effective in a period of ever more stringent budgetary constraints (Argoud, 2008).

When apprehended in a long-term care perspective, the 2009 law analysed in the next section can be understood as the culmination of previous central government attempts at regaining control over the planning and regulation of long-term care services. However, as radical as it may appear, this reform reflects a double compromise between 1° competing health and long-term care planning and regulation paradigms and 2° recentralising and decentralising/democratising tendencies.

## **2. Fine-tuning central-local relations within the social and LTC policy field: the governance models hybridization hypothesis**

### **21. An ambiguous institutional framework**

Broadly speaking, the 2009 Hospital, Patient, Health and Territories reform combines social public health objectives (reducing geographical and social inequalities in health and access to care, to facilitate users and patients’ pathways within the system) with better governance and increased efficiency objectives. These are ambitious aims, whose achievement rests on a no less ambitious institutional and organisational reform.

To some extent, the Regional Health and Autonomy Agencies (RHAAs) follow the path laid out by the regional hospital care, and to a lesser extent health promotion and prevention policies that have been pursued from the mid-1990s onwards. Namely, the aim of the new institutional and organisational structure is to ensure that national policy and budgetary targets are met in time at the regional and local level. With regard to primary care, the implementation of national objectives rests on the utilization of incentive instruments, as imposing constraints on physicians paid on a fee basis is an unthinkable scenario in the historical and current French context. By contrast, the new top down hands-off centralized implementation management style applies to the long term and home care system, and is quite out of sync with the bottom-up policy making history of this sector. This is true even though

one might consider that the 2009 law allows for some integration of the inheritance of the decentralisation of elderly and social care policies in the 1980s and 1990s.

It would be possible to argue that the 2009 law is a French health and long term care policy expert dream come true ...at least, or if only, at the regional level. RHAAs are the result of the merger at the regional level of the former field services of the state competent in health and long-term care, the regional sickness insurance funds, public health and professional advisory bodies and forums. However, institutional and financial fragmentation remains the rule, both at the national level and at the local level. Although the directors receive their terms of references (including yearly targets) from the minister for health and social affairs, the activity of the RHAAs is overseen by a national steering committee made of representatives of the government (including the ministry of finance), the health and social central administrations, sickness insurance funds, and the relevant national agencies (such as the ILSF). Relations between national level bodies and the RHAAs are handled by the Social Ministries Secretariat, while the activity of the RHAAs is also monitored by the ministry of finance. The complexity of these institutional arrangements stems from the reluctance of the above mentioned national bodies when faced with the prospect of losing their prerogatives which, in turn, accounts for the failure to set up a national health agency. Institutional and financial fragmentation persist at the local level also, as the départements keep their decision making, planning and funding prerogatives with regard to social care and operate alongside the territorial offices of the RHAAs. The latter are responsible for the monitoring of LTC services when they benefit from sickness insurance funding.

One of the key institutional objectives of the RHAAs is to conduct the development of regional health and autonomy plans, which are thereafter further detailed into sectoral schemes (hospital and primary care, prevention, long-term care and autonomy) and sectoral programmes. The planning process is conducted by the RHAA executives in accordance with national guidelines, deadlines and financial targets, while taking into account the ILSF programme on the one hand, and the départements plans on the other. From a neo-institutionalist perspective (Mahoney, Thelen, 2010), one has to note that the law does not provide indications with regard to the mechanisms which could ensure that consistency between the RHAA plans, schemes and programmes, the ILSF programme and the départements is achieved.

Aside from the preservation of the départements prerogatives at the local level, the incorporation of the decentralization legacy is also apparent in the organization of the planning process, as is the “health democracy” inherited from previous public health groups and conferences. Namely, while conducting the planning process in accordance with national guidelines, the RHAA executives also have to take into account the opinions expressed within the regional health and autonomy conferences (RHAACs). These conferences consist of stakeholder representatives in the fields of health, prevention and long-term care policies (local government, professional and user organisations, associations and voluntary organisations). As we shall see in the last section of this paper, the RHAACs may also be consulted on matters regarding the territorial division of the RHAAs. Furthermore, specialized commissions, which also comprise representatives of the relevant stakeholders, provide the

RHAA executives with advice on issues pertaining to health care, prevention, long-term care and public policy. The aim of the public policy commission is to co-ordinate the stakeholders involved in the policy making and implementation process (local governments and representatives of the major services providers). Finally, depending on the RHAA executives' strategic choices, local territorial conferences may draw local health programmes according to the regional guidelines (plans), while taking into account the priorities of local stakeholders.

Although RHAA directors are accountable to their minister, they enjoy significant executive powers and autonomy in three respects. First, and this is quite new in the French political and administrative system, they enjoy considerable autonomy in the design of the internal organization and management of the RHAAs, including with regard to the autonomy devoted to the local offices of the agencies. The same applies to the design of the territorial division of the RHAAs, where the above mentioned local health programmes may be drawn up. Finally, as sophisticated as they may appear, the regional and local health democracy forums constitute in no way veto mechanisms, as their opinions are only consultative and may be overridden by the RHAA directors.

This institutional framework is characterized by ambiguities and imprecision with regard to governance styles (decentralization and health democracy versus hands off centralized government based on steering instruments). It also reflects the influence of competing paradigms concerning the development and control of the health and long term care supply (Pierru, 2012). On the one hand, the 2009 law reflects the influence of the health and social care administration senior civil servants, and of the experts who have long advocated a modernization of the Republican model (Jourdain, Bréchat, 2012), namely the French version of the social needs model (Bode, 2017). Such a model rests on the assumption that rigorous approaches and methods allow for a proper assessment of the populations' needs and of the care supply, which may in turn be used as a basis for a prioritization exercise achieved in a democratic and pluralistic manner (rational and democratic processes to produce rational and democratic outcomes). In addition, using epidemiologic and social sciences knowledge, these experts aim to take into account user and patient, trajectories and pathways, within the system. Such is the aim of the highly sophisticated and voluminous methodological guide they produced for use by the RHAAs personnel and their political, professional and nongovernmental partners during the planning process.

