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## The French Paradoxes

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Ever since its first appearance in 1979 in the highly respected journal *The Lancet*, the famous “French paradox” has kept the health media in an uproar (Renaud et al. 1992; Criqui et al. 1994; Goldberg 1995, etc.). In 1991, the renowned American television program “60 Minutes” focused on this surprising French statistic: a country famous for its rich diet not to mention its smokers and alcoholics (in 1991, there were 11,910 deaths directly related to alcohol), comes out on top in studies on cardiac health, with the lowest rates of coronary vascular incidents (infarction). In fact, 4.2 times fewer coronary bypasses are performed in France than in the United States, and 2.1 times fewer than in Canada – and France in general experiences a low incidence of ischemic cardiac disease (including not only myocardial infarction, but angina).<sup>1</sup> And the hubbub shows no signs of abating: *Time* magazine published yet another article on this strange French phenomenon in its July 19, 1999 issue (Lemonick 1999).

Media accounts such as these leave one with the impression that the so-called “French paradox” is the single dominant characteristic of the health situation in France. It is true that alcohol consumption provides protection against a French diet rich in fats, a known risk factor in arteriosclerosis. However, despite this diet, a large proportion of women are underweight (12.1% of 18- to 24-year-olds). In the 55 to 74 age group, only 6.1 percent of men and 6.8 percent of women are considered seriously overweight (Enquête Santé 1992; SESI 1998). From a general point of view, the average life expectancy for a French man in 1991 was 74.2, and for a French woman 82.1. To be French and female in the 1990s is to be at the top of the list in the European Union in terms of life expectancy.<sup>2</sup> France has known one of the most phenomenal gains in life expectancy in the western world: from 1980 to 1994, average life expectancy increased by 2.2 years for men and 2.4 years for women. The picture is the same for active life expectancy<sup>3</sup> or EVSI (life expectancy without being

incapacitated), which, from 1981 to 1991, increased by more than 3 years for men and more than 2.6 years for women. By 1995, infant mortality had dropped significantly as well, hovering today at around 5.1 per thousand (1997).

The general health of the French population thus appears to be satisfactory, both in comparison to other western countries and in terms of progress made. These figures cannot be explained simply by health care expenditures per capita. At about 1,870 dollars per person per year, France compares favorably to both Germany and Quebec, but remains well below the 3,600 dollars per capita spent in the US in 1994<sup>4</sup> – although, as elsewhere, debates on how to control health care costs are a perennial item on the French political agenda, and recent reforms in this area (1996) have met with limited success. Prof. R. Curtis Ellison, at Boston University School of Medicine, cites three factors behind the “French secret” – “wine, food and lifestyle.” But even though medical literature has already publicized the chemistry of both wine and food, there have been few studies in France on health lifestyle participation (Corbett 1994; Lüschen et al. 1995; Cock-erham 1998). How do the French as a population perceive their own health condition? And all clichés aside, what is the statistical and sociological reality of the health situation in France?

In fact, there are several “French paradoxes.” Take the situation of public health policy. In the eyes of a public stunned by the recent scandals over contaminated blood, growth hormones, and the infamous “mad cow” disease, French public health policy appears in many ways to be a failure. Its too-recent development has been handicapped not only by an insufficient institutional infrastructure (Murard and Sylberman 1997), but also by surprisingly limited financial resources (de Kervasdoué 1996; Johanet 1998) and apparent lack of political will. What exactly is at stake here then? Why should the native country of Louis Pasteur be so slow to develop a working public health policy?

Another French paradox: the slow emergence (1970s) of the field of medical sociology, a fact which is surprising in the context of the nation that gave birth not only to sociology (Durkheim) but also to the clinic.<sup>5</sup> It is curious that the France of Bichat, Laennec, and Claude Bernard did not play a more innovative role in making “illness” and “medicine” the objects of sociological study. In fact, modern hospital medicine, which originated in Paris at the turn of the century (Ackerknecht 1967), did not generate interest among sociologists until the 1970s (Herzlich 1973; Stuedler 1974; Chauvenet 1978). Since then the topic of hospitals, however hot it may be politically, has received relatively little attention on the part of the French (or European) sociologists in general. While far from the only paradox to be found upon examining the French public health situation, this characteristic in particular merits closer analysis.

## THE SOCIAL DEMOGRAPHY OF HEALTH

### The Perception of Health Problems

First of all, how do the French themselves perceive their health? According to studies done by the Research Center for the Study and Observation of Life

Conditions (CREDOC), since 1992 the French population as a whole has rated its health as relatively satisfactory, a finding reconfirmed at the end of 1997 by 89 percent of respondents.<sup>6</sup> This opinion (Le Quéau et al. 1998) varies mainly in relationship to the age of the person queried: 95 percent of those aged 20 to 34 reported themselves to be satisfied overall, while only 76 percent of those over 70 felt themselves satisfied with their general state of health. Two-thirds of those questioned thought that the general health of the French population had improved over the last ten years.

On the other hand, when evaluating the future health of the population the figures are clearly less optimistic: only one out of eight people interviewed thought that the overall health of the population will improve in the next ten years. The perception of environmental risks seems to be an important new factor behind this pessimism about the future: 81 percent of individuals interviewed believed that the population is increasingly being exposed to multiple risks. While age did not seem to be a factor in the opinions held by the people interviewed on this point, men remained slightly more optimistic than women. In addition, it is worth noting a strong correlation observed between an optimistic view of the future health of the population and a positive perception of one's own health.

