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EXPERT OPINION

New Public Management, Austerity, and the Alienation of the Medical Profession in France

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Abstract: In the last twenty years, France has gone through health policy changes that are perceived as paradigm shifts. After briefly describing the reforms driven by the new public management and the subsequent re-centralization of the French health system for budgetary purposes, it appears that those reforms had outcomes below expectations. The regrouping of policy decisions within the Regional Health Agencies and the rise of a French Welfare elite weakened the medical profession. Blame-shifting strategy, political dilution, and spatial inequality linger. The COVID-19 epidemic highlights those limitations. The negative societal and political impact of failed public reforms is increasingly evident.

Keywords: France, public administration, health reform, new public management

Introduction

What were the specificities of the implementation of NPM and its outcomes in France? Although some anticipated NPM characteristics, such as the emergence of austerity measures and the establishment of performance indicators, did materialize in France, reforms were path-dependent. New Public Management (NPM) reforms led to administrative recentralization, new accounting mechanisms such as a Diagnostic-Related Group (DRG) scale, competition between care providers, and contractual incentives (eg, patient volume targets, a cap on expenditures). Policymakers underestimated the resistance from key actors such as the medical profession and overestimated NPM's ability to fix issues such as spatial inequality. COVID-19 highlighted many deficiencies in the health system. Austerity, blame-shifting strategies, and the dilution of political responsibilities remain problematic. Public reforms have had outcomes below expectations, and societal and political repercussions are felt today. The implementation of NPM resulted in an overload of complex information that did not ease the definition of health policies. It had unexpected social and political consequences that are still affecting France today.

NPM Policies in Health Care: Stylized Facts

New Public Management emphasizes quantification and performance evaluation of care providers, cost-control (for instance, via the promotion of generic drugs), transparency, greater autonomy of decentralized public organizations, decisions closer to end users, splitting large organizations into sub-units, incentivization, flexibility in HR policies and the creation of market or quasi-market mechanisms separating purchasing and supply functions. NPM and neoliberal economics assume that efficiency benefits will also arise from significant structural reforms. France has introduced competition and choice, leading to the growth of private clinics.[1] As of December 31, 2015, there were 3,089 healthcare providers of different sizes and statuses, including 1,389 public care providers (regional and university hospitals, hospitals, specialized psychiatric hospitals, and long-term care units); 1,009 private for-profit clinics and 691 private non-profit care providers.[2] The insurance sector was not spared. The share of for-profit insurance companies has risen sharply, and nonprofit insurance companies have adopted some for-profit behaviors.[3] For instance, they engaged in mergers or takeovers and accumulated gains instead of reinvesting them to provide their members with more benefits or services. For high-level

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bureaucrats, regulated competition between public and private care providers, the financialization of health services, and private investment were the preferred and necessary routes to improve the health system despite their negative implications for equity.[4]

But despite NPM's "aim at eliminating bureaucratic inefficiency", the reality of market adoption "*proved to be much more complex than market models predicted, which led to increased public interventions to sustain markets while protecting citizens from their undesirable effects*".[5] Hence, France embraced regulated competition but rejected marketization[6] and the provider/purchaser split that constitutes a core element of the Anglo-Saxon "NPM toolbox".[7] The British Commissioning model[8,9] instigated Clinical Commissioning Groups (CCGs). "*Every primary care practice, known as General Practices, was legally required to become a CCG member. CCGs were given responsibility for the commissioning (i.e. planning and purchasing) of most healthcare services for their patient pool, with the ability to purchase abroad range of services from a market of providers*", playing one against another to extract better contracting terms in terms of lower cost or greater quality for their patients. French politicians did not believe that the British model of governance based on a strong purchasing agency[10] such as the Regional Health Agencies (RHAs) might lead to an efficient provision of public services. Moreover, solo practitioners were unwilling to play one care provider against another to demand lower hospitalization fees or cheaper medical tests for their patients as British CCGs do.[11] Reforms also imposed a new perspective on patients, whom they view as customers, able to select the right provider for their needs. The choice of a public or private provider exists in large urban agglomerations, less so in rural areas, due to a shortage of care providers.

