France: nation and world 2

State humanitarian verticalism versus universal health coverage: a century of French international health assistance revisited

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This is the second in a Series of two papers about France

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The French contribution to global public health over the past two centuries has been marked by a fundamental tension between two approaches: State-provided universal free health care and what we propose to call State humanitarian verticalism. Both approaches have historical roots in French colonialism and have led to successes and failures that continue until the present day. In this paper, the second in *The Lancet*'s Series on France, we look at how this tension has evolved. During the French colonial period (1890s to 1950s), the Indigenous Medical Assistance structure was supposed to bring metropolitan France's model of universal and free public health care to the colonies, and French State imperial humanitarianism crystallised in vertical programmes inspired by Louis Pasteur, while vying with early private humanitarian activism in health represented by Albert Schweitzer. From decolonisation to the end of the Cold War (1960–99), French assistance to newly independent states was affected by *sans frontièrisme*, Health for All, and the AIDS pandemic. Since 2000, France has had an active role in development of global health initiatives and favoured multilateral action for health assistance. Today, with adoption of the 2030 Sustainable Development Goals and the challenges of non-communicable diseases, economic inequality, and climate change, French international health assistance needs new direction. In the context of current debate over global health as a universal goal, understanding and acknowledging France's history could help strengthen advocacy in favour of universal health coverage and contribute to advancing global equity through income redistribution, from healthy populations to people who are sick and from wealthy individuals to those who are poor.

Introduction

The French contribution to global public health has historical roots in French colonialism and is marked by a fundamental tension between two approaches: State-provided universal free health care; and what we propose to call State humanitarian verticalism.

On the one hand, French initiatives to improve the health status of populations in developing countries include putting greater emphasis on structural factors as determinants of health outcomes compared with most other high-income countries. In practice, this emphasis includes: taking health and non-health infrastructure into account when designing interventions; focusing on strengthening health systems and, particularly, health infrastructure; transferring not only technology but also the French model of social protection; linking the improvement of health with reduction of inequality and promotion of universal health coverage; and linking health with the need to rebalance north–south relations—eg, unequal terms of trade, intellectual property rights, income and gender inequalities, etc.

On the other hand, French State interventions have reflected, in large part, a pragmatically biomedical orientation, attacking major health problems through what are now termed vertical disease programmes. Taking on form and breadth thanks to the French Empire, and allying itself closely with the colonial project and with doctors from the military, this verticalism became one of two predominant traditions in France's international health assistance.

As noted by Michael Barnett,[1] the standard and abbreviated history of humanitarianism typically portrays it as having been invented at a precise moment—eg, Henri Dunant's witnessing the Battle of Solferino in 1859 and the creation in 1863 of the International Committee of the Red Cross—and as having a set of fundamental principles, such as impartiality, neutrality, and independence. These principles provided humanitarian actors with an apolitical stance, allowing them to claim the ethical high ground and leave politics to governments. In fact, Barnett points out,[1] the history of humanitarianism is much more nuanced and complex: it is considerably older than the Red Cross; its principles were not created *ab initio* but developed over decades; and its scope and diversity of activities has been—even before the end of the Cold War—broader than the activities of non-governmental organisations (NGOs), with states having long been deliverers of humanitarian assistance.

Over the course of almost two centuries, France's State humanitarian verticalism has been in tension with another project that has also been a constant in the history of French international health assistance—namely, State-provided universal free health coverage. As a result, France's global health activities have been marked by attempts to manage the tension between these two approaches and to ensure their complementarity,

depending on the evolution of the historical and political contexts. Focusing on sub-Saharan Africa, in this paper—the second in *The Lancet*'s Series on France—we look at how this tension has played out over three epochs. First, during the colonial period (from the 1890s to the 1950s), the Indigenous Medical Assistance (*Assistance Médicale Indigène*) structure was supposed to bring metropolitan France's model of universal and free public health to the colonies, and French State imperial humanitarianism was crystallised in vertical programmes inspired by Pasteur, while vying with early private humanitarian activism in health represented by Albert Schweitzer. Second, during the period from decolonisation to the aftermath of the Cold War (roughly from 1960 to 1999), this tension was reproduced in what became French bilateral and multilateral assistance to newly independent states and was shaken up by the arrival of French *sans frontièrisme* (without borders), Health for All, and the advent of the AIDS pandemic. Finally, in the period after 2000, France had an active role in the development of global health initiatives, notably by recalibration of its health assistance practices to prioritise multilateral action.

Nowadays, with adoption of the 2030 Sustainable Development Goals, and with global factors such as the rise of non-communicable diseases, growing economic inequality, and the challenges of climate change, French international health is again at a crossroads. Revisiting France's historic tension between universal free health care and State humanitarian verticalism could help strengthen its long-standing advocacy in favour of universal health coverage and, thus, contribute directly to advancing global equity through income redistribution from the healthy to the sick and from the wealthy to the poor.

Colonial period to the era of independence (1890s to 1950s)

State-provided health care and Indigenous Medical Assistance scheme

By contrast with the tightly restricted benevolent activities of *corporations* (guilds), France's 1789 Revolution and the 1793 Declaration of the Rights of Man and of the Citizen provided a new idea of how health care should be provided in France and to whom. Between 1830 and 1905, both a social security system and a system of social assistance were created based on founding principles that remain the core components of the current system.[2,3] First, came the mutual benefit societies (*mutuelles*), which were based on voluntary collective contributions and limited to a few industries or companies. Legally recognised in 1835, they were granted complete freedom of operation in 1898. Later, a system of social assistance was created based on individuals' means or that of their family. Free medical assistance arrived in 1893, social assistance for children in 1904, and assistance for elderly people or those with disabilities in 1905.