Socioeconomic factors obviously play a key role in individual perception, as has been widely shown in medical sociology literature, but these factors are not always easy to identify. The notion of social causality remains complex (Adam and Herzlich 1994). One social variable that clearly has a significant impact on the health of the individual is unemployment. This is particularly obvious in France because of its high unemployment rate (currently above 10% – as high as 12.4% in 1996). While unemployment can occasionally have a positive impact on the health of the worker by reducing exposure to occupational hazards and eliminating the specific stresses of the work environment, it can also have a pathogenic effect, including anxiety, loss of social status, and instability. Oddly enough, according to Bungener and Pierret in 1994, the unemployed were more likely than those employed to describe themselves in good health, even though a significant number of them suffered a higher incidence of multiple pathologies than individuals in the employed population. But by 1997 CREDOC found that the unemployed were half as likely as the employed population to describe themselves as “very satisfied” with their current state of health, and three times more likely to describe themselves as dissatisfied (17% as opposed to 6%). Even those who had a positive perception of their individual health expressed a more negative view of the evolution of the general health of the population. Among those employed, 33 percent of executives and professionals rated themselves “very satisfied,” as opposed to 24 percent of clerks and manual laborers.

Lifestyle issues also appear to be perceived as a determining factor in health. More and more people in France acknowledge the importance of moderating alcohol and tobacco consumption, with 81 percent of respondents agreeing strongly, 14 percent agreeing, and 5 percent disagreeing with this proposition. While young people, and young males in particular, remain more reticent, this reticence decreases with age.

The most striking development since the 1992 CREDOC survey concerns the perception of instability (for example, unemployment or lack of money) as a determining factor in a person's health. By 1997, 73 percent of those interviewed agreed that unemployment had a major effect on health, and 67 percent thought that lack of money also has an impact. Furthermore, we can see a homogenization of responses according to social group, for it is among executives and those with the highest incomes that the greatest shift in opinion took place (+ 15%). This evolution is evidently linked to the increase in unemployment, affecting more than one million people between 1990 and 1996, the year in which unemployment reached a record 3,160,000 people, e.g. 12.4 percent of the active population. If these figures have improved somewhat as a result of the current economic recovery, the fact remains that as of September 1999, over 11 percent of the French labor force remained unemployed.

Finally, the proportion of people believing in the effectiveness of public health campaigns and research for prevention went from 56 percent in 1992 to 75 percent in 1997. But little connection was made between the total number of physicians and the health of the population. In fact, more than 67 percent of people surveyed thought that it would be useless to increase the number of physicians as a way of improving health. Despite a stronger belief in the impact of external factors – both social and environmental – on the health of the population, a majority expressed the opinion that maintaining good health is the responsibility of the individual: in 1997, 69 percent strongly agreed, and 27 percent agreed somewhat. Consistent with the 1992 results, the population in 1997 was split in two on the question of whether or not the government should single out groups with special needs as part of its public health policy. Among those to agree, women over the age of 35 figured most prominently. Those lowest on the socioeconomic ladder were given the highest priority, while the elderly received very little support. Despite 1996 reforms in the health care system stressing the role of regional control – holding regional health conferences, setting up regional hospitalization agencies, etc. – only 10 percent of the population surveyed continued to view the region as a significant locus of public health policy. In a new development, the French have begun to view the emerging European Community as a significant factor in public health policy, despite the fact that its role is still limited in both legal and financial scope. International health crises such as the “mad cow” disease have likely served to reinforce this opinion.

Altogether, it appears that the French hold simultaneously a very individualized view of health as being linked to lifestyle, and an acute awareness of the role of larger factors in the equation, such as “environment, instability, and the need for community.” In the final analysis, manual workers were those who were most concerned with the concept of “good health,” expressed in terms of longevity (a fact which probably reflects their true disadvantage in this regard). By 1997, autonomy (“being able to do what you want” and “not suffer”) had become a major concern compared to in 1992, as had certain ethical debates involving issues such as euthanasia, palliative care, and end-of-life decisions. Fear of illness, which was a major concern for 63 percent of respondents in 1992, is even more so today as expressed by 82 percent. Lastly, the 1997 CREDOC study indicates more

clearly than before, how the French population's increased preoccupation with illness is now associated with the fear of unemployment.

### Statistical Reality

But are these fears borne out by statistics? What are the indicators of the general state of health of the French population, and what are the known determinants of the current health situation?

### High-Risk Behavior

France indeed tops the charts in terms of life expectancy, especially for women, though there remains a gap of eight years in life expectancy between the sexes. The French also enjoy low infant mortality rates, as well as low rates of cardiovascular illness, (though the latter remains the principal cause of death: 32% of the total in 1996).

However, this excellent global performance should not hide several important problems. Among the 60,000 annual deaths considered to be "avoidable," 40,000 are (according to the HCSP) directly related to lifestyle, such as reckless driving and/or the consumption of tobacco or alcohol. While the average alcohol consumption per adult has been dropping since the 1960s, the opposite is true for young people of both sexes. Even more troublesome are recent changes in adolescent drinking habits, with an increase in periodic binge drinking, especially on weekends, sometimes mixed with psychotropic medications or illicit drugs. As a result, alcohol is now being considered by the health authorities as almost a psychoactive substance along with tobacco and illegal drugs.

In a broader context, these changes represent what could almost be called a cultural revolution at the heart of the French public health situation, as shown in Roques' 1998 report. On the one hand, the statistics demonstrate the serious consequences of excessive alcohol consumption for public health. On the other hand (as has even been noted by the HCSP itself) traditional French denial in the face of the disease combined with the importance of alcohol to the nation's economy represents an enormous obstacle to any overt political action against alcoholism, despite numerous warnings about its dangers. Just as in the case of gun control in the USA, the problem of alcohol consumption in France is not only a public health problem, but a larger social issue with roots deeply embedded in French culture.

Worse, alcohol is not alone on the public health docket. In 1996 it was estimated that there were approximately 13.5 million smokers in France. Despite the Evin law of 1993, which banished all advertising for tobacco and prohibited smoking in public places, the current trends in tobacco consumption are alarming. More women and more young people are smoking than ever before. As for men, the blue-collar workers top the list in cigarette consumption, followed by white-collar workers and executives. Conversely, among women it is office employees and the intermediate professions who smoke the most, followed by blue-collar workers. Nicotine addiction during the third trimester of pregnancy has increased as well, going from 15 percent in 1981 to 25 percent in 1996. Investigations in six

different sites aimed at evaluating the enforcement of the Evin law revealed what can only be called indifference toward the new regulations concerning smoking; fully half of the companies surveyed did not take them into account in any way (ORS 1995). Not only that, but in the case of public education, 45 percent of students, 40 percent of supervisors and 20 percent of teachers had been caught with a lit cigarette inside the school buildings

High-risk behavior is not exclusively defined by the consumption of alcohol or other substances – reckless driving is also high on the list. Ninety percent of automobile accidents in France are estimated, in one way or another, to be the fault of the driver. Though (at 48%) alcohol-related accidents are responsible for nearly half of all traffic fatalities, reckless driving is cited as the primary culprit in 30 percent of traffic fatalities, and not wearing a seat belt (mandatory since 1975) comes in third at 24 percent.