However, after 2007 and the election of Nicolas Sarkozy, the 2009 law and the RHAAs became part of a general review of public policy inspired by the Canadian and Swedish examples (Bezès, 2010). The aim was to reform the French public administration, governance and management style, so as to increase efficiency while maintaining quality and services outcomes. However, while the Canadian and Swedish reforms were preceded by prolonged audits, the French exercise was conducted by a few senior civil servants working on existing administrative reports and was rushed in a few weeks. The spirit of this wider reform was conveyed in the 2009 law by senior civil servants from the ministry of finance, and private sector consultants were also among the contributors to the draft. Their contributions were inspired by a policy paradigm, which contrasts with the above mentioned modernized Republican model, with a focus on public spending containment, a reliance on market or

quasi-market mechanisms, while insisting on the “free choice” of users. Critiques argue that such an approach translates into swift and indiscriminate rationing of public resources without preliminary prioritization. “Free choice” applies only to those users and patients with enough resources to top up public provision, which is shrinking as public resources are more and more thinly spread on a vast and indiscriminate array of services and allowances (Argoud, 2009).

As a consequence, while the 2009 law exhibits the influence of the modernized Republican model (under the guise of the health democracy and planning mechanisms), it also reflects the influence of this alternative, “neo-managerial”, swift rationing model, which is apparent in two respects. First, although, as already mentioned, RHAA directors and executives enjoy a significant organisational and managerial autonomy; they have little room for manoeuvre regarding the compliance with national objectives, deadlines and budgetary targets. Those are not imposed upon them in a classical, centralizing, Weberian bureaucratic manner, but rather through the deployment of hands-off (at a distance) steering instruments from the top, e.g. contracts which set objectives, performance agreements, monitoring and reporting tools. Secondly, the modernized Republican model is combined with the introduction of quasi market mechanisms, namely priorities detailed in regional sectoral programmes (e.g. in long-term care) may lead to calls for tender for new or innovative services.

Preceding considerations indicate that, despite their radical appearance, the 2009 law and the setting up of the new RHAs constitute only a partial reform insofar as integration is only achieved at the regional level, while tendencies to institutional and financial fragmentation tend to reproduce rather than being curbed. In addition, the new institutional framework is characterized by imprecision and uncertainties (with regard to the articulation of the different planning levels) and also by ambiguities. This is the case whether one considers the policy paradigms underpinning the new institutional framework (modernized Republican-social needs model versus market inspired, free choice and neo-managerial model) or governance related issues (health democracy and decentralization versus top down steering and discretionary powers of the regional executives).

The last two sections of this paper will focus on the governance of the tensions arising from the ambiguities and uncertainties contained in the institutional framework. Examples will include the lack of indications regarding the combination of national LTC funding programmes, regional and local social and LTC schemes, or the discrepancy between the imperative nature of centrally imposed priorities and budgetary targets on the one hand, and the advisory character of the decisions made in health democracy forums on the other. Considering the organisational and operational margins granted to RHAA executives, it is possible to infer variations regarding the governance of the above mentioned tensions.

In order to characterise these variations it is proposed to rely on the approach developed by Torfing and Triantafillou (2013), which focuses to the evolution of governance styles in modern democracies. One of the merits of this conceptual framework is that it enables both to capture and to provide an analytical account of the a priori confusing combination of centralist, neo-managerial and more democratic components contained in the institutional

framework of social and LTC policies at the regional and local levels. Such an approach could not only enable to address a puzzling question in France, namely, how to characterise the governance of social and LTC policies after the implementation of the 2009 law, but also to address it in a fashion that makes comparison with other European countries possible.

## **22. The governance model hybridization hypothesis**

Relying on an extensive literature review, Torfing and Triantafillou (2013) distinguish between three governance models or types. The classical public administration type is derived from the Weberian model where civil servants comply with hierarchical (and ultimately political) orders, implementing established rules and procedures, and also basing their work on the best possible technical expertise. Two further types come under the guise of interactive governance (see also, Torfing et al., 2013).

The new public management governance model is characterised by the search for increased efficiency. Policy implementation is steered “at a distance”, with governments relying on instruments/tools such as competitive tendering, performance agreements, benchmarking, quality assurance based on customers choice and satisfaction. Analysts such as Bezès (2017) point to different versions and tensions or contradiction existing within the NPM model. One version originates from the public choice critique of public bureaucracies deemed self-serving and too autonomous from elected politicians. A “social-democratic” version of NPM is based on the premise that, once they have been assigned targets by elected politicians, civil servants (and also private and third sector providers) should be granted operational autonomy to achieve them. In both cases, evaluation processes enable to assess the achievement of the assigned targets.

The third type or model underlined by Torfing and Triantafillou (2013) is New Public Governance. NPG refers to participatory and more collaborative forms of governing, which involve the empowerment of stakeholders such as users/citizens, professionals, third sector and voluntary organisation, as well as other local actors (see also Osborne, 2010). The aim of the NPM model is to achieve efficiency through the introduction of competition and market or quasi-market mechanisms. The NPG model is deemed to be favourable to policy innovation, to the development of better responses to existing needs or responses to new or unmet needs, based on pluralism and cooperation. The virtues attributed to the NPG model are therefore similar to those attributed to participatory democracy mechanisms (Blondieaux, 2008; Mazeaud et al. 2012).

Torfing and Triantafillou’s analytical framework is based on Easton’s political and administrative system model and will be used here to analyse the French sub-central LTC policy system (see table p. 10). As evidenced in the first section of this paper with regard to social and LTC policies, Torfing and Triantafillou contend that “new” governance models (i.e. NPG) do not replace older ones (i.e. APC and NPM). Rather, one is likely to observe a superimposition and hybridisation of these governance models or types. To illustrate this point, RHAA directors have been nicknamed “health prefects” (Palier, 2015) while the state council (the highest public law jurisdiction in France) has confirmed that they are hierarchically submitted to the secretary of state for health and social affairs, which points to

the survival of the classical public administration model. However, RHAA executives are bound to the government (ministry for health and social affairs) by performance agreements (NPM) while having to consult and consider the advice of the regional health and autonomy conferences (NPG).

The results presented in this paper are based on a study conducted in two (2013-15) and then three French regions (2015-17), with a focus on two départements in each region. 90 semi-structured interviews have been conducted with political, administrative, professional and third sector decision makers, as well as with user representatives. Methods used also involved documentary analyses and participatory observations (local forums, working groups, and training of user representatives). The research focused on the first phase of the implementation of the 2009 law (2010-2016).

Hypotheses regarding the hybridisation of the governance and the management of central local (and other, associated) tensions in the social and LTC field will be considered in two steps. First, the third section of this paper focuses on the consequences of the ambiguities and uncertainties contained in the new institutional framework, namely on the engagement of social and LTC policy actors will in a trial and error learning process with regard to the management of tensions. This process results in the learning/construction of governance rules that vary according to the social and LTC sub-sector or issues considered, and broadly apply to the three regions considered. Broadly speaking, these rules amount to a confinement or delimitation of the social and LTC policies issues that can be managed according to principles approaching the NPG model. However, as shall be seen in the fourth section of this paper, the dynamics of NPG (“health democracy” in this case) may vary according to the regions considered.