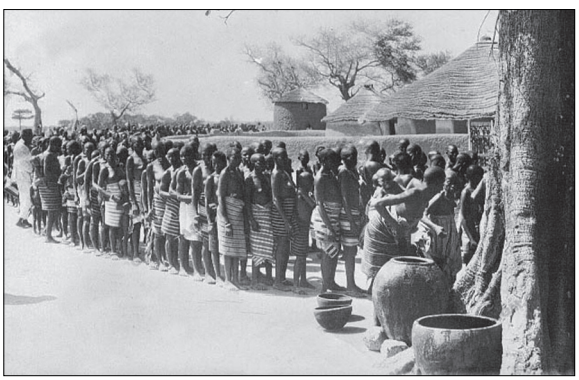

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Figure 1: **A gathering of the population in Ségou, French Sudan**

The shortcomings and limitations of these forms of assistance gave birth early in the 20th century to the first attempts to create a social security system in France, a system of which the basic principles were built in 1945 and remain in force.[4,5] As stated by the Ordinance of Oct 4, 1945, "Justified by an elementary concern for social justice…social security is the guarantee given to everyone in all circumstances that they will have the resources needed for their sustenance and that of their family in decent conditions". Provisions were later set out covering sickness, maternity, disability, old age, and death. The Law of May 22, 1946, established the principle of generalised coverage for the entire population, which in turn was the basis for the current State-planned health-care system—general, universal, and mostly free of charge at the point of access.[6,7]

French international assistance professionals often evoke this universal health system when proposing structural changes or broad, long-term reforms for health systems in developing countries. However, although the history of the French health-care system is well known, the fact that France's practices in its colonies differed greatly from those on the continent is not. Relationships between colonies and metropolitan France derived directly from the Republican principles of 1789 and its ambiguities: the Republic was one and indivisible and colonies were supposed to be an intrinsic part of and reflect the Republic in every particular.[8] Despite a discourse that invoked the same ideas as those reigning in metropolitan France, the reality was a multi-tiered system in which internal tensions emerged and slowly increased during this period (1890s to 1960).

In theory, indigenous peoples had the same rights of access to health services as did Europeans via the Indigenous Medical Assistance scheme created in the early 20th century (figure 1). This scheme was supposed to offer the same access to health services as in metropolitan France since health was one of the three grand elements vaunted as representing the civilising mission of France at the time, along with education and the fight against slavery.[9] Yet very quickly, the Indigenous Medical Assistance scheme ran out of money because

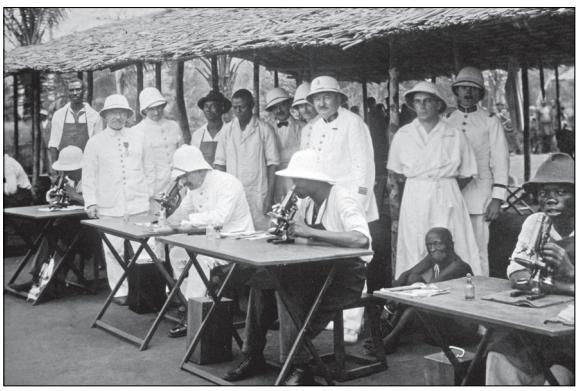

Figure 2: **Eugène Jamot and the mission against sleeping sickness in Africa**

the colonial authorities remembered that the African colonies were supposed to turn a profit and not be a burden on the French State.[10]

During the first phase of the colonial period (1890s to 1940), France faced a strong contradiction between its civilising mission and the constraint that the colonies should contribute to state coffers, since almost all the French population remained hostile to the colonial enterprise.[11] In practice, France's health efforts in its African colonies focused on large vertical programmes to fight epidemics. At the same time, a new situation arose outside of the State but that had a powerful effect on it: non-governmental assistance efforts that attempted to remedy the insufficiencies of the Indigenous Medical Assistance scheme. Both were informed not only by compassion but also by remorse and a desire for redemption. Identified with the towering figures of Pasteur and Schweitzer respectively, they provide us with two antithetical yet iconic models of French health assistance in its colonies.

Imperial state humanitarian efforts focused on vertical programmes

The Pasteur model (referred to as Pasteurism) was implemented in the French colonial empire after World War I at a time when French colonial authorities began to organise treatment and mass prophylaxis in colonised territories, granting broad authority to the Pasteur Institute.[12–14] The strategy pursued by Pasteurians was focused on epidemics and—specifically—on sleeping sickness in Africa, the defeat of which was judged the first challenge for any large colonial project there. In this respect, the vast campaign against sleeping sickness launched in Cameroon by Eugène Jamot was impressive in scale: the mission had more than 30 European doctors and assistants, 150 indigenous nurses, and a large entourage of local staff (figure 2).[15,16] For several years, Jamot's mobile health teams toured much of Cameroon to carry out mass screening of the population, summarily gathering the people and using draconian methods.[17] Individuals positive for sleeping sickness were sent to treatment teams, with some patients having a large "T" (for trypanosomiasis) painted on their chests.[18]

With this large-scale action, carried out in collaboration with the French military's medical service, Pasteurism in Africa was a scientific laboratory for the fight against epidemics, and a political laboratory for good colonisation.[19] For the Pasteurians, many of whom were military doctors with scientific progress (through health and education) and State intervention the two cornerstones of their actions, the fight against epidemics was the mission *par excellence* of France in Africa.

Pasteurians identified themselves as State humanitarians, and their focus was mainly to save lives; they were fervent critics of colonial medicine, with its distinction between Europeans and indigenous people and were often described as crusaders.[14] Jamot declared that the early years of colonisation had destabilised indigenous communities in various ways, with sleeping sickness epidemics being the most visible and tragic result.[14,20] Colonialism, therefore, had to take responsibility for the perils to which indigenous populations had been exposed, and civilian authorities should subordinate their immediate economic interests to the urgent eradication of these medical scourges—described by Jamot as "*un devoir de justice*",[20] a matter of justice.