France embraced NPM-endorsed quantification of outputs or activity rather than the evaluation of patient outcomes, novel accounting mechanisms such as the DRG scale, and other contractual provisions (eg, pay-for-performance schemes, management by objective, patient volume target) to facilitate effective governance. In addition, "non-punitive responsive regulations can also enforce compliance".[12] Successive governments from both the Left and the Right shared a similar focus on cost containment, promoted a continued dominance of hierarchical modes of control along with a vertical line of command, supported the RHAs, and trusted the same programmatic actors for policy implementation.[13] Salient reforms also included the implementation of accounting standards[14] as well as benchmarking (via the adoption of DRGs and patient volume targets…), which heralded the emergence of the society of control[15] over professional bureaucracies (eg, hospitals) thanks to the rise of IT. Integrated health information systems routinely collect treatment and personal health data in hospitals. The administrative dashboard enabled the health authorities to manage distant healthcare actors, such as networks of hospitals, from a central command post. In 2019, the Health System Innovation Fund received €20 million and additional funding from regions. The agency theory was the basis for this massive use of performance indicators. Means must be found to ensure that the "principal" (the government) will obtain the best cooperation from the "agent" (the medical profession), knowing that everyone has a possibly discordant goal. The former desires to regain its authority to enforce fiscal discipline, while the latter seeks to benefit from its efforts, thus potentially undermining the former's intentions.

Delegation of Public Health Services

NPM reforms primarily affected public hospitals, which represent the largest source of health expenditures (34% or 59 billion euros), paid for by Social Security.[16] Public hospitals also account for 61% of hospital beds. 15% of beds are in private non-profit care providers and 24% in private for-profit clinics,[2] according to Drees (2017). There was no privatization of public hospitals. Other industries (eg, the airline and telecommunication sectors…) were privatized with less difficulty.[1] Health authorities delegated services to private care providers, including maternity care, rehabilitation, and emergency services. Contrary to the elite of international institutions,[17] the French public does not support the privatization of its public services, even less so for services as critical as health. French citizens have traditionally looked to their government to ensure their well-being and offer essential public services. This trust has led to a preference for private contracting over outright privatization. Outsourcing enables the state to retain a certain degree of authority and supervision while engaging private enterprises to provide particular services on a per-case basis. Private contracting is also accepted because it is subjected to performance evaluation. In contrast, privatization is not because it is perceived as a transfer of public resources to private entities without proper supervision. However, the closure - rather than privatization - of the smaller public hospitals, or their regrouping within larger facilities for safety reasons

(eg larger hospitals have better health outcomes than smaller ones), will eventually lead to their substitution by a private operator, even though the "empirical evidence does not systematically support the hypothesis of lower costs and higher efficiency when private organizations deliver public services".[18] Though needs are higher due to population aging, the reduction of public hospital beds (69,000 between 2003 and 2017) put patients at risk. Moreover, downsizing is associated with worse service quality due to job retrenchment.[19] This became evident as the COVID-19 epidemic unfolded. Private hospitals lagged as patients were primarily channeled to public hospitals, and coordination between public and private hospitals was poor.

The Administrative Restructuring

The 2009 HPST Hospital Patient Health Territories Act created the Regional Health Agencies (RHAs) that regrouped all healthcare responsibilities, not just hospital policies, as in the earlier Regional Hospitalization Agencies. The RHAs were to bring efficiency gains (eg, economies of scale), solve the agency problem between top-level policymakers and physicians, and improve hospital governance. While, in theory, policies and frameworks are tailored to local situations, the Ministry of Health and the Central Health Authorities remain the major decision-makers via their control over budgeting resources. The Ministry of Health, the Social Security (SHI), and the National Sickness Fund signed a four-year contract establishing health service goals and resources. A National Coordination Committee (NCP) supervises their redistribution among the RHAs. Funding of the RHAs depends on a risk-adjusted allocation system designed to minimize health disparities across regions.