The political systems of CPA, NPM, and NPG (Torfing and Triantafillou, 2013)

	Input	Withinput	Output	Feedback
Classical Public Administration	Voting and pressure groups	Bureaucracy: public, based on professional standards	Authoritative rule based regulation and supply-driven services aiming to ensure equity	Periodic elections and constitutional accountability
New Public Management	Voting Users/customers choice and satisfaction	Strategic performance management and quasi-markets: public vs. private	Deregulation and demand-driven services aiming to ensure efficiency and user satisfaction	Performance measurement and sanctions through competition
New Public Governance	Voting Arenas for <i>empowered participation</i> bringing together public and private actors in continued dialogue	<i>Collaboration</i> between different levels, sectors, and actors: public plus private	<i>New tools</i> empowering and engaging stakeholders in public problem solving and service production	<i>Multiple forms of Accountability</i> based on a variety of standards attuned to organizational learning

### **3. Trial and error learning and the emergence of sub-sectoral variations in the hybridisation of governance models in the social and LTC field**

Central-local tensions in the social and LTC field can be analysed as resulting from a multidimensional rescaling involving planning and resources distribution with regard to social and LTC (Giraud, 2015). Tensions are both related to, and exacerbated by, the parallel reinforcement of budgetary constraints on the one hand and, on the other, national guidelines, for instance with regard to the quality and the personalisation of care (i.e. making care pathways more fluid and geared to the needs and wishes of individuals). Such guidelines also specify the type of services that should be provided. In this section, we provide first an analysis of the planning process, and then of the resources allocation process during the 2011-2016 period. With regard to the management of central-local tensions this period can be considered as a trial and error (social and institutional) learning phase (Grin, Loeber, 2006) involving the experimentation of various combinations of governance styles. The end result is a framing of “health democracy”, in other words the demarcation of the limited boundaries within which NPG rules can apply. The focus of this section is on common features or trends observed in the three regions that were studied. Regional and infra-regional variations in the dynamics of health democracy will be considered in the next (fourth) section.

#### **3.1. Social and LTC planning**

As mentioned in the first section of this paper, one of the key objectives initially assigned to the RHAA executives is to develop Regional and Health Autonomy plans including three

sectoral schemes (health care, prevention, social and long-term care), which are further detailed in programmes quantifying the services available and specifying resources allocation. When driving this process, RHAA executives act initially as regional health and LTC policies brokers, attempting to combine national priorities and those of regional and local stakeholders, to reach a compromise. In order to do so, RHAA executives and agents also endeavour to implement methods derived from the social needs model, i.e. based on a rational and pluralistic evaluation of social needs. Such a strategy is akin to a NPG governance style, insofar as RHAA executives and agents take on board advices formulated within the Regional Health and Autonomy Conferences with a view to enhancing their (democratic) legitimacy.

One case in point is the delimitation of health territories. In the first region studied, the RHAA executive option was to divide the region into four health territories that would have been coterminous with the départements, with a view to facilitate the coordination between health services on the one hand and, on the other, social and LTC services whose responsibility lies essentially, or is shared, with the conseils départementaux. As 65% of the members of the Regional Health and Autonomy Conference (RHAAC) were favouring an 8 territories option (i.e. in keeping with the former regional hospital agency territorial organisation), the RHAA executive bowed to this advice. As explained by the RHAA social and LTC director at the time, “this was the first decision of the executive director. He therefore decided not to oppose the RHAAC advice whereas he [legally] could have done, as this was just an advice”. A similar rationale prevailed in the second region, albeit with very different results in terms of territorial organisation (two health territories comprising of two départements each). Whereas the RHAA executive advocated the “coterminosity” solution, the decision was to accept the advice of the HATC in the name of “democracy” (member of the RHAA executive). In the third region, the “coterminosity” solution was an object of consensus between the RHAA executive and the health and autonomy regional conference.

Similar democratic intents were apparent at the beginning of the planning process, which involved high stakes with regard to the legitimacy of the RHAAs, since policy and services priorities outlined in regional health and LTC schemes (and more detailed programmes) were meant to pave the way for future calls for tender and for project proposals. As already mentioned, legal authorisation and funding for the creation, adaptation or extension of LTC services cannot (as before 2009) result from pressures exerted, or negotiations conducted, at the local (départements) level between local stakeholders, local government social services and field services of the state social and health administration. Rather, services creation, extension or adaptation are meant to result from a more top-down process, involving responses to calls for tender or projects, fitting pre-established priorities in the social (départements) and LTC (RHAA) schemes. Justification for this new configuration rests on two types of arguments. The first one is a more rational response to social needs, with a view to ensure that the evolution of services respond to rigorously assessed social needs and is more egalitarian. In other words, the evolution of social and LTC services should not depend on the strength of local pressures and social mobilisations (as unsatisfied needs may exist in areas where no such pressures are exerted). However, another aim is also to increase efficiency and to ensure that regional spending limits with regard to social and LTC spending

are adhered to. To quote one RHAA executive member, service providers, and to some extent local government officials, must understand that, from this moment onwards, “this is the end of the Christmas list with regard to social and LTC services”. In a very classical fashion, NPM and competitive tendering processes may also serve public resources rationing purposes. Hence the significance of the organisation of the planning process, where the acceptance of (or non-opposition to) stringent spending limits may depend on the perceived rationality, pluralism and quality of the exercise.

To this effect, the 2009 law and ILSF methodological guide indicated that a two year concertation period was to allow for the production and analysis of data, with a view to assess and to prioritise social needs at the regional levels. This methodological guide constituted in effect a detailed translation of the modernised French republican (social needs) planning model. As such it included a rational component (rigorous production and analysis of demographic, social, epidemiological and services data), but also a pluralistic component as the prioritisation was to be discussed with the regional health and autonomy conference (RHAAC), which would in turn produce a detailed advice. Such a process fits aspects of the NPG model, even though the advice of the RHAACs does not bind the RHAA executives.

However, the planning process also features characteristics that are close to the NPM model, as the RHAAs must comply with priorities, deadlines and targets set at the national level by the ministry for health and social affairs and also by the members of the national steering committee. Finally, unwritten rules inherited from the French classical (and centralised) public administration model also guide the planning process. National priorities, deadlines and targets must be met, but without creating social and political tensions at the regional and local levels. In this respect, the political (ministerial) expectations placed on the shoulders of the RHAA directors do not differ from those that are placed on the prefects.