Pasteurians also affirmed loudly and clearly the engagement of the French State and colonial apparatus and held high the civilising mission of Europe, with health as one of the cornerstones of the colonial mission—ie, requiring that indigenous populations submit to the benefits of European scientific achievements to protect them from pathogens and viruses, of which they were unwitting victims. Pasteurians lectured not only French colonial administrators but also other colonial powers: diseases knew no borders, and Pasteurism embodied the national genius in a context where European rivalries were played out as much in the spectacular eradication of an outbreak as on the battlefield.[19,21]

In this context, serious conflicts arose between Pasteurians and some colonial administrators, who would not agree easily to suspend the profitable colonial project in order to eradicate diseases, and their arguments are noteworthy.[12,22] Particularly under fire was the institutional autonomy of Pasteurians, with which they had been able to make rules and submit local populations and colonial administrators alike to their authority as crusaders and incarnations of state humanitarianism. Their demands on behalf of a worthy cause—ie, the health of populations—and the civilising project of colonisation were also questioned. Jamot was the object of controversies with the French colonial administration because of the methods he used, although these views were shared largely by other colonial doctors from, notably, Belgium and Great Britain, and sparked resistance and rebellion among indigenous populations.[23] Eventually, Jamot and other Pasteurians faced criticism over the violence of their approach, their focus on one disease to the detriment of the overall health of populations, and the effectiveness of treatment. Buoyed

by this criticism, the Ministry of Colonies in 1932 summoned Jamot to France in 1935, where he died 2 years later, and suspended the autonomous service dealing with sleeping sickness and integrated it within the Indigenous Medical Assistance scheme.

Nonetheless, the Pasteurian effort in Africa permanently marked the colonial period, and its conflicts were quickly swept under the table in favour of a myth—that of a paragon of France's medical and health *œuvre*.[24,25] This brings us to the nub of a paradox: the achievement of the Pasteurians—particularly their codification of public health practices—made them both privileged actors of the colonial project and creators of a tradition of a State humanitarian verticalism against major diseases that survived well beyond decolonisation and that is still with us today. For example, the US President's Emergency Plan for AIDS Relief (PEPFAR), which was launched in 2003 and is sometimes described as the biggest global public health intervention programme in history, could be viewed as a US prolongation of this Pasteurian tradition, adapted to the context of 21st century globalisation.[26]

Private humanitarian activism in health

In 1913, Albert Schweitzer began a tradition that would resonate deeply in French ideas and practices regarding health over the years, independent of the State's efforts but often having a strong effect on them. Trained as a classical musician and Protestant theologian, he chose later in life to study medicine so that he could go deep into Central Africa—a place defined by the slave trade. Schweitzer lived before World War I in Germany, and he became French with the Treaty of Versailles. Schweitzer made a very deliberate choice: to move to what he regarded as the primitive world (*sauvagerie*) and the locus of suffering and to heal the local communities both physically and spiritually.[27] Referred to as the *Grand Docteur*, he regarded his hospital in Lambaréné, Gabon, as both confessional and clinical, a place where—unlike the practice of Pasteurism's mobile health teams—he would offer both medical and pastoral care.[28–31]

Also by contrast with Pasteurians, Schweitzer did not worship science and progress and did not adhere to modernity's teachings about narratives of progress or the role assigned to the public sector. He was not impressed by the State and greatly annoyed the French administration in Gabon, which he was able to ignore from his hospital on the banks of the river Ogooué. A doctor without borders before the term had been coined, Schweitzer was constantly on the move between Lambaréné, Europe, and the USA as his reputation became increasingly global, and he took advantage of this fame to raise funds for Lambaréné through concerts and conferences and by rallying the support of the Unitarian fellowship—a Protestant offshoot to which he belonged for many years—and of international figures, including Albert Einstein.[28,30–32] Although Schweitzer was the subject of criticism and controversy for his egocentricity and the quality of medical care provided at Lambaréné, the image of the *Grand Docteur* prevailed, and he was awarded the Nobel Peace Prize in 1952, which was publicised widely in France, despite Schweitzer never receiving much support from its citizens.[33]

In common with Pasteurians, Schweitzer operated in a register of remorse and atonement. Similar to other people at the time, who were undertaking faith-based projects in African colonies (eg, nursing orders of nuns),[34] he set colonialism the task of atoning for the evil committed on the African continent over the centuries and of fulfilling a humanitarian duty, owing less to charity than to an ethical imperative for repair and redemption.[35] Moreover, Schweitzer expressed scepticism about the privileged position assigned to the State (such as it was in Africa—ie, the colonial administration) in looking after afflicted people, through his promotion of private initiatives providing individual care in specific locations, his attempts to alleviate the suffering of small numbers of individuals at the local level, and his use of international networks outside the colonial spheres.

As far back as the early 1920s and 1930s, tension could be discerned in colonial health activities between two approaches. In the absence of a free, universal, and State-based health-care system that existed only on paper in the colonies (ie, the Indigenous Medical Assistance scheme), French interventions in health were provided mainly through the Empire's State humanitarian verticalism aimed at major diseases and in line with Pasteur. In parallel, a private humanitarianism arose that was generalist, local, and often faith-based. Both were defined not only by compassion, but also (and perhaps most importantly) by a critique of colonisation, remorse and guilt, and the will to atone.