Ever since the advent of the AIDS epidemic, sexual behavior has been added to the list of high-risk behaviors. This has aroused the interest both of public authorities (in terms of research funding, particularly for the study of sexual behavior) and of sociologists. As a result, KAPB-style (Knowledge, Attitudes, Beliefs and Practices) investigations sought to make the connection between the perception of risk and subsequent behavioral modifications. However, while the population appears to be remarkably well-informed about the risks of contracting AIDS, this knowledge does not seem to have had a strong impact on changes in sexual behavior (Moatti, Dab, and Pollack 1990).

In addition to investigating specific populations at risk (D. Carricaburu's 1993 study on hemophiliacs, the 1994 KAPB studies of teenagers, of populations in the Antilles and Guyane, and the homosexual community), larger cross-sections of society were polled (Spira and Bajos 1993) in an attempt to measure modifications in sexual behavior since the last global investigation in 1972 ("*Enquête Simon*"). Results show that the average age of first sexual encounter is 17 for men and 18 for women, (though it must be noted that these figures are lower amongst the lower classes). Condoms were used by more than three-quarters of the young people surveyed in 1994 compared with only 56 percent in 1989 (1994 KAPB Survey on teenagers). Teen pregnancy was at 3.3 percent; with 72 percent of these pregnancies ending in termination. With regard to the risk of sexually-transmitted diseases, the most radical changes appear to have taken place in the homosexual community, with a strong increase in the number of participants surveyed who rely on the tracking test; 65 percent of homosexuals surveyed in 1995 are tested several times a year, versus 48 percent in 1993.

Ever since the outbreak of the AIDS epidemic, sexuality, more than any other category of high-risk behavior, has been the chief object of scrutiny of numerous sociological studies related to the concept of "social representation" (Herzlich 1973), a well-developed trend in French medical sociology. Thus, from the moment of its appearance, the discourse on AIDS has been analyzed as the very "essence of evil" (Augé and Herzlich 1984) in modern society. These sociological studies have doubtless contributed to the definition of AIDS as a *social* problem rather than an epidemiological problem, a definition specific to the French health policy approach.

The link between unemployment and health perceived by the French as a problem is a statistical reality too, with unskilled workers suffering the most. In 1997, 15.8 percent of blue-collar workers were without employment, compared with only 5.1 percent for white-collar workers. While little work has been done on the impact of stress linked to unemployment on the individual (Le Disert 1985; Bungener and Pierret 1994), we do know that the risk of mortality among the unemployed in 1982 was almost triple that of those employed between 1982 and 1987. Not only that, but between 1990 and that in 1995 it was fully 90 percent higher – a disparity present across all social groups regardless of class or education (Mesrine 1998).

### Gender Disparities

In 1998 a comparative study of Europe and America (Badeyan et al., INSEE 1998) revealed the curious fact that France has one of the highest death rates from cancer among men, and one of the lowest among women. Women are more likely to suffer from cardiovascular illnesses (36% of deaths) than from cancer (23%). On the other hand, France holds the negative distinction of having a high rate of traumas and violent deaths (suicides, traffic accidents, etc.), with over 10 percent of deaths among men and 7 percent of deaths among women falling into this category.

France thus has a disproportionately high “premature” male mortality rate (defined as death occurring before age 65) in comparison with other European countries (cf. table 15.1). It is interesting to note that the greatest gap between the sexes occurs between the ages of 25 and 74, (when the risk of death for men is 2.5 times higher than that for women), while after age 74 the male mortality rate drops to only 1.5 times as high as the female rate. France’s premature death rate among “young” men (a category spanning ages 25 to 44) is twice as high as that in Great Britain, the Netherlands, and Sweden. The greatest gap between male and female mortality rates occurs in the incidence of cancer of the upper gastro-intestinal tract and in lung cancer. For these pathologies, the mortality rate for men remains striking: the risk of death among males multiplies by a factor of 9 and 7 respectively overall, and for deaths before age 65, by a factor of 11 and 7. Next in line, with double the risk for men in each case: AIDS,<sup>7</sup> suicide, alcoholism, traffic accidents, stomach cancer, infarction, and respiratory illness.

**Table 15.1** Male surmortality by age, 1996 and 1991 (ratio male/female)

	1996	1991
Total	1.83	1.81
< 25 years	1.87	1.86
25–44 years	2.40	2.64
45–64 years	2.50	2.58
65–74 years	2.42	2.39
> 75 years	1.57	1.53

Source: Inserm SC8.

Statistics also corroborate a general tendency already observed previously (Cockerham 1998), – the greater incidence of high-risk behavior among men, such as tobacco and alcohol use (accounting for 6% of premature deaths in 1995) and reckless driving. Deaths labeled “avoidable” (those linked to high-risk behaviors) were thus shown to be four times as significant for French men as deaths related to failures in the quality of health care – e.g. deaths that could have been averted through better preventative care and management.<sup>8</sup> By contrast, deficiencies in the health care system (and particularly early detection) were shown to affect women more frequently. As a result, breast cancer represents 12.2 percent of premature deaths among females out of 4.2 percent of total deaths in 1996. However, differences between the sexes in terms of high-risk behaviors are beginning to blur. The rate of cancers linked to alcohol and tobacco consumption among young, French women has shown a marked increase. It is feared that France is following in the footsteps of the United States in this respect – French female mortality rates from tobacco are currently comparable to those seen in the United States in the mid-1960s.