In theory, regional agencies must be 'autonomous' and 'innovative' to ensure more "territorialized" health policies. Although RHAs can be viewed as a step forward in transferring responsibility to the local level, the Ministry of Health retains the authority to appoint the RHA director. Moreover, RHAs are constrained by national regulations and financial oversight that follow the traditional French centralization model. The central government (the Ministry of Health, Ministry of Budget, Ministry of Economy and Finance…) sets health policy goals, allocates resources to achieve them, and sets benchmarks to determine if these objectives are achieved. Social Security defines the lump sum allocated to each RHA. Therefore, the RHA's financial autonomy is limited. The Ministry of Economy and Finance - not the RHA - is also responsible for filling the new positions of finance directors mandated by the HPST law. A National Cap on Health Expenditures is set at the highest level annually (eg, by parliament) and is not determined by the RHAs.[1]

Nakatani et al[20] and Antón et al[21] found a negative relationship between decentralization of the health system and health outcomes. On the other hand, Chastonay et al[22] argue that decentralization is linked to improved health outcomes such as a longer life expectancy, lower infant mortality, and higher healthcare costs. Though higher costs can be partially attributed to the increased complexity, transaction, and contracting costs of a decentralized health system,[23] these higher costs positively impact health outcomes due to higher investment in health facilities.[24,25] Moreover, decentralization improves health equity by reducing intra-regional variations in health outcomes.[26] This suggests that centralization adversely affects the quality of the health system. The French recentralized health system illustrates the point. It performed below expectations in critical areas. The infant mortality rate (3.8 deaths per 1000 live births) is above the EU average (3.4 deaths per 1000 live births) and has slightly increased since 2013. France also performs below the EU average for preventable mortality.[27]

According to Nakatani et al,[20] good governance is also critical in enhancing healthcare delivery during national emergencies. During the COVID-19 crisis, decentralization,[28] or the simultaneous coordination of centralization and decentralization, can ensure a more effective response to the crisis.[29] The COVID-19 pandemic exposes the limits of the French recentralization reforms. At first, there was an unprecedented centralization of health governance.[30] In the first few months of the pandemic, the government adopted a "one size fits all" approach, enforcing a uniform containment strategy (such as social distancing, mask mandates, and travel restrictions) throughout France, even though the epidemic did not affect all the provinces in the same way and with the same severity. The central government managed hospital capacity, including transferring patients between regions and even to foreign countries like Germany, which has nearly four times more ICU beds than France (29 per 100,000 residents against 7,5 for France), allocating medical supplies, and distributing vaccines. The French president formed a *Defence Council* consisting of the Prime Minister and a small group of handpicked advisors who became responsible for all health policies.[31] Many local and regional officials criticized the government's decision-making process due to its highly centralized and opaque nature.[31] Another indication of the

concentration of decision-making power was the declaration of a "state of emergency", which authorized the government to implement policies through executive orders without parliamentary approval.[31] The RHAs, directly linked to the Ministry of Health, were in charge of local steering.[32] The Prefect and the RHA often opposed local initiatives, such as a local decree mandating a curfew or wearing masks. However, the RHAs lacked responsiveness. They appeared to be a "fuzzy compromise" between proponents of a centralized system dating back to Napoleon and supporters of an Anglo-Saxon-modeled decentralized system.[33,34] The lack of coordination among Regional Health Authorities (RHAs) and the misalignment of policy responses at the national level weakened the country's ability to address the COVID-19 epidemic. Decentralization occurred during the second phase of the epidemic, as the local government implemented territorialized measures (curfews) in collaboration with regional authorities.[31] The blame game was in full swing, with the central government trying to shift responsibility to the regions to avoid another nationwide lockdown, which could only exacerbate the population's anger against the government. However, the epidemic could not be contained, and a national lockdown had to be declared. The results of this lack of preparedness, policy shift, delays, and weakened hospital infrastructure became evident. On March 6, 2022, the fatality rate per resident was 50% higher in France (2,272 deaths per million inhabitants) than in Germany (1,496 deaths per million). On January 13, 2023, it was still 25% higher in France (2,453 deaths per million inhabitants) than in Germany (1,964 deaths per million), and comparable to supposedly less robust healthcare systems such as those of Spain (2,480 deaths per million inhabitants), and Portugal (2,500 deaths per million inhabitants).