From decolonisation to the aftermath of the Cold War (1960–99)

The tension in colonial health activities became increasingly difficult to manage between the wave of colonial independence that started in the 1950s and the end of the Cold War. Before this period, France had been especially parsimonious in its colonial policies and, in practice, had reduced its presumptions regarding its civilising mission. Now France increased spending, creating simultaneously the CFA franc currency and specialised public investment organisations such as FIDES (Investment Fund for Economic and Social Development) and CCFOM (Central Fund for the French Overseas Territories, the ancestor of today's French Development Agency). During that time, the French Government was torn on the one hand between its wish to export its national model of State-based health care through its development assistance and, on the other, its twin tradition of State humanitarian verticalism. Over time, France would also be increasingly at odds with some growing international trends.

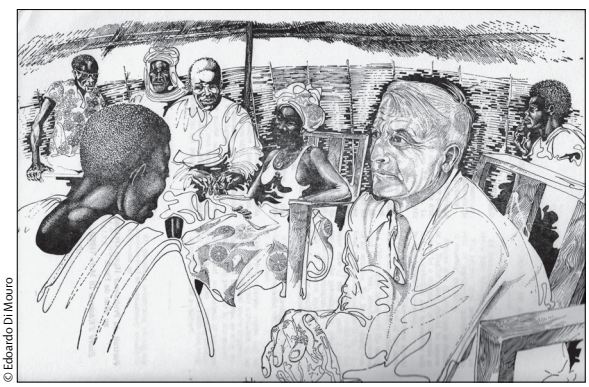

Figure 3: **Portrait of Henri Collomb at Fann Hospital**
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Technical assistance for newly independent nations to build local health systems

Most young African states placed priority on training doctors in all specialties and on building medical centres. In other words, these nations emphasised the specifically curative dimension of medical modernity, considering that the preventive or prophylactic dimension—notably, that which had prevailed formerly, as vaccination campaigns and efforts against major epidemics—was too reminiscent of the colonial epoch and perceived coercion on their populations. With that objective in mind, the new heads of government sent thousands of their young compatriots to universities, often of the ex-colonial powers or Communist countries. At the same time, they attracted many *cooperants* (expatriates) from these same countries to provide training and to devise or run the programmes—some of substantial size and supported by international largesse—that were supposed to bring national development.

As independence arrived, the French bilateral assistance that replaced colonial activities accompanied this set of priorities by providing technical assistance for primary health care and health-related social protection. This was, in some ways, a distant echo of the Indigenous Medical Assistance scheme, attempting to provide for the newly independent states some semblance of the range of services available in France. Substantial numbers of French experts and professionals provided technical assistance during this early post-colonial period. In 1965, for example, 8350 French personnel were recorded by the Secretariat of State for Foreign Affairs and Cooperation as providing technical assistance in 16 African states, in areas ranging from education to the judiciary and infrastructure. Of these, about 12% were working in the area of health, the largest after education.[36] Such technical assistance programmes typically took the form of sending French doctors to support the creation of medical schools, provide training, and work directly in hospitals as *professionels de substitution*.

An example of this work in practice was the ethnopsychiatry undertaken during the 1960s at the Fann Hospital in Dakar, Senegal, directed by Henri Collomb (figure 3). Under the Second Plan of FIDES, a neuropsychiatric unit was created as the first element of a university hospital and asylum for people with contagious diseases or mental illness in Dakar's Fann suburb. The first patients were received in October, 1956, during the transition period of the Reform Act for Overseas Territories (the *Loi-cadre* of June 23, 1956) that preceded formal independence. Fann became the foundation stone of psychiatry in Senegal, which was strongly marked by Collomb during his two decades of service there between 1959 and 1978. Collomb had begun his career as a military doctor in 1939 in Djibouti, followed by stints in Somalia, Ethiopia, and Indochina. He arrived in Dakar in 1958, where he became the first holder of the chair of neuropsychiatry at the University of Dakar. Gathering a team comprised of French and African doctors, psychologists, psychoanalysts, healers, and social science researchers, he created what became known as the School of Dakar (*École de Dakar*, often referred to as the *École de Fann*). This original approach to ethnopsychiatry, although based in the context of French assistance in health for the former colonised countries, constituted a break with colonial psychiatry and strongly influenced psychiatric practice in Senegal and more widely in French-speaking Africa.[38–41]

Persistence in French assistance to newly independent countries

Along with its tradition of State vertical humanitarianism, French bilateral assistance also supported the new states in their efforts to maintain vertical programming after independence.[42] Thus, vaccination campaigns continued with the involvement of French experts, often military doctors as before. Some of them came through the Ministry of National Defence arrangements that started in 1962 and under which young servicemen with the necessary professional qualifications could volunteer for technical assistance assignments in developing countries.[36]

French State humanitarianism in health through vertical programmes often closely resembled colonial approaches because many of the building blocks of medical infrastructure remained, sometimes under different names. For example, the autonomous service to control sleeping sickness in French Equatorial Africa and French West Africa in the period 1920–30 became the OCCGE (Organisation for Coordination and Cooperation in the Control of the Major Endemic Diseases) and OCEEAC (Coordination of Epidemic Control in Central Africa).[12] These programmes would later be supported by WHO.

In this context, France's largest involvement in vertical programmes during this period was its leadership in the control of onchocerciasis (river blindness). This began with the work of French scientists from ORSTOM—now France's Institute for Research and Development (IRD)—working in cooperation with the OCCGE, which undertook a series of pilot studies in black fly eradication

in Burkina Faso and neighbouring areas in the early 1960s.[43] These initiatives led, in the late 1960s, to ambitious targeted programming on a regional basis using aerial larviciding. With the initial support of France, USAID, and WHO, the Onchocerciasis Control Programme in the River Volta Basin Area (OCP, later renamed the Onchocerciasis Control Programme in West Africa) was created in 1974 under the aegis of WHO. The OCP's objectives eventually widened to include promotion of socioeconomic development. By the 1980s, treatment with ivermectin was introduced, and the capacity of recipient countries to undertake their own community-based treatment programming and surveillance was built up.[44]

French *sans frontièrisme*, Health for All, and structural adjustment

In the latter part of the post-colonial period, the State model of social protection and health programming remained politically sustainable in France. However, when applied to official development assistance, this model was not only challenged by deployment of French non-governmental *sans frontièrisme* but also increasingly at odds with growing international trends in health.