In the area of mental health, suicide rates in France – as in most countries – are higher among males (3.1%) than females (1.3%). Moreover, from 1991 to 1996, there was an increase in the number of suicides among men between the ages of 15 and 44. On the other hand, depression, especially so-called major depression, known to be a characteristically female trait (Cockerham 1996; Kessler et al. 1994) remains so even in France. A recent study (Lépine et al. 1997) ranks France, along with the United Kingdom, as the European leader in terms of overall rates of depression. Regarding psychotropic drugs sales, France shows 3 to 4 times higher rates than elsewhere.

Gender as well as social class plays a role in who benefits the most from available health care. Statistically, women consult a doctor more frequently than do men, as well as being more likely to consult a specialist (62% against 56%). Since 1970, this gap in health care between the sexes has increased in nearly every domain. On the other hand, men seek medical care for accidents twice as often as women do. French medical demography thus follows the same general tendencies as have already been observed elsewhere, both on the statistical level and on the level of individual behavior (Cockerham 1997). Still, behavioral differences, while gradually diminishing, remain more exaggerated in France than elsewhere, in particular with regard to high-risk behavior.

### **Social and Regional Disparities**

Just as typical of the French situation are differences between regions. Infant mortality rates vary widely from region to region, ranging from 7 to 7.5 percent in northern France to 5.4 to 5.7 percent in the southeast and the west. The respective ranking of the regions has changed very little in recent years. Similarly, overall mortality (generally on the decline) varies greatly by region, and these discrepancies show no sign of narrowing. In 1996, Pas-de-Calais remained the region with the highest overall mortality in France, a statistic that has remained constant ever since World War II. A 1998 study conducted by INSEE found that the life expectancy for men in North Pas-de-Calais was only 71, with 27 percent

of deaths occurring before the age of 65. This region maintains records for most pathologies: deaths from cardiovascular illness, illnesses of the respiratory and digestive systems, and alcoholism. Before the age of 65, alcohol causes twice as many deaths as would normally occur – in fact, among women between the ages of 35 and 64, cirrhoses of the liver represented the number one cause of death, ranking even higher than breast cancer! These regional disparities, of which Pas-de-Calais is only one example, are not related solely to socioeconomic hardship, but also to a lack of medical facilities.

There are a great many well-known studies in both Europe (Fox 1989; Leclerc 1989; Lahelma and Valkonen 1990) and the USA linking significant variation in mortality rates among social and economic groups to unfavorable socioeconomic conditions. However, in a recent European study (Kunst 1997), France was shown to have a wider statistical variation in this respect than the majority of other European countries. In France, the risk of death for men between 35 and 60 years of age varies from 10 percent for white-collar workers to 20 percent for blue-collar workers. Those at greatest risk are agricultural employees, manual laborers, and service industry employees. Not only do the differences between the different categories not average out evenly, but they become even more exaggerated as the population moves into old age, as the more “privileged” categories (such as executives and liberal professions) are the most likely to profit from increased life expectancy. Interestingly enough, the largest discrepancies in life expectancy among social and economic groups were found with relation to pathologies involving alcoholism. One can see why the “French paradox,” linking lowered risks of ischaemic cardiopathies to the (moderate) consumption of alcohol, could hardly be a widespread notion in French public health policies!

Although few disparities exist between various social groups with respect to the availability of medical care (Mormiche 1995), the exact nature of these visits differs markedly according to both age and social class. Members of the upper classes are more likely to practice preventative health care, while members of the lower classes often do not consult a doctor until their condition is serious enough to require hospitalization.

Finally, throughout the 1990s the French infant mortality rate declined dramatically, from 7.3 percent in 1990 to 5.1 percent in 1997, a positive change that can be attributed to a combination of increased prenatal care and educational programs (such as the campaign against Sudden Infant Death Syndrome). From 1981 to 1995 the percentage of women undergoing seven or more prenatal checkups increased from 43 to 73 percent. In addition, ultrasound monitoring has become more common since 1981: in 1987, half of all pregnant women had at least two or three ultrasounds, and 48.5 percent had more. Between 1981 and 1995, hospitalization rates for high-risk pregnancies rose from 16 to 20 percent. However, while the proportion of unmonitored pregnancies remained very low (estimated at less than 0.2%), other factors besides prenatal care are at work in the premature birth rates. 13.5 percent of women claiming to have no support had a premature baby, as opposed to 7.5 percent of those with a variety of available resources, and 5.5 percent of those with their own income (Badeyan et al. 1998). Socially disadvantaged women are thus at greater risk of having a

premature birth. In addition, compared to the statistics for the Scandinavian countries or the United Kingdom, the number of maternal deaths in France remains high (linked perhaps to higher average age at time of pregnancy?), despite generally favorable indicators for prenatal health.

Despite undeniable progress (including a 21% reduction in avoidable premature mortality of either sex due to high-risk behavior), the French situation can thus be characterized by serious inequalities in general health, not only between social and economic groups but also between the sexes (particularly amongst young people), and finally between geographic regions. As a result, and despite the government's proclamation in 1998 guaranteeing access to health care for all, the rising poverty and exclusion levels remain the top priorities of the HCSP (High Committee on Public Health), the organization responsible for monitoring the French health situation since 1994.

## THE SYSTEM OF HEALTH COVERAGE

### The Organization of the French Health Care System

#### GENERAL STRUCTURE

Overall, France devotes 10 percent of its national wealth to financing health care (versus 7% in 1970). Despite this increase, the French system is characterized by fragmented management of health policies and a multiplication of regulatory channels (Stasse 1999). It is only since the introduction of the global health care budget in 1983<sup>9</sup> as well as the health care reform of 1996, that the central role of the State in the French Social Security system has finally been recognized.