DRGs as an Accounting Mechanisms and the Elusive Quest for Quality

Apart from this top-down administrative reshuffle, the DRG scale restructured accounting methods in health care, homogenized the compensation of all hospitals, and aimed at controlling the professional bureaucracy (eg, physicians) from an administrative dashboard. While yardsticks such as DRGs are designed to govern or steer from "a distance",[35,36] they are biased toward cost control rather than equity and quality of care.[1] They appear to be "relevant for simple and standard procedures that require a short hospital stay (eg, maternity or ambulatory care)" but apply with difficulty to long-term care, more complex procedures, or severely ill patients who require a greater individualization of care.[1,37] DRGs were initially calibrated for a sample of average patients that excluded the more severe cases or more vulnerable patients suffering from comorbidities (eg, chronic disease). By emphasizing activity-based payments rather than payment for outcomes or payment-by-results,[38] the Diagnostic-Related Group prompts providers to select the most profitable procedure rather than the most appropriate one. In response, there is a greater emphasis on compensating hospitals fairly to address concerns that a private healthcare system may eventually undermine the public sector by cherry-picking patients, leaving the more complex and expensive cases or least profitable patients to public hospitals. The latest DRG compensation scale reflects patients' greater severity and complexity thanks to the addition of four levels of severity with different compensation levels for each. The COVID-19 epidemic illustrates the limitation of DRG payments. The type of symptoms and duration varies widely from one patient to another, which makes setting a standard fee per COVID-19 case impossible. Despite the rise of evidence-based medicine,[39] the shift from a simplistic conception of output, such as the number and type of procedure, as in the DRG scale, to a more complex one that measures actual patient outcomes and quality of care has yet to be achieved. There is little data on the quality of health services in France.[1] There is no information on how patient status at discharge affects readmission rates and how the pressure to make a profit can adversely affect patient outcomes despite France having one of the largest private healthcare sectors in Europe. In the US, nonprofit hospitals have "a statistically significant negative association with readmission rates".[40] Even when quality is assessed, penalties for care providers after patients are readmitted to public hospitals (which would indicate that they have not been treated properly in the first place) seem to have no effect.[41]

Discussion

Centralization and the Conversion to Austerity

Concentration, centralization, and top-down decision-making illustrate the French transformation of the state in the aftermath of the 2008 recession.[1,42] It created a "window of opportunity" to promote centralization and cost-containment

as part of the solution to the crisis,[43] shifting reforms from "welfare state restructuring" to "austerity"[44] with little consultation from the medical profession and patient representatives. As suggested by Pinto et al,[45] austerity measures prompted a centralization of the financial resources within the RHAs. Professionals rightfully perceived this restructuring not as ideologically and politically motivated but as fiscal discipline hiding behind evidence-based policy, which provides support to Lucas's view of evidence-based policy "as a resource that may or may not further entrepreneurial plans" and "in which actors exercise judgment and collaborate regarding policy change".[46] In practice, that policy change led to a conversion to austerity at the expense of quality and responsiveness. That threatened citizens' view of health as a human right.[47] Public reformers and high-level bureaucrats tried to translate problems such as the lack of means (ie, the underfunding of public hospitals) into organizational issues, with the intent to "hold the medical profession responsible for the difficulties they encounter in their daily practice".[48] The centralization of the health system did little to contain the COVID-19 epidemic. It did not prepare the system for a major outbreak. Earlier austerity measures prevented the health system from addressing new health emergencies.