Such considerations motivated the choices of RHAA executives to go beyond the requirements of the law and the methodological guidelines with regard to the democratization of the planning process. This was the case in two of the three regions studied where professional concertation bodies or regional technical committees that were not stipulated by the 2009 law were created. The aim was to allow for the contribution of a diversity of stakeholders in the planning process, under the guise of needs assessment reports, proposals and criticism. During the initial phase (2010-11), delays in the enactment of national planning priorities made it possible for RHAA agents and executives to consider (or to appear as considering) the priorities advocated by stakeholders. In addition, RHAA executives interpreted the lack of guidelines regarding the combination of the ILSF social and LTC resources allocation programme as meaning that regional funding programmes would logically derive from regional schemes.

National decisions made in mid-2011 proved the RHAAs wrong on both counts. Faced with the late enactment of national regional planning guidelines, most RHAAs chose to finalise the planning process according to initial regional choices. This was both because re-enacting the process would prove too cumbersome and technically impossible, and also because the deadlines imposed by the social and health ministries were an absolute imperative. In this case

complying with hierarchically imposed national deadlines was deemed more important than conforming with national planning priorities guidelines. In addition, even though they were legally binding, regional plans and schemes did not carry financial commitments, as the implementation of priorities and objectives is subjected to the availability of public resources.

However, ministerial and ILSF decisions regarding the precedence of the national LTC funding programme carried more significant consequences, both from the point of view of the actors involved, and with regard to the characterisation of the new regional and local social and LTC policies governance regime. First, the decision to uphold the ILSF national LTC resources allocation programmes was viewed by stakeholder representatives as emptying the planning process of its rational and democratic (NPG) meaning. Given the tight deadlines allocated to the planning process, voluntary organisations, services providers, users and local government representatives already had the feeling that they had been rushed into producing detailed services and needs assessment. In addition, RHAs lacked the human resources and the time to process the data and reports produced by the stakeholders. The latter were therefore under the impression that few of the data they had produced, and the proposals they had made were to be found in the regional social and LTC schemes. This was especially the case within the disability sector, where the planning process was hampered by the lack of comprehensive and reliable data, both with regard to demographics and to existing services.

Imposing the ILSF LTC funding programme was perceived as depriving the work carried out and the debates conducted during the planning process from any meaningful consequences. Pointedly, such a decision emphasized one of the key dimensions of the framing (or delimitation of the scope) of new public governance in the LTC and health sectors at the regional level. Namely, consultation (not to mention participation) stops where significant amounts of public resources are involved. Another aspect is, as shall be seen in the next point, the selection of the issues to be discussed, which had to overlap with regional or national priorities.

### **33. Framing “health democracy”**

As shall be seen in the last section of this paper, the dynamics of health and LTC democracy may vary according to the regional and even the infra-regional units considered. However, the study conducted in three regions tends to demonstrate that common “rules” apply, that tend to frame and limit the scope, as well as guide health democracy. A first set of (formal) rules limiting the scope of health democracy is enshrined in the 2009 law, and appears to create an asymmetry between hierarchical and neo-managerial powers on the one hand, and participatory powers on the other. It will be seen that this asymmetry also affects local representative democracy under the guise of local government. As already alluded to, RHA executives are hierarchically submitted to their ministerial bosses, who may dismiss executive directors without having to provide justification. Such hierarchical powers may be used to sanction a failure to meet strategic targets, deadlines or financial objectives. No such sanctions exist in the case where the advice produced by the health democracy forums is not taken into account, since regional and local conferences are only advisory bodies.

Aside from this formal rules, but connected to them, exist managerial and informal rules. Managerial and financial rules must first and foremost be considered as their bearing is highly significant. Not only did the imposition of the ILSF funding programme severely limit the effective scope of the planning process, it also severely curtailed the strategic margins of the RHAAs with regard to the regional implementation of LTC policy. The autonomous financial margin of the RHAAs amounts to at best 2% of the budgets they have to manage and consists mainly of the Regional Intervention Funds, which may be complemented by the (limited) budget surpluses of individual services. RHAAs have precious little room for manoeuvre in the allocation of LTC services resources, which they carry out on behalf the ILSF. The latter allocates funds on a regional basis, according to a set of demographic and socio-economic criteria, which are modulated according to service equipment rates in order to reduce regional and infra-regional disparities. Spreadsheets transmitted to the RHAAs indicate the type and tariff of the services, with little possibility to adjust the allocation of funds according to local needs or choices, as they could be formulated by stakeholders, services providers or départements. RHAAs and their services are bound by a contract specifying objectives to the ILSF, which is itself bound to the government by a similar contract, and closely monitored by the French national audit office (Cour des comptes). Such a trickle down approach to performance agreements makes for powerful instruments, enabling a close steering and monitoring of the regional agents who are in charge of the implementation of the ILSF LTC resources allocation formula.

While the LTC democracy input appears negligible when compared to this neo-managerial dynamic, one could argue that the influence of local representative democracy, under the guise of départements, is only partly superior. Départements admittedly co-fund LTC, which depend on their resources as far as the social care and social assistance components of the services are considered. Such an interdependency situation could place them in reasonable negotiating positions, had their own resources not been curtailed by the shrinking of their fiscal base (for which they depend only on one local stamp duty tax), while central-local transfers are at best in line with inflation. In other words, départements may refuse to co-fund LTC services according to the ILSF programme. However, this would mean that they would be starved from additional funding with regard to LTC, as very little alternative sources are available. It is therefore not surprising that one of the debates agitating French public law, local government and social policy experts touches the effective status of the départements: still genuine (decentralised) local government or social and LTC services operator?

Preceding developments may appear exceedingly technical and dry. However, they are necessary if one is to understand the, often informal and unwritten, rules that govern the framing of LTC democracy. One key public policy and administrative language word in this respect is “animation”. Its original meaning is rooted in the history of the French post-revolution state, and further evolutions are related to developments in cultural, youth policy and urban regeneration with a final (for now) transplantation in the health and LTC field. A literal translation for the term “Etat animateur” is almost impossible to find, although “organising” or “organiser” state might come close. A classical explanation would rely on the long-term consequences of the abolition of corporations during the French revolution, which,

in a Tocquevillian perspective, is at the root of the weakness of civil society in France. However, brokers and intermediaries are necessary to organise society and, as citizens will not mobilise to organise it (at least not in appropriate fashions), it is up to the state and its agents, which embody a general or public interest, to carry out this essential task.