The structure of the French Health Care system was initially dictated by a sort of compromise between employers and unions. The difficulty arose from the fact that health care, as an institution, was caught between two opposing poles. While in one sense control of the system lay entirely in the hands of doctors and their patients, the financing was controlled by employers and unions. As if this weren't complicated enough, the State, originally intended to remain a neutral third party in this dynamic, proved unable to maintain this intermediary position. The tension between these three factors lies at the heart of the genesis of the French institutional configuration.

In fact, the French health system, unlike the British nationalized system or the German system of regional and professional co-administration, continues to combine the participation of employers, government regulation, and health care professionals. Financing is assured primarily by the "Social Security system," created in 1945 out of roughly 15 different branches of health insurance, each offering different degrees of coverage. Health insurance is consequently managed by the various branches according to the occupation of the individual.

In addition to the "general plan," which covers employees in commerce and industry and represents the most significant portion of the insured population,

there are also a great many occupational groups, such as miners and railroad employees and so forth. Furthermore, a significant percentage of the population holds some form of complementary coverage through mutual and insurance companies. The French Social Security system has fixed prices for most forms of standard medical care, paid directly to the care provider. While it is common practice to exceed these fixed prices, the patient is still liable for all additional costs. Even within the context of covered expenditures, a portion of the cost for certain procedures, called "*ticket modérateur*," remains the responsibility of the patient, in an effort on the part of the system to discourage policy-holders from incurring frivolous expense. There are exceptions in which the patient is completely covered; these generally fall into one of three categories: serious pathology (cancer, AIDS, etc.), certain medical procedures and treatments (such as fertility treatments), or finally certain specific situations (disability or childbirth, etc.). Lastly, the State has always theoretically taken under its wing those uninsured or without resources (free medical care existing in principle since 1905) as is reaffirmed and stated more clearly in the law of 1992.

The French have the freedom to choose their own doctors and can directly consult any specialist without the intermediary of a primary care physician. They can also choose either a private or a public care facility (Duriez et al. 1996) without affecting their financial liability for care received. For outpatient care, professional and medical infrastructures remain primarily in the private sector. The public sector dominates, however, in the arena of hospitalization and collective programs (such as public health education and prevention).

In addition to allowing free access to specialists, the French system distinguishes itself from its European neighbors with regard to the distribution of goods and medical services. Not only do the majority of specialists have private practices in urban centers rather than working in hospitals, but also an important fraction of hospitals are privately run for profit. As a result, the role of the general practitioner in screening and controlling access to specialized care is thereby greatly reduced compared to that of his or her counterpart in other western countries.

Additionally, alternative forms of medical care, a common resource in French society, enjoy quasi-institutional recognition. For example, 65 percent of costs for homeopathic treatment are reimbursed by the public system. It should be noted that in France, it is the doctors who prescribe homeopathic drugs, thereby simultaneously controlling access to both clinical medicine and alternative medicines.

## RECENT REFORMS

As of 1996, the Parliament (which previously held no direct authority over the health care system except insofar as it controlled the national budget), directly controls the entire public health budget. It is now the responsibility of the Parliament to fix the rate of inflation of health care costs each year. This rate constitutes a fiscal ceiling that is binding for all participants to the health insurance system. While the new budgetary laws concerning the French Social Security system have brought these participants closer to political decision-makers at the national level,

compartmentalization remains a major problem. In 1993 an attempt was made to modernize the system by creating a series of organizations comparable to those already existing in the United States (a French equivalent to the Food and Drug Administration is one example). An entire program built around both cost management and standardization of care is thus under development, at the regional as well as the local level (for example the creation of ANAES, or National Agency for the Evaluation and Accreditation of Health Care Institutions). However, one must be careful not to mistake this reinforcement of regional responsibilities for a move toward decentralization. In spite of recent reforms, the French health care system (particularly in comparison to its immediate neighbors in the West) suffers from an accumulation of different institutional strategies, some structural and some procedural. This multiplication of strategies often paralyzes health care providers in the performance of their duties and renders even more difficult the implementation of any coherent and logical system on a large scale. The reasons of such poorly planned institutional health environment are probably due to the relatively late development of the concept of "public health" in France, compared to other countries.

### **Which Public Health Policy?**

#### **A LONG-OVERDUE CHANGE**

According to certain historians (Murard and Sylberman 1996), the question of public health, and consequently of collective management of disease and health, has long attracted little attention. Public health and sanitation have been devalued in relationship to the "clinic" (Foucault 1963), which to this day enjoys an unrivaled level of prestige. In fact, up until World War II, unlike Great Britain or Germany, public health and sanitation remained primarily a local affair, existing within only a very precarious institutional framework.

The reticence demonstrated by the State when it came to intervening on the local level in health matters (except in the event of epidemic) stemmed partly from political considerations. Local authorities were little inclined to participate in any move which might be construed as a remnant of authoritarianism (in part for electoral reasons). The hesitation on the part of the local authorities also stemmed from a simultaneous desire to safeguard private property while still protecting individual liberties (hence the difficulty in getting any intervention accepted). For a long time no social support in matters of public health existed to compensate for the failure of the authorities – neither from the political parties, nor from the doctors, however Pasteurian.

The particular nature of the French public health system stems from the combination of all these factors – administrative impotence born of a lack of means, the fragmentation of authority (and thus responsibility), and the devalorization of the most basic components of public health medicine, as well as of prevention programs (De Kervasdoué 1996; Johanet 1998). It seems that the State has great difficulty knowing how its own health care system functions and evolves. In fact, up until the recent creation of the ANAES, no means of evaluating and monitoring the quality of care in hospitals were in place. It is only

since 1994 that a true diagnosis of the situation has been established (by the HCSP),<sup>10</sup> with the creation of programs for disease control such as the “*veille sanitaire*,” and for identifying sources of pollution. However, while this would indicate that “public health care had thus finally achieved citizenship,” or full validity in the eyes of the State, the HCSP was still deploring the weakness of public health policies in terms of environmental risks (for example in the case of asbestos), and lack of statistical data as recently as 1998.