The many sources of inspiration for *sans frontièrisme* are beyond the scope of our review.[2,45–49] One of the main founders of this idea, Bernard Kouchner, traced the creation of Médecins Sans Frontières (MSF, or Doctors without Borders) mainly to the failure of the Red Cross to speak out about Nazi extermination camps during World War II.[50] However, another less well-known historical linkage connects MSF to the colonial history of France, particularly in Africa, which is framed as the continuation of that history while highlighting its distinctively French dimension.[51] Before MSF was created in 1971, several of the founders (including Kouchner) had worked for the Red Cross in the colony of Biafra at a time when Gaullist policy supported the attempted secession of this part of Nigeria, while Great Britain and the Soviet Union were the main backers of the Federal Nigerian Government.[52] This conflict entered world awareness in 1968, when images of starving children suddenly saturated the mass media, enabling a substantial rise in the funding and prominence of international NGOs.

Anchored in this double registry of remorse and desire to make amends, Kouchner and his colleagues aimed "to establish an independent organisation that would focus on emergency medicine, speak out about the causes of human suffering and cut through red tape to deliver aid fast and effectively".[53] The MSF founders also belonged to the dual heritage represented by both Schweitzer and Pasteurians. They shared with both traditions a heroic dimension of their actions, with charismatic figures whose fame was recognised on an international scale.[25] Similar to Schweitzer, although not sharing the formally religious aspect of his project at Lambaréné, the MSF founders sent words into battle, breaking a more or less intentional silence about the dead and suffering in distant populations–"the wretched of the earth".[54] And similar to the Pasteurians, with their focus on vertical programmes, MSF displayed the willingness to go to the front lines of health and be effective in emergency situations, forcing local authorities to suspend official obstacles and tolerate their crossing of borders.

The French State, with its health assistance policies and practices in developing countries, and particularly in Africa, would increasingly be challenged during this period on its private flank by a growing French non-governmental *sans frontièrisme*, characterised among other historical linkages by its Pasteurian heritage of humanitarian verticalism, but this time bypassing the State. France would also find itself on the sidelines of multilateral health initiatives that took the opposite direction from the free universal health coverage that France aimed to promote.

In 1977, WHO's goal of Health for All by the year 2000 was adopted by its governing body, the World Health Assembly.[55] This approach, supported by France, explicitly included building up local health infrastructure as well as tackling the diseases and conditions that most commonly affected populations in developing countries. The approach received its highest profile in September, 1978, at the International Conference on Primary Health Care in Alma Ata, Kazakhstan. The conference declaration formally adopted primary health care as the vehicle through which comprehensive, universal, equitable, and affordable health-care services could be provided to populations.[56,57]

However, a countertrend was gathering steam, as the 1980s witnessed a wave of structural adjustment programmes that would translate in the health sector, particularly in Africa, into a move to make local populations accountable for their health. The Bamako Initiative of 1987 was initially viewed as a way to deal with the outcomes of severe economic crises facing sub-Saharan Africa, the negative effects of adjustment programmes on health, and the reluctance of donors to continue to fund recurrent costs of primary health-care programmes;[58] therefore, it was judged a positive move by French experts and authorities.[59] Although user fees at the point of health-care delivery were not new in Africa and had existed for years in some English-speaking countries (eg, Ethiopia, Namibia, and South Africa), the Bamako Initiative prompted their general application to most sub-Saharan countries, including the French-speaking ones.[60] The explicit rationale for introducing such cost-recovery mechanisms was to raise revenue that could be directly controlled at the primary care level and more easily channelled to improve quality of service and drug availability through community participation in the management of health facilities.[61]

However, this approach ignored the simple micro-economic fact that price elasticity of demand for health care is not constant across income groups—ie, user fees

work against the primary health model, making many basic treatments and medicines more expensive and, therefore, less accessible for many people in developing countries.[62] Over time, researchers from Belgium, France, and francophone African countries generated conclusive evidence that out-of-pocket payments for user fees are the most inequitable (regressive) pattern of financing for health care,[63–65] and that cost-recovery policies do not contribute substantially to the financial sustainability of health systems because they cause lower-income groups to bear a greater burden of health expenditures as a proportion of their income. After more than 20 years, international consensus was obtained on this matter, and the preface of the 2010 *World Health Report* by WHO's Director General, Margaret Chan, clearly stated that "user fees have punished the poor".[66]

As the 1990s came to an end, many developing countries were experiencing financial crises, while developed countries substantially reduced their contributions to development assistance. The monetary value of total French official development assistance was cut by nearly half between 1991 and 2000 and accounted for only 0·36% of gross national income.[67] Moreover, health contributions were among those affected most by this decreasing trend. Thus, although health represented the greatest share of total French official development assistance in the 1980s, with numerous initiatives in training and technical assistance, it was no longer the case at the beginning of the 21st century, when its share only accounted for 4% of the total (*vs* 11% on average in OECD [Organisation for Economic Co-operation and Development] countries). In the poorest developing countries, health systems were struggling to stay afloat as rising demands for basic health care collided with rising costs of services. The primary health-care model of free services in the public sector was under increasing strain at a time when health systems, notably in French-speaking Africa, were being "distracted from their public health goals to improve the health of the general population and [had] become mainly devoted to defend corporatist interests of health professionals and pharmaceutical industries".[68]