Although rooted in historical knowledge, such a storytelling ignores numerous instances of social mobilisation (of which the development of disability services in post-war France is only one example – Claveranne et al., 2012). However, this storytelling constitutes a part of the Republican public service ethos, even if it is now blended with an efficiency imperative. Within the cultural and youth sector, “animation” policies aimed both to mobilise and to educate populations. However, the underlying meaning acquired by “animation” in the urban regeneration field according to Donzelot and Estèbe (1993) is of particular interest when considering health and LTC policies, and their democratic component. In the 1980s French urban deprived area context, social “animation” policies aimed at mobilising underprivileged populations affected by social and territorial exclusion, while guiding them towards practical and achievable objectives (engaging in social, subsidised activities), that is, objectives distant from revolutionary expectations, and compatible with supply side policies.

Such an analysis chimes with the discourse of RHAA agents in charge of territorial “animation” when they describe their brief. Their first mission is to mobilise stakeholder (users, service providers, professional organisations, and local government officials) in order to literally “enliven” health and LTC democracy ...and to keep it so. In practice, this “animation” brief is directed towards territorial health conferences, but also concerns the implementation of contractual instruments, such as local health contracts signed between the RHAAs, local government, and possibly voluntary and professional organisations in order to develop health promotion and prevention initiatives. Beyond recruiting voluntary and professional organisation stakeholders, user representatives, as well as local elected public officials, a significant share of the activity of these territorial “animateurs” is to train them, and also to steer and guide their initiatives once they are involved. The training component applies especially to user representatives, but other stakeholders may equally require an initiation to the intricacies of health and LTC governance and regulation, and also to the technicalities of health promotion and prevention, as well as LTC. With regard to user representatives, health democracy training was funded by the RHAAs’ Regional Intervention Funds. Beyond improving the knowledge of the health and LTC system, the aim was to educate users to the Republican spirit of health democracy. Namely, they should understand and accept that, when they operate in regional health and autonomy forums, they do not speak for themselves, not even for those affected by similar health and autonomy issues, but for users and patients as a whole.

Although these conferences may be considered as belonging to the NPG component of the regional and local health and LTC sub-systems, the recruitment and organisation of user (and other stakeholder) representatives harks back to the neo-corporatist arrangements governing the relations between the state and civil society in the French classical public administration model (Jobert, Muller, 1987). For instance, the rise of patients and health services users as recognised and accepted actors within the health system dates back to the mid-80s and the

HIV crisis. Although the first militants of the fight against aids were characterised by strong social and cultural backgrounds, the development of user and patient organisations was steered and guided by medical professionals (Letourmy, Naïditch, 2009). In addition, only patients and user representatives belonging to an association recognised both by the national health services user umbrella organisation (Collectif Interassociatif sur la Santé until 2016) and the state may be recruited, and attend the regional and territorial health and autonomy conferences.

To some extent, health and autonomy democracy at the regional and infra-regional level seems to function along lines inherited from the French neo-corporatist tradition, while the philosophy of territorial “animation”, as explained by RHAA managers and agents, brings to mind the hypothesis developed by Donzelot and Estebe with regard to urban regeneration policy in the 1980s and 90s. Once they have recruited stakeholder representatives (not always an easy task as shall be seen in section 4), RHAA agents have to maintain their involvement in order to “keep health democracy alive”, but they must also steer and guide their activity. This amounts to an exercise in “metagovernance” i.e. a “reflexive, strategic, and inherently political mode of governance that aims to sponsor and frame interactive policy processes, bring actors together, facilitate collaboration, mediate conflict, support decision making, and ensure implementation of negotiated solutions” (Torfing, Triantafillou, 2013). In this respect, hierarchical rules and neo-managerial targets impose limits on the health and autonomy issues that may be discussed, and on the priorities that may be included in local health contracts.

RHAA executives and agents must therefore convey two types of criteria when steering debates or negotiating local health contract. Firstly, issues and priorities discussed should be compatible with the RHAA priorities, which themselves are derived from national guidelines (e.g. preventing chronic illnesses, improving access to care for elderly and disabled people). Secondly, above mentioned issues and priorities should not involve additional spending. When interviewed, both RHAA agents and executive members underlined their ability (and to some extent obligation) to select the issues and priorities likely to be debated in health and autonomy conferences and/or included in local health contracts. Advice regarding the creation or extensions of LTC services was likely not to be considered by RHAA executives. Agents in charge of the negotiation of local health contracts had to explain to stakeholders (including local elected public officials) that priorities of this type may not be usefully included in local health contracts, as they may involve additional funding, which could not be provided by the RHAA within the framework of local health contracts. In effect, little resources were devoted to local health contracts, aside from the provision of support during the territorial health and LTC needs assessment phase, and for co-ordination activities during the first year. In addition, and as already mentioned, resource allocation with regard to the health care components of LTC services depend ultimately on the ILSF funding programme.

The new institutional configuration set up for French LTC policies 2009 was ambiguous in two respects, with regard to the paradigms guiding services planning (rational and pluralist social needs model versus swift neo-managerial rationing) and with regard to the governance style combining the APC, NPM and NPG models. The implementation of the reform was also a trial and error, learning process. Namely, between 2009 and 2011, most RHAA executives

attempted to implement the pluralistic and rational services planning approach, while going beyond the requirements of the law when consulting and taking the advice of stakeholders. However, it quickly became apparent that the weight of deadlines and financial targets, imposed in a heavily hierarchical and centralised manner, meant that they had to shift their approaches and strategies in two respects: conforming financial targets (i.e. to the ILSF resources allocation instruments) while framing (i.e. limiting the scope) of health democracy (Hudebine et al., 2015).

Preceding observations may lead to the conclusion that health and LTC democracy in France is a futile exercise. Such an assessment could be relevant when considering that one of the criteria for an effective participative democracy is that deliberations, debates and concertation may have an impact on resources allocation (Blondieaux, 2008; Mazeaud et al. 2012). Aside from the funding of working groups or training sessions, few occurrences of direct and observable influence of the health democracy forums have been observed in the three regions studied. One of these instances concerned the situation of informal and family helpers having to care for elderly or disabled parents. Improving access to health care for mentally disabled people and people with learning difficulties figured among other issues pushed forwards in health and autonomy conferences, and also within départements participatory forums. However, it is difficult to assert a specific impact of the regional and local participatory forums in this respect. Ensuing decisions made for improving this problem (among which, health professionals training, as well as the adaptation of information and communication material) also responded to a national mobilisation endorsed by the ministry for health and social affairs.

