The Historical Journal, 41, 4 (1998), pp. 1055–1087 Printed in the United Kingdom

THE SOCIAL TRANSFORMATION OF HOSPITALS AND THE RISE OF MEDICAL INSURANCE IN FRANCE, 1914–1943*

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ABSTRACT. *This article explores the impact of the First World War on the social reform movement in France, emphasizing hospital policy and medical insurance. I argue that the war gave birth to a concerted reform movement which succeeded in bringing about fundamental changes to health care policy. During the inter-war years, the French embarked on a mission to replace the traditional hospital, the* maison des pauvres, *with modern facilities designed to cater to the middle class as well as to the poor. In 1928, a landmark law was passed which extended medical insurance to workers and the lower middle class. By 1940, over one half of the population was covered by medical insurance, and dozens of modern hospitals had been constructed. The impetuses to this national reform legislation were the numerous local experiments, whose stories I examine in some detail. Despite the image of Third Republic 'decadence', the success of health policy reform during the 1920s and 1930s shows that France was indeed capable of important domestic reforms. Under Vichy, these reforms were consolidated and after the Liberation, Vichy's efforts were saluted and affirmed by French politicians.*

Although there has been a great deal of interest in the French pronatalist legislation of the post-First World War period, the important changes in hospital policy and the advent of medical insurance during the inter-war years have not received the attention they deserve from historians.[1] We know, in very general terms, that the hospitals began to open up to the middle class during

* I thank Jackie Duffin, George Weisz, and the journal's anonymous referees for their advice. Funding for this project was generously provided by the Hannah Institute for the History of Medicine, Toronto.

[1] This subject receives only a passing remark in P. Guillaume's recent synthesis, *Le rôle social du médecin depuis deux siècles, 1800–1945* (Paris, 1996), and is not mentioned in C. Maillard, *Histoire de l'hôpital de 1940 à nos jours : comment la santé est devenue une affaire d'état* (Paris, 1986); O. Faure, *Histoire sociale de la médecine* (Paris, 1994); J. Imbert, *Histoire des hôpitaux en France* (Toulouse, 1982), and *Les hôpitaux en France* (7th edn, Paris, 1996). Abbreviations: AAP, Archives de l'Assistance Publique, Paris; AP-CMA, Assistance Publique de Paris, Comptes Morales et Administratifs; AP-CS, Assistance Publique de Paris, Procès-Verbaux des Séances du Conseil de Surveillance; BMO-CMP, Bulletin Municipal Officiel–Conseil Municipal de Paris, Délibérations; CSAP, Conseil supérieur de l'assistance publique, fascicules; AML, Archives Municipales de Lyon; HCL-D, Hospices Civils de Lyon, Délibérations; HCL-CMA, Hospices Civils de Lyon, Comptes Morales et Administratifs; CML, Conseil Municipal de Lyon; CGR, Conseil Général du Rhône, Délibérations; *RH*, *Revue des hôpitaux*; *RHF*, *Revue hospitalière de France*; *CM*, *Concours médical* (*Le*); *REB*, *Revue des établissements de bienfaisance*; *RP*, *Revue philanthropique*; *JE*, *Journal des économistes*; *RS*, *Réforme sociale* (*La*); *REP*, *Revue d'économie politique*; *RPP*, *Revue politique et parlementaire*.

the 1920s, but we know little about the ways in which this process unfolded. How, for instance, were the hospitals affected by the landmark 1928 health insurance law? Surely the social transformation of hospitalization and increased access to medical care during inter-war France is as important a social trend as the spread of consumer culture at this time.[2]

It was during the inter-war period that the French began to think of the hospital in ways which we would recognize today. After the war, a wide range of social services was introduced at the national level, from family allowances to health insurance. This was also a time of quiet yet bustling reform at the local level – a story which has not yet been told. New municipal institutions such as semi-public health clinics designed for the middle classes, retirement homes, maternity clinics, public pools and baths, sports stadiums, workers' cultural centres and gardens, public housing complexes, and job placement centres proliferated. Dozens of modern hospitals were built, from Albi to Troyes to Montpellier to Périgueux. The 1920s and 1930s saw the most rapid development of social services in the history of France to date. A new chapter had opened in the history of French social policy.