Opening the way for global health successes and failures (2000–15)

Beginning in the late 1990s, several events occurred that had far-reaching effects on health assistance efforts around the world. First, the end of the Cold War and the aftermath of the Soviet Union's disappearance brought to a close the bipolar global politics that had reigned since the end of World War II. What emerged to replace it was a depolarised world that would change the nature of international governance, including the traditional shapes of bilateral and multilateral health assistance. Second, the years from 2000 to 2015 featured the implementation of the Millennium Development Goals (MDGs), a set of benchmarks against which development—including the three Goals directly related to health—could be measured.[69] They also justified a revival of development assistance flows, notably a very substantial increase in total official development assistance from member countries of the OECD Development Assistance Committee.[70] Third, in a way that was unnoticed at the time, the advent of the AIDS pandemic led to a renewed emphasis on State (through bilateral and multilateral assistance) humanitarian verticalism, with the explicit goal to save individual human lives and to bring advanced diagnostic and pharmaceutical interventions to those who need it in places where public health infrastructure at the nation–State level was weak or non-existent. By the beginning of 2000, a unique opportunity for global health initiatives had been created.

Embodying the State humanitarian paradigm within vertical programmes

The post-independence period leading up to the late 1980s saw the defeat of a development paradigm that held up the French model of social and health protection as a kind of holy grail, if not as an achievable objective. Whereas France's presence as a force in international health development and assistance debates had been waning in the 1980s, AIDS now gave France the opportunity to reconcile the tension by simultaneously becoming the strongest advocate of State (bilateral and multilateral) vertical programming while arguing that it was the best way of instituting structural reforms.

The advent of AIDS brought increased support for vertical disease-targeted programming, not only for prevention of HIV transmission and treatment of its direct outcomes but also for the related but, hitherto, somewhat neglected problems of tuberculosis and malaria. This vertical approach was supported by a huge upsurge of civil society activity in developed countries, most strikingly through the efforts of NGOs such as AIDES and ACT UP but also through the Red Cross and faith-based groups. France took an early lead in the international response to AIDS, starting with pioneering biomedical research by French scientists and with early support of WHO's Global Programme on AIDS in 1987 and of the cross-agency United Nations (UN) structure UNAIDS in the second half of the 1990s.

During his time as French President from 1995 to 2007, Jacques Chirac personally played a prominent part in this effort, and the fight against AIDS was one of the rare areas in which consensus characterised the positions and policies of usually opposed French political parties. Indeed, the other leading political figure who framed France's international contribution to the AIDS response was MSF founder Bernard Kouchner, who was Minister of Health in 1992–93, under the socialist presidency of François Mitterrand, and later in 2002–03, in Lionel Jospin's socialist government of cohabitation with conservative President Chirac. Kouchner ultimately became Minister of Foreign Affairs in 2007–10, in the right-wing government of

President Nicolas Sarkozy contributing to the continuity of French international health strategy despite political alternation between opposing parties.

At a time when most international experts considered that promoting access to antiretroviral drugs for HIV-infected adults and children in developing countries was not a feasible goal because of poor infrastructure, risk of viral resistance, alternative priorities, and risk of increasing health inequalities for groups affected by other diseases, Chirac and Kouchner were the first prominent world politicians to declare that the gulf of inequality between the north and the south on this issue was politically and morally unacceptable.[71,72] In 1997, at the 10th International Conference on AIDS and Sexually Transmitted Diseases in Africa, they launched an International Solidarity Therapeutic Fund aimed at providing financial support for access to antiretroviral drugs and other medical agents and devices for people living with HIV and AIDS. It served as a pilot project and was part of the international endeavour that led to the creation of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) in 2003, for which the USA and France became the first two donors. In addition to the experiences of middle-income countries such as Brazil, Chile, and Thailand, which introduced antiretroviral drugs into their general programmes of HIV and AIDS care, researchers contributed actively to the evaluation of experimental programmes in sub-Saharan Africa and the Caribbean, which showed how access to antiretroviral drugs could become an appropriate, rational, and cost-effective investment choice, even in low-income countries.[73,74] This double political and scientific commitment, perhaps best exemplified by Michel Kazatchkine (Director of the French Agency for AIDS and Hepatitis Research and, latterly, the first Executive Director of the Global Fund),[75] contributed substantially to the design of the Global Fund in various facets: first, that it allocated a large part of its resources not only to prevention programmes but also to expanding access to effective and affordable drugs; second, that it increased global attention to human rights and augmented access to services for the most vulnerable and at-risk populations; and third, that its governance was structured explicitly in 2001 as a unique and innovative model of partnership in international development financing, giving voice to implementers, civil society, and the private sector in addition to recipient and donor governments.

In the context of the long-standing debate about the interplay of disease-specific programmes or selected health interventions with integrated health systems, which has characterised the area of global health since 2000,[76] France's historical trajectory puts it in a strong position to argue that State humanitarian verticalism (particularly in its multilateral format) provided an opportunity to solve structural issues in health-care delivery. France supported the idea of using vertical programmes to strengthen health systems—eg, by arguing that the fight against AIDS would strengthen decentralisation of health care in countries such as Cameroon, Ivory Coast, and Senegal.[77–81] Inclusion of free access to antiretroviral treatment at the point of service delivery as a component of WHO's public health approach to HIV and AIDS facilitated provision of free-of-charge HIV-related drugs in a growing number of low-income countries and helped revive the broader debate about the inappropriateness of cost-recovery policies.[82] Moreover, France was a strong advocate of the idea that improvements in public health of the population are judged a prerequisite, rather than an outcome, of economic growth,[83] and that scaling up investment in the fight against pandemics could generate net macroeconomic benefits.[84] In a similar vein, France was a proponent of the idea of using vertical programmes to promote differential pricing for access to essential medicines and increased flexibility in international norms for intellectual property rights—eg, the 2001 Doha revision of the Trade-Related Aspects of Intellectual Property Rights agreement and subsequent negotiations.[85]