The likeliest or most significant impact of new public governance may be on organisational and professional cultures in public organisations (Torfing J., Triantafillou P., 2013; Torfing et al., 2013) as shall be seen in the fourth section of this paper. However, the documentary analyses, observations and interviews point to the relevance of culture as a contributing factor among others, when trying to account for inter and infra-regional variations with regard to the hybridisation of LTC of governance styles, and also with regard to metagovernance. As pointed out by Torfing and Triantafillou (2013), the challenge for public actors steering the implementation of policies combining participatory and neo-managerial components “is to shape and influence interactive governance without reverting to traditional forms of command and control”. In this respects, metagovernance “results” vary greatly according to the regional and infra-regional units considered. As shall be seen in the next section, such results may be related to strategic (and indeed political) choices made by RHAAs executives and, to some extent, agents in charge of territorial “animation”. However, they are also (regional and infra-regional) context-dependent.

#### **4. Regional variations in the dynamics of health democracy**

The formula “dynamics of health democracy” is here meant to encompass aspects that have already been mentioned in this paper, among which the vitality of health and the metagovernance style of democracy forums. This section relies on a preliminary study of the data collected. A sketch, rather than an analysis, of the regional variations observed when focusing on the dynamics of health democracy, with a focus on two (related) aspects, namely

variations, 1° in the territorial “animation” and 2° in the regional metagovernance of health democracy.

#### **41. Regional variations in the territorial “animation” of health democracy**

As already mentioned, the recruitment of stakeholder representatives functions along neo-corporatist lines, i.e. members of the health democracy forums have to be recruited among professional, voluntary, user and services providers organisations that are deemed as representative from a regulatory perspective. No data regarding membership of the various organisations involved at the regional level was immediately available (hence the above mentioned need for further analysis and research). However, when interviewed, RHAA agents in charge of the “animation” of health democracy forums reported difficulties that varied, to an extent, according to the region considered.

In the first region studied, difficulties were experienced when recruiting health forum members, especially user representatives, both at the regional level and at the local level. As a consequence stakeholder representative cumulating two or three representative mandates were not a rare occurrence. Faced with multiple requests from the RHAA requiring their involvement in several committees, commissions, conferences and working groups (if only to meet legal obligation), active user representatives often felt overwhelmed, and sometimes compared their schedule to that of a senior executive. Similar difficulties were encountered in the second region, albeit they were confined to the local (territorial health conferences) level. Such was less the case in the third region studied, even though recruiting stakeholder representatives still required specific efforts on behalf of RHAA agents. A common feature was that stakeholder representatives may hold mandate in several health democracy and départements participatory forums, with such a phenomenon being more pronounced in the case of the first region. Finally (and this is also a common feature), middle-class and/or former trade-unionists were over-represented of (i.e. more than 90%) among user representatives.

Observations reported by RHAA agents and stakeholder representatives interviewed in the first region studied incite to formulate a hypothesis to be further explored regarding the factors to which such variations could be ascribed. The first region, where the difficulties in recruiting stakeholder representatives were the greatest is affected by a pronounced demographic and socio-economic decline. One may infer that such factors could have an impact on the dynamism of voluntary organisations and civil society. Conversely, the third region studied is characterised by a history of strong social mobilisations on economic, social, regional identity and environmental issues. An observation may serve to illustrate this latter point, although it is related to départements rather than to health democracy forums. For département agents in the third region, one of the problems encountered when organising stakeholder participation in the social planning process is not the dearth of volunteers, but the opposite. Namely, départements agents are faced with an excess of applications to attend the working groups set up with a view to, as an example, assess the implementation of disability and old age social care plans and to develop future priorities. In this case, the issue is less “animation” than the rationing of participation in order to keep it manageable (e.g. one

stakeholder may only attend one working group and, if so, won't be able to be a member of the social care plan steering committee).

Preceding observations contrast sharply with the difficulties reported by RHAA agents working at the local (territorial health conferences) level regarding the “animation” of health democracy in the first two regions. Mobilising user representatives to attend territorial conferences meeting in the first region proved a difficult task and attendance representatives to territorial health conference meetings was therefore low, but this problem was not confined to this category of stakeholders and affected other categories of stakeholder representatives. Such was the case of elected local public officials, RHAA agents attributing their low involvement to a lack of interest in the elderly population and to long-term care issues, which they first and foremost viewed as a source of cost for local public finances. Low attendance of stakeholders was also related to choices made by the regional health and autonomy agency and conference with regard to the territorial delimitation of the local health conferences (i.e. made of two départements). The consequences of such a territorial configuration was that issues discussed within local health and autonomy conferences were not markedly different from those discussed in the regional health and autonomy conference. This would account for the loss of interest of a significant number of their members, who stopped attending which, in turn, led to frequent cancellations of the local conference meetings as the legal quorum was not met.

Whereas territorial conferences were coterminous with départements, similar difficulties were encountered by RHAA agents in one département of the second region studied. Issues were quite different in the second département studied in this region. Whereas the first département studied is a densely populated area, the second one is a rural, mountainous, sparsely populated one. Recruiting stakeholder representatives in the latter département was not issue, as voluntary, provider and professional organisations traditionally rely on social mobilisation and lobbying to form coalitions and to convey their specific situation and needs in the distant (200 km) regional capital. However, low density also means that stakeholder representatives cumulate mandates in the territorial health conferences and département participatory forums. Such a history of local social mobilisation and coalition forming also meant that framing the territorial health conference debates according to RHAA priorities proved a difficult task.

Mirroring preceding remarks about the success of départements participatory planning forums, territorial health conferences were much more active in the third region. Stakeholder attendance was never an issue and several working groups proved very active, debating and making proposals about issues such as the situation of informal and family helpers caring for disabled and elderly people. Experiments were also conducted to develop the specifications of a geriatric network in a participatory fashion. Although the latter initiative did not come to fruition due to the tight deadlines imposed the RHAA headquarters, the first one was welcome by the RHAA executive, resulting in the informal and family helpers issue gaining a higher profile in the regional LTC policy.