This evolution is astonishingly late in coming for a country that is by tradition both solidly Jacobean and strongly centralized. In fact, it is only in the aftermath of the recent avalanche of scandals – contaminated blood in 1991, growth hormone, and Creutzfeldt-Jakob’s disease, etc. – that the medical bankruptcy of a country lacking any real public health policy has finally become apparent (Setbon 1993). The multiple deficiencies of the system are reflected by the statistics, as in the case of posttransfusion contamination, 3.2 times higher in France than the European average, and 7.8 times higher in France than in Germany (Morelle 1996). The limited action of the State in combination with the lack of accountability demonstrated by those responsible in the medical profession will eventually expose the failure of the French health system to the public, as well as question the very legitimacy of the political, administrative, and medical institutions responsible. It will also reveal another characteristic of the French system; the autonomy of the medical field and its influence on the State (Fassin 1996).

### THE POWER STRUCTURE OF FRENCH MEDICINE

While the majority of developed countries (and in particular the United States) are currently experiencing a decline of the power of the medical establishment, France continues to follow its own path. “*L’Ordre des médecins*,”<sup>11</sup> well-known for its conservative stance, and even the French medical profession in general, have been very opposed to all attempts at reform (witness for example their resistance to patient access to medical charts (1995), their struggle against any form of collective sanction (1996), or the medical specialists’ strike of 1998). Among health professionals of all sorts, physicians today still hold a central position. In fact, the power held by hospital physician unions is all the more remarkable given that it is in no way founded in law (Stasse 1999). Unions of independent doctors, on the other hand, have the legal right to contract with health insurance organizations.

Finally, the medical standpoint has always held priority in France in the chain of any health policy decision-making, possibly even at the expense of other social factors. In fact, the very nature of the French health care system has been determined much more by the medical and institutional side of the system than by the patient. One cannot therefore truly speak of the same decline in the power of the medical establishment in France as has been observed elsewhere (Hassen-teufel 1997). In fact, rather than a simple loss of influence on the part of the medical establishment, what is really at stake is a profound reconfiguration of the power structure combined with a search for new modes of legitimization (Aïach and Fassin 1996). The indignation expressed by the patients – first with the cancer survey<sup>12</sup> in November of 1998 and then more recently with the *États*

*Généralux de la Santé* of 1999 – testifies to the lack of transparency of the whole health care system combined with a typically French taste for secrecy in the medical profession.

The remarkable significance of the professional medical power shows up in the legislative domain as well. “Patients’ rights” as a legal term doesn’t even appear until 1991 (Evin 1999) and indicates a level of reticence still present in the profession to this day. It is true that the Huriet law (1988), protecting patients undergoing experimental therapies and requiring their consent, has been in place for some time, and informed consent (art. 36 of the French Medical Deontology Code) is now admissible in a court of law. Nevertheless in a recent case (June 9, 1998) a Jehovah’s Witness, though he had clearly expressed in advance his refusal to have a blood transfusion, was subsequently given a blood transfusion in a situation of medical emergency. When the case went before a judge, the court prioritized the “physician’s respect of the obligation to protect life and health.” In similar fashion, even though the physician has, under recent legislation, the obligation not only to inform the patient but also to provide proof that the patient has been so informed (Decision by the French Court of “Cassation” on February 25, 1997), he or she can nevertheless, in the name of “the apapeutic justification” (art. 35 of the “*Code de déontologie*”), choose not to inform the patient of a serious diagnosis or risks related to treatment if he or she believes that such a revelation would be harmful to the patient. In cases of terminating life support, while the family of the patient is informed as a general rule, they are not the ones who make the decision. In France this decision remains in the hands of the physicians, as shown in a recent investigation.<sup>13</sup>

Within the context of the French health care system, the patient is thus far from having any real autonomy, in spite of recent (though limited) changes. In addition, even though the National Advisory Committee on Medical Ethics recommends getting the proxy’s consent when the patient is incapable of consent, this consent is not required, thereby depriving the family of any direct control. While it is true that confidentiality cannot legally be maintained to the detriment of the patient, the definition of what constitutes “detriment” nevertheless seem to remain in the hands of the physician. The issues surrounding informed consent and confidentiality thus remain, along with the issue of individual access to one’s medical charts and records (accessible in theory following the hospital reform law of 1991), the subject of constant debate among patients and more generally health care consumers in France today.

## THE EMERGENCE OF CLAIMS AND THE HEALTH CARE CONSUMER

However, one of the more remarkable recent developments in the French health world is the emergence of a new factor, hitherto forsaken and rarely consulted: the patient, or rather the health care consumer. In a country characterized until very recently by the weakness of any patients’ organizations, and by a paternalistic model of the doctor–patient relationship as well as by a highly medicalized vision of social problems, some notable changes have taken place.

The ways in which the French health care system has chosen to deal with the AIDS epidemic represent a veritable revolution in the manner in which the health

care institution assumes responsibility for a patient. For a variety of reasons (ranging from social control to the epidemiological threat), this approach was instituted in an exemplary way. Admittedly, many of the institutional transformations that have been taking place as a result of the AIDS epidemic borrow from devices already in place and from previously tested initiatives (palliative care, pain management, psychological support, home medical care, and so forth). But they were readapted, reorganized in record time to respond to the needs of patients suffering from HIV. The acceleration of these transformations is undoubtedly one of the major facts of this epidemic<sup>14</sup> in the French case.

Beyond these institutional modifications, we are also witnessing a true ideological revolution. Two factors – the obligation to tell the patient the truth in the case of AIDS, and the lack of any real therapeutic solution in the early days of the epidemic – abruptly modified the traditional doctor–patient relationship by imposing a new transparency of communication. The law of silence rooted in a paternalistic model of doctor–patient relationship was suddenly not acceptable; the AIDS patient was right away “socialized” within the medical sphere (contrary to the standard clinical vision, which typically gives precedence to the pathological over the social). It is in this way that the AIDS patient assumes the role of a true “social reformer” (Defert 1989). The specific mobilization around AIDS, in particular the efforts of patients’ groups (Pollak 1992) and the institution of a “politics of compassion” in spite of shortages (Barbot 1998), thus contributed to these radical transformations on the level of the social representation of disease.