Performance Definition and Physician Alienation

The definition of performance in health care is set by the current dominant stakeholder (eg, the Welfare elite, the Ministry of Health),[49] not by a coalition of stakeholders that would include patient representatives and physicians' unions. Performance criteria sought to reassert the center (eg the Ministry of Health, the Central Health Authorities)[1] to restore fiscal discipline ie Governance by Public Finances[50] at the expense of access or affordability for the public.[1] Performance indicators consist of short-term financial goals (eg, hospitals' net revenue) that lead to the closure of emergency services in city centers or maternity hospitals in rural areas as these proved too expensive to operate. These cost containment measures were also at the expense of long-term public health objectives, including access to health services (eg, longer driving times for citizens), quality (eg, hospital league tables still do not exist, patient readmission rates are not recorded), and equity. Moreover, they depend on a context or preferences that often reflect policy-makers' views at a given time rather than citizens' preoccupations. In health care, those indicators range from *Efficacy* (does it satisfy a health care need? Do the services provide the quality a patient can legitimately expect no matter the costs?), as demanded by patients and physicians, to *Efficiency* (is the service provided at a reasonable price?), as expected by the Government and Social Security, to *Service Attributes* (eg, accessibility of care providers, waiting times, as per the patients' view). The emphasis of reforms on efficiency questioned the values of civil servants, not just health care professionals. Can civil servants embrace the quest for performance set by the central health authorities and remain committed to shared public values?[51] In healthcare, the pursuit for "efficiency" was associated with a deterioration of the quality of care,[48,52] as exemplified by saturated Emergency Departments (EDs), long waiting lists, and the rise of hallway medicine in public hospitals. Lux[53] identifies a wide range of attitudes of collective actors (eg health professionals) ranging from total rejection, as exemplified by the street demonstrations in the aftermath of the 2009 HPST law, to acceptance in a multidimensional approach (eg financial, organizational, social and societal), and pacification.[54,55] Coping strategies,[56,57] ranged from hostility to pacification, but never acquiescence, as more emergency physicians went on strikes, as in May 2019 (95 EDs services were on strike) and August 2019 (213 EDs went on strike) to protest against the lack of resources. Healthcare professionals remain strongly attached to access and quality as opposed to the fiscal discipline of the Regional Health Authorities. Performance-based competition between care providers and management by objectives alone cannot discipline healthcare professionals, as they have professional, public, and organizational values that may conflict with those of the Welfare elite. Moreover, "indicators cannot replace the judgment of informed people".[58] Hence, the need to fight against our corporate obsession with yardsticks and performance reporting,[59] to accept that many public values can be neither quantified nor prioritized and that we will disagree over the choice of indicators.

NPM, Blame-Shifting Strategies and the Dilution of Political Responsibilities

Despite the rise of health economics as a full-fledged discipline in the 1990s and a tradition of costs and benefits analysis in many other public areas such as transportation and infrastructure, accountability to the public, be it horizontal or vertical, is lacking. As in other industries, NPM-driven quantification of outputs and the verticalization of decisions (ie top-down decision-making process from the Ministry of Health to the Regional Health Agencies) led to rule breeding[60] and

a strengthening of the audit society[61] rather than greater accountability to the public. The quest for a transparent government remains elusive[1], despite more regulations and anti-corruption mechanisms.[62] A decree (decree n° 2016–1939, of 28th December 2016) reinforced regulatory measures in the aftermath of the Mediator scandal to prevent conflicts of interest between health professionals and healthcare organizations. NPM-driven outsourcing, agencification, contracting out, the delegation and outsourcing of responsibilities to external private providers[19] all create opportunities for politicians to shift the blame to outsiders.[63] Negative repercussions regarding reputation loss are short-term for the government, as the private provider takes all the blame. Patients and the medical profession suffered from novel forms of power obstructing regulations[64] or "regulatory disempowerment". A reduced public access to information, the concentration of decision-making power among high-level appointed - rather than elected - bureaucrats, the removal of patient representatives from the hospital board of directors, and the dissolution of political responsibilities, as exemplified by the inability to identify those responsible for the failed PPPs in the construction of hospitals (8.000 defects for the Sud Francilien Hospitals)[65] and the poor handling of the COVID-19 crisis by French public authorities[66] also confirms Taleb's more recent work:[67] No decision makers has to endure the consequences of his/her decision. Therefore, new mechanisms are needed to prevent blame-shifting between appointed bureaucrats and politicians and the use of NPM as a reputation-protecting tool.