Such dynamics may be ascribed to an already mentioned regional history of social mobilisation. However, they are also related to choices made by the RHAA executive and to a

regional health policy history. Territorial health conferences were preceded by local health conferences placed under the auspices of the former regional health authority. In this region, local health conferences benefited from an organisational, methodological support provided by co-ordinators, whose post were funded by the regional health agency. The choice made by the RHAA was to maintain this support and to extend the remit of the co-ordinators to long-term care. While territorial health conferences did not meet what is considered as a crucial criteria regarding participatory democracy (namely, having at least a partial say on budgetary matters), they satisfied another one, namely being granted with resources devoted to co-ordination, organisation, methodological and technical support.

#### **42. Regional variations in the metagovernance of health democracy**

In order to gain a better understanding of the dynamics of local health democracy that have been analysed in the previous paragraphs, it is also necessary to consider regional variations with regard to the framing (metagovernance) of health democracy. Regional metagovernance (and health democracy framing) styles may be understood as resulting from the weight of centrally imposed target and budget priorities on the one hand, and from the strategical choices made by RHAA executives on the other. However regional social and political dynamics may also come into play, and have an impact on the evolution of the institutional configuration of health and long-term care policies.

Such an approach could enable to characterise the dynamics of health democracy in the three regions studied. **In the first region, metagovernance/framing of health democracy was guided by national targets and regulatory obligations with regard the consultation of stakeholders**, which might be considered as a challenge for the RHAA agents considering the above mentioned recruitment and mobilisation difficulties. In this case, stakeholders representatives were often required to provide needs or information assessments (e.g. with regard to disabled people access to health care) and to contribute to the implementation of the ensuing recommendations (e.g. improving user and patient access to information and to their rights).

Compliance with national targets and regulatory obligations is also a component of the metagovernance of health democracy in the two other regions. However, these cases also illustrated the ability of local and regional actors to influence if not construct institutional rules while implementing (i.e. appropriating, adapting, complementing) them. **In the second region, what could be termed a creative implementation of institutional rules regarding health democracy was mainly a (regional) top-down process**, while, **in the third one, it was also a top-down process involving negotiations and mutual adjustments between the RHAA executive and the health democracy (and also local government) leaders.**

In the second region, RHAA agents initially displayed wariness as to what should be the power and influence of health democracy forums. The co-optation of a retired health administration senior civil servant (former executive director of the regional hospital agency) to preside the regional health and autonomy conference might be understood in this light. However, difficulties encountered in the “animation” of health democracy led to a search for more proactive stakeholder representatives, i.e. able to effectively contribute to the

implementation of national targets and regulatory obligations, and to attempts to “force” them to take initiatives.

From 2015 onwards, the RHAA executive chose to mobilise the health and autonomy conference to tackle a complex issue, namely the planning and development multiple services and inter-disciplinary networks network, with the aim to allow for personalised user and patient, help and health care pathways. To this effect, thematic commissions involving both RHAA and regional health and autonomy conferences members were created, while the RHAA set up a series of events where patients and users would present their help and care experience before audiences comprised of stakeholders and RHAA members. The aim was to “open the mind” of RHAA agents and to encourage mutual understanding, in order to facilitate networking and joint networking, notably with the framework of working groups dedicated to health and care pathways.

In this case, top-down “animation” of health democracy, which included the staging of user and patient experiences, appears conceived of (by the RHAA executive) as a “catalyst” aimed at creating both internal (RHAA) dynamics and openness to foster joint working with other stakeholders in the health, long-term and social care sectors. Within the RHAA, such a strategy is deemed to have facilitated an increased acceptance of resource transfers from the hospital sector to the LTC sector – disability and old age. In the second region studied and in line with virtues attributed to the NPG model, the metagovernance of health democracy is aimed at achieving cultural and organisational change with a view to better tackle complex issues (e.g. developing policies and planning in order to allow for personalised help and care pathways), that are also at the heart of central government strategy.

The third region studied stands in contrast to the previous ones, insofar as it can be analysed as a case where the dynamics of health democracy proceeded from a more dialectical relationship between the RHAA and the health democracy stakeholders (including départements), and where the latter actively contributed to the shaping of institutional rules. One peculiar characteristic of the organisation and functioning in this region has already been mentioned, namely the resourcing, by the RHAA, of co-ordinators providing an organisational, methodological and technical support to the territorial health conferences. When interviewed, RHAA executive members tacitly acknowledged that the decision to continue the inheritance of the former regional hospital agency in this respect effectively amounted to the resourcing of a countervailing power, even though such a consequence was not anticipated.

However, other factors came into play to create a more dialectical dynamic in the functioning of health democracy. To start with, this region was an exceptional case insofar as both health democracy and local representative bodies (local government, namely the region and three départements out of four) rejected the regional health plan and the sectoral schemes (including the LTC one) proposed by the RHAA executive. Such a negative (although advisory) vote reflected a deep disappointment with the results of the planning process on two counts. First, in the eyes of the stakeholders, the regional planning documents (especially the LTC scheme) failed to incorporate the contributions made by the stakeholders (data regarding existing

disability services and their needs of disabled people proved a sensitive issue) while ignoring their priorities (including the départements social care schemes). Second, oversight of the stakeholders' contributions was compounded by the decision of the RHAA executive to renege on the funding of new services that were authorised before 2009. Such a rejection also reflected a political opposition to central government, especially to the comprehensive policy review aimed at cutting public spending.

Unexpectedly, such an inauspicious start resulted in a favourable dynamic allowing for an (albeit limited) extension of the sphere of health democracy. As the advisory rejection of the rejection of the regional health plans and schemes (including LTC) came at a political and reputational cost for the RHAA executive, a charter of good conduct was drafted and signed with départements in order to secure the consideration of their policy and financial priorities. In addition, the president of the regional health and autonomy conference (a retired university senior lecturer) skilfully used the threat of political and reputational risks in order to gain some traction on the RHAA executive. As an illustration of the success of this strategy, the regional health and autonomy conference secured the agreement of the RHAA to ensure that territorial health conferences be consulted when regional plans and schemes were updated and evaluated (a provision later enshrined in the 2016 health law). The end result was what was perceived as a more constructive relationship, where the RHAA executive accepted that the input of health democracy forums may lead to a reordering of regional priorities. Namely, existing priorities such as the needs of informal helpers, or disabled people access to health care may be pushed higher on the agenda. Also, the RHAA executive may consider the alerts given by the health democracy forums regarding the adverse effects of the implementation of some specific policy instrument or measure (e.g. occupational hazards for “mobile” nurses working night shifts on behalf of nine LTC services in order to achieve efficiency savings).