French involvement in vertical global health initiatives was also used as a way to experiment with innovative financing models. For example, UNITAID is an international purchasing facility for medicines that aims to reduce costs and increase the accessibility of treatments for HIV and AIDS, malaria, and tuberculosis. It was launched in 2006 by Brazil, Chile, France, Norway, and the UK;[86] France finances more than half of the organisation's budget through an international solidarity levy on air tickets.[87] Some of the major accomplishments of UNITAID have been to help obtain a striking drop in the price of paediatric antiretroviral drugs as well as to facilitate further access to artemisinin-based combinations for malaria treatment.[88,89] Another example is the Global Vaccine Alliance (GAVI), which channels most of its funding through the International Finance Facility for Immunisation (IFFIm). IFFIm was created in 2006 to accelerate the availability and predictability of funds for immunisation, and it allows GAVI to de-link its vaccination programmes from cash inflows from pledges. This innovative mechanism raises money by issuing vaccine bonds in the capital markets and repaying these bonds with long-term donor pledges.[90]

Egalitarian approaches to structural reform of health systems

In addition to championing State vertical humanitarian initiatives, France remained consistent with its twin historical tradition of promoting state-funded, free, and egalitarian access to health. It supported several approaches to egalitarian reforms of health systems: extensive risk pooling for health-care financing; substitution of prepayment insurance mechanisms for user fees at the point of delivery; and promotion of mandatory population-based social insurance. Social insurance differs from private insurance because individual and

household contributions are not based on personal health risks and increase with income, thereby contributing to both protection of the sickest and most vulnerable populations and progressive income redistribution. In a notable example, in 2008, France joined Germany, Switzerland, Spain, and several multilateral organisations (eg, the International Labour Organization, the African Development Bank, WHO, and the World Bank) to implement the Providing for Health (P4H) partnership, which aims to support low-income and middle-income countries in their efforts to establish "sustainable health and social protection systems for universal health coverage and social health protection, based on the values of universality and equity".[91]

The 2010 *World Health Report* notes that there are many ways to achieve universal health coverage and every country should devise its own route to achieve this goal.[66] However, since 2000, substantial progress has been made towards including health insurance development in national policies for universal health coverage.[92] Before the 1990s, some health insurance schemes existed but they were fragmented, only targeted the formal sector of the economy, and did not entail firm commitments in the State budget, despite claims to be social security-type systems in many French-speaking countries. A second phase began in the 1990s and focused on micro health insurance, with the objective of organising prepayment forms of health services for informal-sector households. In most countries in central and west Africa, community-based health insurance schemes were created based on the model of mutual health organisations, which provide some financial protection for their beneficiaries by reducing out-of-pocket spending.[93]

However, health insurance schemes have little effect on the quality of care or the efficiency with which care is produced, and they serve only a small section of the population. To achieve universal health coverage, these types of community financing arrangements at best are complementary to other more effective systems of health financing.[94] Other ideas are more in line with French egalitarian social security principles: mandatory membership in health insurance schemes, progressively extended to all sectors of the population; reaffirmation of the guiding roles of the state sector and its administrative apparatus; and high priority to avoid exclusion of the poorest people from access to health services.[95,96] Although every country has its own way of reforming health financing, two broad approaches are visible: either they build a unique institutional pattern, which provides specific groups of the population with a form of coverage; or they link a particular form of coverage with each population sector, gradually implementing the corresponding schemes as resources become available. The effect of social health insurance on achieving universal health coverage remains difficult to assess.[97] Although beneficiaries have received better access to health services, results are mixed or uncertain about the sustainability of financing the entire health sector, changes in health professionals' behaviour (particularly in public facilities), and reduction of socioeconomic and gender inequities in access to care.

At the beginning of the 21st century, France again tried to reconcile the inherent tensions between French State humanitarian assistance through vertical programmes and its plea for egalitarian health-care reform. But this subtle equilibrium is increasingly facing threats and risks of collapse. The de facto priority given by France to vertical multilateral global health initiatives in the past 15 years has made it increasingly difficult to simultaneously maintain the goal of contributing to important egalitarian health-care reforms, the main reason being financial constraints. France's recent contribution to global health was possible because of an overall rise in official development assistance, as in most other developed countries; in France's case this monetary assistance almost doubled between 2000 and 2012.[98] However, France is ranked eighth as an international donor for global health and fourth in Europe. The country might not have the additional resources to simultaneously maintain its strong presence in multilateral vertical initiatives and increase the funding support it needs to solidify its advocacy of health coverage, and to regain some autonomy of action through ambitious bilateral programmes. After the global financial crisis in 2008, and the European Union-directed obligation to reduce public deficits to 3% of gross domestic product, since 2013 the French official development assistance budget has remained flat; in 2015, the budget was 0·48% of gross national income,[98] less than the target of 0·7%. Pressure on public expenditure has also led to important cuts in the deployment of French technical expertise abroad. Although France maintains an extensive diplomatic network, the number of ministry staff assigned to development cooperation fell notably between 2010 and 2013. In parallel, on one hand France has been emphasising the economic dimension of its diplomacy, while on the other, the French Development Agency (AFD)—the development banking arm of the Ministry of Foreign Affairs—has seen its role strengthened. France also has provided fewer grants and more loans in its total official development assistance portfolio, and the loans predominantly support productive sectors in middle-income countries.