The situation of the AIDS patient went a long way toward breaking up what was, up until that point, an extremely powerful identification between a person’s professional situation (and health coverage) and his or her degree of social integration.<sup>15</sup> In addition it has provided the nucleus for a movement of genuine solidarity (unlike the sometimes only rhetorical solidarity expressed toward the unemployed), as was amply demonstrated by the outcry surrounding the affair of the tri-therapies in 1996.<sup>16</sup> The AIDS patient is henceforth the focal point of all forms of tolerance, thus justifying both institutional solicitude and national solidarity. This is particularly true since the 1991 scandal over contaminated blood, which finally succeeded in separating AIDS as a disease from the context of “sin,” so pervasive up until that point. From that point on, the patient was perceived as the innocent victim, both of the disease and of institutional malpractice.

Where the plight of the AIDS patient is unique is the manner in which it has transformed a public health problem into a social issue. For the first time in French public health policy, a uniquely patient-centered approach was formulated in response to an epidemiological problem. This is in marked contrast to viewing epidemiological problems as strictly sanitary or medical issues, as has so often been the case in the past. The AIDS patient has never (contrary to other pathologies), been objectified or treated like a “disease,” but rather has always been treated like an individual. Within the political as well as the institutional domain, the methods for assuming responsibility have now acquired a new “ethical” reference. This new-found importance of individual over collective interests represents a true break with the traditional model of public health policies (Orfali 1997).

And yet, in spite of the exemplary approach that has been taken to the issue of AIDS (an issue which has reverberated strongly throughout a public opinion already sensitized to the serious institutional deficiencies by the recent scandals), has anything really changed on the level of medical and hospital practices? Is there any evidence of a genuine shift toward a more patient-centered care?

Nothing could be less certain, as was most emphatically revealed in the most recent national surveys on health care (*États Généraux de la santé*), a system of surveys that was originally established in an attempt to promote a “medical democracy.” In fact, it would seem that the transformations that took place in response to the AIDS epidemic have remained specific to the epidemic and have not extended to the rest of the health care system. Not only were the medical and institutional adaptations resulting from the AIDS epidemic not applied to other pathologies, they weren’t really extended to the rest of hospital care either, thereby creating even greater institutional disparities in quality and type of patient care. In the final analysis, despite a number of indirect repercussions, the impact of the revolutionary policies surrounding AIDS on French health care remains rather limited when seen in the context of the system as a whole.

The French health care system’s tardiness in addressing the needs and the role of its patients<sup>17</sup> (as well as in developing an efficient public health policy) undoubtedly reflects the separation between the medical and the social spheres so characteristic of the French system. From this point of view, the current demand for the patient to take control of and to participate in his or her own health care (a field heretofore strictly limited to the medical profession and neglected by the State) is all the more interesting. This desire originates in an increased general social demand to participate in a society whose institutions’ very legitimacy is being called into question. This movement is not limited to the health sector, but also relates to other spheres of social life, such as education, labor market, etc. That people’s personal experiences no longer match the normative goals of institutions such as school, family, or medicine, etc. has become a more clearly accepted perception, but one that has been in fact more developed by general sociology (Dubet 1987, 1994; Lapeyronnie et al. 1992) than by medical sociology in particular, at least in France.

### Where Does French Medical Sociology Stand Now?

Not only is public health in France a new concept, but medical sociology as well is a relatively recent development (dating from the 1970s). That both should develop so relatively late in the game is perhaps not simply the result of chance – the two aspects are in fact more strongly linked than may initially be apparent. Admittedly, medical sociology has finally come into its own, and medical sociologists are called upon more and more to intervene at the institutional level. However, this same medical sociology still has few ties with medical schools, in contrast with the situation in America and in neighboring European countries (Cockerham 1983). In an academic community that remains largely unreceptive to any discipline still in search of legitimization, this lack of support from medical schools has very likely restricted the development of medical sociology

as a field (Claus 1983). The limiting nature of specific training, especially one in which the vast majority of existing literature is in English,<sup>18</sup> is undoubtedly another factor which has slowed its development, as is demonstrated by the fact that the first French Medical Sociology textbook was published as recently as 1994 (Adam and Herzlich).<sup>19</sup>

How is it that the country which saw the simultaneous birth of both sociology (Durkheim) and the clinic (Bichat; Laennec; Corvisart) can be so slow to make advances in medical sociology and public health? Paradoxically, it is perhaps this very coincidence which explains the later divorce. Widespread reservations about studying social determinism in a field apparently governed exclusively by biological mechanisms have played an important role in the late development of medical sociology. In addition, in France the "founding fathers of sociology" in particular manifest an aversion to biological explanations, or to any kind of "social Darwinism." Durkheim is a particularly good example of this phenomenon, despite his study on suicide. Also, it should be noted that sociology developed at a time when medicine did not yet occupy a solid institutional and professional position, but was still in the process of defining itself as such. While sociology affirmed the autonomy of the social sphere, at the same time, the medical realm was defining itself exclusively on the basis of the opposite assertion, the autonomy of the pathological sphere. These two worlds thus appeared to be in direct and irreparable opposition from the beginning. After all, the development of the clinic (Foucault 1963) may very well have sounded the death-knell for the socialized conception of the individual in medicine, thereby eliminating from its field of investigation this social element, this subjectivity which only confused the objectivity of "pathological fact." This fundamental conception of the nature of medicine has its roots in the very heart of the Parisian hospital (Ackernecht 1967). And in France it is the *clinic* which will triumph (to a certain extent) to the detriment of the *hygiene* and a more lay-referral type of medicine.

This opposition and these tensions are still present in today's medical profession and in the French health system (Brémond 1999). They inform many of the reservations on the part of the medical profession with respect to managed care/medicine or to any social organization of coverage not necessarily based on strictly medical expertise (including the problem of the rising cost of health care). Moreover, the governing vision in France (except in the case of AIDS) is clearly one of a medicalization of all social problems. Initially responsible for determining the strictly pathological, physicians are now in the position of defining what is ethical as well (Orfali 1997; Paillet 1997), even if the profession has prudently begun to borrow from other disciplines (law, economics, or psychology, etc.). Decision-making in health care (at least in France) remains still largely dominated by the medical expertise.