When describing the advances made by health democracy actors in the third region, the frequent use of the “may” verb does not aim to convey a hypothetical precaution. Rather, it reflects the fact that the consideration of the health democracy forums advice and proposals depends on the decisions made by the members of the RHAA executive and, ultimately, the executive directors. Their decisions may be informed by their conviction, for instance with regard to what a good LTC policy should be, but it was also conditioned by their strategic positioning. Namely, however RHAA executive members may value the contributions made by the health democracy forums, their professional (civil servant) duty is to make decisions that ensure a swift and effective implementation of central government (and ISLF) priorities and financial targets. In other words, the regional example illustrating the maximum extent of health democracy is still a far cry from the ideal types developed or promoted by the new public governance (or participatory democracy) advocates.

## **Conclusion**

Centralisation or re-centralisation fails to adequately capture the complexity of the changes that have affected the governance of French LTC policy in the last fifteen years. These concepts may nevertheless be initially used to remind the starting point of this paper. Namely, and in line with observations made in other European countries (Theobald, Ozanne, 2016), it is possible to argue that the increased (but still partial) universalisation of long-term care in

France, under the guise of the personal autonomy allowance for elderly people and of the improved disability compensation allowance, has been accompanied by a form of recentralisation of the policy processes. Indeed, the first central government's serious attempts at regaining control over the planning and regulation of LTC services at the local level have taken place only one year (2002) after the enactment of the first of the two above mentioned allowances.

The first section of this paper aimed to provide a historical background for the analysis of the evolution of the governance of French social and long-term care policies at the regional and local levels. From the beginning of the 2000s onwards, one of the key aims of the reforms has been for central government and administrations to regain control over the planning and regulation of long-term care services. Such reforms constituted a source of increasing central-local tensions, as they involved a reduction of the margins of the local governments and local health administrations for developing the informal arrangements devised since the beginning of the 1980s, in order to manage the consequences of the institutional and financial fragmentation of the field.

The second section of this paper aims to show that the 2009 Hospital, Patients, Health and Territories reform can be analysed as a culmination of this trend and proposes a framework for analysing ensuing evolutions regarding the governance of long-term care policies regional and local levels. Regional Health and Autonomy agencies represent an unprecedented (if confined to the regional level) attempt at merging the planning and regulation of the health care, prevention and long-term care sectors. The new 2009 institutional framework is nevertheless not devoid of ambiguities and imprecisions, either regarding planning and regulation (rational and pluralist “social needs” Republican model versus swift neo-managerial rationing) or the governance of LTC policies (health democracy and preservation of decentralisation versus recentralisation). Hence the relevance of the approach developed by J. Torfing and various other authors, distinguishing between three governance ideal types (APC, NPM and NGP), but also the relevance of their hypothesis regarding forms of hybridisations when studying governance in concrete. The above mentioned authors also raise the issue the metagovernance, i.e. the combination of these governance styles and the management of the ensuing tensions.

The third section of this paper is devoted to the analysis of the implementation of the 2009 reform, with a focus on the governance hybridisation issue. Using a neo-institutionalist approach to analyse the implementation of the 2009 reform also enables to apprehend it as a trial and error process, where actors learn from their mistakes in attempting to solve the ambiguities and to fill the voids in the new institutional rules. In a nutshell, the above mentioned institutional contradictions are solved to the benefit of a governance style combining historically rooted APC traits (obedience to central government, administration and agencies, and neo-corporatist management of the relations with stakeholders) and NPM traits (steering at a distance through target setting, performance agreements and assessment instruments). Central hierarchy, targets and deadlines take precedence over the input of health democracy forums, arguably with more margins granted to RHAAs than to traditional field services of the state, as far as the choice of organisational, territorial and strategical means to

achieve the above mentioned ends are concerned. Finally, it is proposed that an analysis of the French notion of “territorial” animation and of its implementation enables to capture the main traits of the metagovernance of health democracy in the LTC fields: an art of the possible within the boundaries set by hierarchical orders and neo-managerial targets and deadlines.

Even though the only partially formalised rules guiding metagovernance are quite powerful, they allow for infra-regional and regional variations in the dynamics of health democracy. As shown in the fourth section of this paper, “animation” of territorial health democracy first and foremost depends on the availability of stakeholder representatives, which may itself be ascribed to wider factors such as social, economic and demographic dynamism within the territories considered. Territorial and strategic choices may also have an impact; not only regarding the vitality of health democracy at the most local level; but equally regarding its metagovernance at the regional level.

The fourth section of this paper concludes with an attempt at characterising three regional health democracy governance styles. The first one refers to a region affected by social, economic and demographic decline, where the difficulties in the “animation” of health democracy are compounded by the territorial delimitation choices made by the RHAA and the regional health and autonomy conference. Here, the main challenge with regard to the metagovernance of health democracy is to comply with regulatory obligations and to meet the targets set at the national level, which involves obtaining an input from stakeholder representatives. In the second region studied, initial wariness concerning an excessive influence of health democracy forums has progressively given way to attempts at activating it. The end result is a top-down, region wide, “animation” style of health democracy where the staging of users, patients and frontline staff is aimed at achieving internal (RHAA) and external (stakeholders) cultural change in order to find solution to complex issues (personalised help and care pathways) and to foster inter-professional and inter-sectoral networking and joint working. A final example (third region) is one of a more dialectical health democracy metagovernance style, where the extent of health democracy and the relation of the participatory forums with the RHAA are also the result of bottom-up pressures and negotiations.

The (re)centralisation of LTC policy making and implementation in France is a source of tensions arising from budgetary constraints, but also from what is perceived as a disregard for regional and local specific and complex situations and needs, and also for the actual effects of policies that are implemented from the top. New public governance advocates claim that the model they promote may contribute to the solution of such problems. Although further analysis is required, the results presented in this paper tend to show that French regional and health democracy forums are not the loci where solutions for these tensions will be discussed, and even less decided. One explanation may lay in the shape the governance styles hybridisation actually takes in the case of regional and local LTC policy in France, which may be broadly characterised as a combination of hierarchical and neo-managerial government, whose priorities take precedence over the input of participatory forums. As already mentioned, the actual functioning of the latter is a far cry from the new public governance ideal-type. However, the study conducted in three regions also shows that, when health

democracy forums function along lines that are less distant from the NPG ideal-type, they may serve as tribunes for voicing neglected or forgotten needs, alerting about the adverse effects of specific policies and measures, and in the best of cases, marginally mitigate them or experiment innovative ways of alleviating them. One has also to observe that the health democracy leaders' arguments reveal proximity with the rational and pluralist social needs LTC planning and regulation paradigm.

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