Putting global health at the centre of the fight against the great inequality divide

The French approach to international public health is now at a crossroads: France has to confront revision of the global development agenda, including adoption by the UN of the Sustainable Development Goals. Furthermore, the tension that was once characteristic of France—between universal free health care and State humanitarian verticalism—is now shared by global health worldwide. Furthermore, this tension has ramifications that are wider than public health, relating to intellectual property rights, human rights, economic

development and equity, and both the practice and architecture of international aid governance.

A first challenge to global health springs from the growing scale, duration, and complexity of demands on UN humanitarian activities, for which the issue at stake is the actual extension of the domain of humanitarianism over development.[99,100] Humanitarian interventions could increasingly be motivated by global health security considerations, focusing on naturally occurring or man-made infectious diseases that are emerging or sensitive to climate change, which are seen to threaten wealthy countries. Alternatively, humanitarian interventions might be motivated by political and economic considerations that are, at first glance, far removed from global health but for which health serves as an entry point.[9] Although such motivations can facilitate action, they carry the risk that vertical interventions will be scaled up in rapid unbalanced ways that fail to take into account the need to improve and expand health-care systems. Under such circumstances, health advances might be achieved for some high-profile diseases or conditions (eg, the Ebola outbreak in 2014–15), but health systems development as a whole can be unbalanced and important areas of health left underserved.

A second challenge is posed by the growing number of former low-income countries that are being recategorised as lower-middle-income and upper-middle-income countries, despite the fact that inequality in economic growth means that large proportions of their populations remain in dire poverty and that many millions of people who have moved out of poverty are highly vulnerable to economic recessions.[101,102] For example, GAVI's use of national income—once an accepted proxy measure of poverty—to set eligibility criteria is slowly but surely disqualifying many of the world's poor populations from receiving assistance.[103]

A third substantial difficulty arises from the outcomes of the epidemiological and demographic transition. Health systems are straining to deal with the growing burden of non-communicable diseases while having to make complex intergenerational trade-offs as older people make increasing demands on health budgets.[104]

The fourth and most daunting challenge to global health arises from the unprecedented rise of intercountry and intracountry inequality in income and wealth. Global income inequality is higher than ever in human history and is trending upwards.[33] It has been estimated that the share of total world wealth, including financial and non-financial assets, land, housing, and liabilities, held by the richest 10% and 1% of individuals is higher than 70% and 30%, respectively, whereas the share of the lower half is less than 4%.[105]

France's deliberate choice to prioritise multilateralism has enabled the country to have a major role in the area of global health in recent years—notably, the fight against HIV and AIDS, tuberculosis, and malaria, and emphasising innovative financing and access to medicines. What made France relatively influential in shaping the global health agenda of the 21st century was its distinctive choice to prioritise multilateral channels for funding, by contrast with not only other countries but also other sectors of French official development assistance.[98]

Nowadays, French health aid is increasingly channelled through a multilateralism in which France's influence is in decline, and vertical approaches retain the highest de facto priority despite the continuing structural rhetoric. France's choice to subordinate its political and diplomatic capacity to play a part in the global health debate in favour of building its recognition and influence in the governing bodies of very few multilateral organisations and global initiatives exposes it to political volatility and underestimation of its contribution, as was pointed out by recent independent assessments of French contributions to the Global Fund and the Muskoka Initiative.[106,107]

In the face of this, a return to bilateralism is tempting. Even with a steady level of official development assistance resources, the temptation is to regain wider margins of action by reallocating budget away from global health multilateral organisations towards bilateral aid or alternative forms of regional and interagency cooperation. A small move in that direction was the introduction of the 5% Initiative, in which 5% of total French contributions to the Global Fund was earmarked for projects piloted directly by French technical agencies.[108] However, additional reallocation of funds from support for multilateral global health initiatives to alternative channels could be quite difficult, because the most vocal NGO are deeply attached to the involvement of France in the Global Fund and GAVI. The announcement by French President François Hollande at the UN Sustainable Development Goals summit in September, 2015, that the country will double its official development assistance effort by 2020, will definitely help French health assistance to regain additional margins of action.

Instead of succumbing to the temptation of returning to bilateralism, the real challenge is a fuller multilateral engagement, which remains the most feasible path to achieving important goals in the face of the great inequality divide—eg, universal health care. A necessary condition would be that this engagement is done at proper scale, not only financially but also politically. By contrast with other major donors, France currently dedicates a very small proportion of its official development assistance to UN agencies, funds, and programmes specialising in health. A strong, coherent, and consistent high-level presence is needed in the governance of such multilateral governing bodies, to participate fully in their urgent and essential reinvention.

Beyond the area of health, in 2015, France had a key role in the ongoing renewal of the UN approach to development: at the Addis Ababa conference on development financing; at the New York conference on the objectives of sustainable development; and at the UN

Climate Change Conference (COP21) in Paris. These three conferences form a coherent whole, quite noticeable by the French contribution—a good illustration being the Technology Facilitation Mechanism. Through the efforts of their ambassadors to the UN, Antonio Patriota and François Delattre, Brazil and France jointly made the UN adopt a Technology Facilitation Mechanism for sharing innovative technologies and practices in the service of development goals. Besides its own merits, this promising mechanism—which helped to unblock the negotiations on development financing—can assist in renewing the UN's commitment to these issues, moving from too often sterile debates to pragmatic operational discussion.

If such creative engagement with the reinvention of multilateralism—an urgent and essential project—is applied to health initiatives, revisiting France's historic tension between universal free health care and State humanitarian verticalism could help strengthen its long-standing advocacy in favour of universal health coverage. It could, thus, contribute directly to advancing global equity through income distribution: from the healthy to the sick, and from the wealthy to the poor.

Contributors

LA-D did the literature review, collected and analysed data, and wrote the paper. J-PD, AW, J-FD, and J-PM suggested additional themes and provided substantial input to writing of the paper.

Declaration of interests

We declare no competing interests.

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