It is certainly not our intention within the limits of this discussion to analyze the specific development of French medical sociology. At most we will try first to formulate a few hypotheses based on the paradoxes we have observed up to this point. Dominant from the moment of its inception, the clinical vision gained further strength on the basis of its own prestige (Claude Bernard). In this context, medical sociology was slow to emerge, finally appearing in the 1970s in conjunction with the first controversies over medical power and the first

hospital and medical studies reforms (Herzlich 1973; Steudler 1974; Chauvenet 1978). More than elsewhere, to borrow the expression of A. Touraine, “all of the elements that go to make up a society were not immediately recognized as belonging to the social sphere,”<sup>20</sup> in a context so heavily dominated not only by the medical, but also by the very “clinical gaze.”

In addition, while the United States was developing a more empirical school of sociology, often quantitative, French sociology at that time initially favored a more general, theoretical approach. But what most clearly differentiates French medical sociology is the prioritization of discourse over practices as a source of information for analysis. It is here that Foucault’s heritage becomes apparent. The analysis of discourse surrounding disease and health, as well as of medical discourse in general are the dominant themes of medical sociology “à la française.” Who speaks? What makes sense? The means of enunciation, production, and legitimization of discourse as well as the power dynamics of it are thus at the heart of these approaches, often inspired either by contemporary trends in Bourdieu’s sociology of social reproduction<sup>21</sup> (Boltanski 1971), or, from a more anthropological and psychosocial perspective, by work on social representations – of disease in the case of Herzlich (1973) or Chauvenet (1978), and more precisely of cancer in the case of Pinell (1992).

Today, medical sociology in France represents a much more diverse field. Many studies borrow from the dominant paradigms of medical sociology (interactionism, ethnomethodology, etc.). What these studies have in common overall is a greater focus on fieldwork. During recent decades, several ethnographic studies, most often inspired by the model of the “negotiated order” (Strauss 1963; Strauss et al. 1985), have been carried out on the experience of illness across various social strata, involving various types of patient (Baszanger 1986; Pollak and Schiltz 1987; Dodier 1993). There also exist a great many studies on specific populations – the elderly (Guillemard 1986), the handicapped, substance abusers, etc. Health care organizations such as hospitals, are either addressed by so-called “strategic analysis” (Crozier 1963, 1986), or more practical studies (Gonnet 1992), or else analyzed along more ethnographic lines (Peneff 1992).

Lastly, the inception within what constitutes “medical” sociology is perhaps not as clear in France as it is elsewhere, and on purpose; questions of health are now considered as “social” problems just as issues surrounding education, social marginalization, suburban violence, etc., and are assumed to originate in general sociology. The transformations which take place in the world of health and medicine today are seen thus to have social implications which exceed the simple limited field of the hospital, the disease or the medical institution.

The temptation for the French sociology is undoubtedly (and even more so than elsewhere) to connect health issues to some sort of broader “ultimate” conception of society.

### Notes

- 1 Source: La Documentation française, 1998.
- 2 Source: Insee, statistiques de l’état civil.

- 3 Active life expectancy: A global indicator of the health of a population, consisting of the number of years out of the total life span of the individual that are lived without illness or handicap resulting in incapacitation of the individual. Two levels of incapacity are distinguished – moderate and severe.
- 4 Source: indicateurs sociosanitaires, comparaisons internationales, évolution 1980–1994, Sesi et Diris. *La Documentation française*, 1998.
- 5 See Foucault (1963).
- 6 It must be noted that as this was a telephone survey certain sectors of the population were not contacted for their opinion, specifically those in nursing homes and the homeless.
- 7 Since 1996, France has experienced a dramatic drop in the number of AIDS cases; while in 1995 there were 5,208 new cases and 3,876 deaths by AIDS in France, in 1997 this had dropped to 2,289 new cases diagnosed and 1,311 deaths.
- 8 *La santé en France*, September 1998.
- 9 This reform, which has succeeded in slowing the growth of expenditure in public hospitals (from 15% per annum to 4% in 1996), consists of financing the hospitals through an annual budget instead of individually reimbursing the hospital according to each patient's care.
- 10 Report “*Health in France*” (*La santé en France*) by the High Committee of Public Health, 1994.
- 11 All 182,000 French doctors are required to register with the “Ordre des Médecins,” the French equivalent of a kind of AMA, created under the Vichy government to control access to the profession and maintain a certain standard of medical ethics.
- 12 Organized by the government, the “Etats Généraux” are a vast survey of the health care system throughout the country. Two surveys of this type have taken place to date, one on cancer, the other on health.
- 13 Survey by the French Association of Intensive Care (Société de réanimation de langue française), in *Réanimation urgences*, vol. 6, 1998.
- 14 Creation in record time of the ATU (temporary authorization of the use of certain drugs for human use) in 1994; creation of the CISIH (Center of information and care for human immune-deficiency) since 1987, with the aim “of closely associating patient care facilities and medical technology services and research in order to offer a better quality of care and services to the patients”; creation of the City-Hospital networks in 1991 etc.
- 15 Admittedly, unemployment had already started this separation, but in spite of its prevalence, it only very recently acquired a “positive” definition within the social sphere.
- 16 In February 1996, the national Council of AIDS proposed to determine access to these therapies (in case of a shortage) by drawing lots. It resulted in a nationwide outcry.
- 17 For example, the various hospital boards of directors were only opened up to patient advocates in 1996.
- 18 The first translations date back to 1970 with an anthology of texts published by C. Herzlich, *Médecines, maladie et société*, Paris–La Hague: Mouton.
- 19 By comparison the first handbook in German language dates back to 1974 (Siegrist 1974) as mentioned by Cockerham (1983).
- 20 Preface of A. Touraine (Steudler 1974).
- 21 Even if this particular sociologist never worked in the field of medical sociology.

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