Failed Activation Policies and the Surveillance Society

Rapid advances in our ability to collect, analyze, and disseminate information are transforming public administration.[68] New opportunities for real-time insights into behavioral patterns appear in the French healthcare system, as evidenced by the rise of epidemiology and population studies,[69] thanks to the addition of IT departments in every French hospital. Value-based management in health care has triggered an "insatiable demand for knowledge that seeks to map the health outcomes and the associated costs of treatment".[70] The government promoted smart technologies, machine learning,[71] the use of artificial intelligence in health care, and the digitalization of public services to improve information sharing, joint care protocols, and regional planning of local populations' general needs. However, not every IT initiative succeeded. Only 3% of the population downloaded the StopCovid application. End of June 2020, it had only identified 14 cases, despite its cost of 200,000 euros per month for taxpayers.[72] Reforms also presume that policymakers can process all the information that comes their way. However, when individuals are presented with too much information and many options, they cannot process it due to their bounded rationality. The most optimal decisions are out of reach, as individuals prefer routine and habits.[73] In theory, the NPM's reliance on information technologies promises greater certainty. In practice, it proved elusive.[74] The COVID-19 epidemic proves the point. Despite greater availability of information, outcomes were below expectations, as patients were being flown to distant public hospitals while nearby private hospitals remained empty. Medical services of the fire brigades were underutilized. Forecasts regarding the spread of COVID-19 were often inaccurate despite the rise of epidemiology studies. Poor policy planning led to a Personal Protective Equipment (PPE) shortage. The extensive collection of data raises more questions than answers for policy-makers. What information should be collected? What do we make of it? How can we convert these data into health policies? Will it increase certainty, as it does for epidemiological studies, or pose a threat to gradually "sleep-walking into a surveillance society" ?[74] Government transformation programs that rely heavily on IT may slowly foster a surveillance society that "fails to comprehend what citizenship entails".[74]

Enduring Spatial Inequity

The problem of the Medically-Underserved Areas (MOU) (18% of the French population lives in a MUA) is longstanding.[1,75] Hospital capacity and status vary across the French provinces. According to Drees,[76] private clinics are nonexistent in the provinces of Aveyron, Lozère, and Mayotte . On the other hand, they account for 40% or more of the total bed capacity in these regions: Haute-Garonne, Hérault, Pyrénées-Orientales, Tarn-et-Garonne or even Corsica, Bouches-du-Rhône and Seine Saint-Denis. Hence, issues related to territorial[77] and health inequity,[78] as exemplified by regional differences of up to 80% in the probability of dying of a heart attack within 15 days,[79] remain only partially addressed. The restructuring of hospitals led to a re-concentration of resources in large cities despite citizens' complaints about the lack of key facilities such as emergency services and maternity hospitals in rural areas. The rise of magnet hospitals[80] at the expense of local hospitals in rural areas illustrates the point. Geographic inequity is now being

addressed with a piecemeal approach, for instance, by removing the quota system for academic health centers. Back then, academic health centers could not cope with the influx of medical students (35,000 in 1963; 59,800 in 1967). Furthermore, medical students will work at least six months of their last year of post-graduate studies in Medically Underserved Areas (MUAs). 1,100 French hospitals were reorganized into' approximately 150 Regional Hospital Groups (RHG). These will set up local networks of public and private actors, which implies formalizing coordination mechanisms and hiring network managers.[81] Each Regional Health Agency (RHA) created RHGs in its respective area. In retrospect, these have had very different sizes, ranging from two to 20 facilities, covering between 50,000 and 2 million inhabitants.[82] However, evidence of their effectiveness is lacking, as each RHG seems to have its own logic. While some used their actual geographic markets (hospitals' catchment areas) to create new hospital groups, others relied on administrative borders (eg districts, regions) to form networks of care providers. Cooperation with private clinics is needed to address the local shortage of resources and increased costs.[83] Moreover, their coordination capacity depends on cultural factors, such as mutual trust.[84] The latter is often lacking between public and private hospitals. For example, private hospitals were underutilized during the COVID-19 pandemic. The government preferred to resort to military field hospitals rather than private hospitals to address the shortage of beds. The Association of Private Hospitals even pled the Minister of Health and the Regional Health Agencies to requisition 10,000 beds in private hospitals to alleviate the load of public hospitals during the COVID-19 pandemic.

Societal and Political Repercussions

At the juncture of multiple areas (eg, economics, welfare, public administration, geography), the healthcare system poses a wicked problem. The societal and political repercussions of NPM were often underestimated. Like other nations,[85] the French working class is under strain. Symptoms are multiple. These include alienation and dispossession of their values, political exclusion,[86] and alterophobia.[87] There is a growing defiance against "reigning neoliberal elites",[88] an Anglo-Saxon-modelled political over-representation of the rich[89] and a powerful caste of high-level civil servants that are untouchable.[90] On top of that, add the "perception that arrangements are not fair, despite liberal democratic ideals of free and equal citizenship".[91] Other compounding factors include geographic marginalization and isolation;[92] the fiscal stress of the smaller municipalities and a demographic crisis in rural areas. NPM's shortcomings led to a more critical questioning of its early promoters, notably the French political elites. Moreover, it also reiterated calls for a revamping of the EU.[93] Hence, a renewed class warfare[94] against inequity and globalization,[95] as exemplified by the 2016 *Nuit Debout* movement that protested against liberal labor market reforms. Started in rural and semi-urban areas, the *Yellow Vest*[1] movement that mobilized without the involvement of trade unions or community leaders[96] also illustrates the point. French politicians underestimated the causes of citizens' frustration. They could not address them with adequate policies. While France is not devoid of populist leaders who want to gain office and "shake things up",[97,98] French populism manifests itself differently. It called for the direct participation of citizens in public policy via referendums and further administrative decentralization,[1] as in Proudhon's theory.[99,100]

Conclusion

We find partial validation of Fernández-Gutiérrez and Van de Walle research[101] on the contextualized nature of administrative values, as these vary across countries, times, and institutions. France emphasized the recentralization of health policy decisions within the Regional Health Agencies and the Ministry of Health. However, the response brought by the French government to the COVID-19 epidemic did not meet expectations, highlighting the need for decentralization.[102] Officials at the top of the hierarchy and those with a business or economics education, including Graduates of the French National School of Public Administration (ENA), emphasize fiscal discipline. Due to NPM, France's administrative culture now has a stronger efficiency orientation.[101] However, that direction does not reflect the preoccupations of citizens, who value equity, affordability, and access. Accountability to the public has receded. Reforms also highlight the techno system's pivotal role in shaping contemporary society[103] at the expense of citizens and healthcare professionals and the consequences of austerity measures when catastrophic events occur. NPM-driven lean management led to a shortage of hospital beds. The COVID-19 epidemic revealed geographic inequalities in accessing care.[104] It prompted a short-lived debate on the necessity to revive industrial policies[105] and manufacture Personal

Protective Equipment (PPE) to reduce dependency on foreign suppliers. France's inability to develop and mass-produce a major vaccine even months after the disease outbreak was "a significant blow to its scientific prestige"[31] and another symptom of its deindustrialization. Major catastrophes such as COVID-19 neither changed the course of centralization reforms that failed to deliver on their promises nor reversed long-term trends (eg receding innovation, deindustrialization).

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Data sharing does not apply to this article as no new data were created or analyzed in this study.

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