The progress made on this front is remarkable, considering the severe financial crisis which beset France in the aftermath of the war. But the French were now willing to pay for new social services. Our view of inter-war France is usually coloured by images of fiscal crisis, political spinelessness, and 'decadence'. We know that wartime economic *dirigisme* gave way to liberalism during the 1920s; technocrats intent on economic modernization emerged during the war, only to have their plans thwarted soon thereafter. Insofar as the history of social policy is concerned, this image of a complacent return to liberal normalcy and the image of the 'hollow years' does not apply, for these years were crucial in the development of hospital services and of national social services in general.[3]

The traditional view of France's political flabbiness during the inter-war years stems from the nation's failure to withstand the Germans in 1940. But if it is now accepted that victory in the First World War seemed to contemporaries to have vindicated the unstable, fragmented political system of the Third Republic, the opposite was true where the country's social safety net was

[2] This theme is absent from the standard histories spanning the inter-war period. See, for example, J.-J. Becker and S. Berstein, *Victoire et frustrations, 1914–1929* (Paris, 1990); P. Bernard and H. Dubief, *The decline of the Third Republic, 1914–1938*, trans. A. Forster (Cambridge, 1985); A. Sauvy, *Histoire économique de la France entre les deux guerres, 1916–1931* (4 vols., Paris, 1965–75). S. Reynolds's new book, *France between the wars: gender and politics* (London, 1996), contains a good chapter on the social services but nothing is said about the hospitals. Often, the landmark social insurance law of 1928 is mentioned in one sentence or paragraph by historians. Misunderstandings, too, abound: M.-J. Imbault-Huart, for example, wrote in the widely read French journal, *Le débat*, 79 (1994), reprinted in *L'état providence: arguments pour une réforme* (Paris, 1996), p. 294: 'l'état refusera jusqu'en 1941 de prendre acte de la transformation de l'hôpital en centre de soins', and 'seuls les indigents étaient admis à l'hôpital jusqu'en 1941'. This article will show that this is inaccurate.

[3] R. Kuisel, *Capitalism and the state in modern France* (Cambridge, 1981). For the most recent expression of this view, see E. Weber, *The hollow years: France in the 1930s* (New York, 1994).

concerned. There were precious few politicians who emerged from the war satisfied with the nation's social services. The war called forth a concerted reformist agenda and this vision carried over into the 1920s and 1930s. Several scholars, among them Richard Tomlinson, Françoise Thébaud, Susan Pedersen, Mary Louise Roberts and Marie-Monique Huss, have shown that a sense of urgency permeated the air; France must catch up, must better care for its 'human capital', lest the nation disappear from the face of the earth.[4]

Not only did this sense of urgency give birth to pronatalist social policies, so too did it inspire general health care reform. Rising to the rostrum of the chamber of deputies in February 1920, Dr Edouard Grinda, the architect of the 1928 medical insurance law, cited the British National Insurance Act of 1911 and called for an even more ambitious national health system on the grounds that 'France has always been at the avant-garde of civilized nations and has given birth to so many generous ideas of justice and social solidarity'. Lamentably, 'everyone who has compared our [social services] with those of other countries has sadly concluded that their inferiority is manifest.'[5] Important changes to hospitals and health policy grew out of these concerns, which were widely held across the political spectrum. In 1928, parliament passed the most important piece of social legislation in the history of the nation to date, providing health insurance to one third of the population. French social policy development tested the nation's policy will and the result was a success in every regard: political, social, medical. The Third Republic was, after all, capable of effecting much needed reform, at least in this area.

I

The achievement of the inter-war years is all the more remarkable considering the position from which the French started. On the eve of the First World War, Edouard Herriot, mayor of Lyon and future prime minister, deplored the fact that 'in France we have done nothing, in the domain of [public] assistance, in favour of the middle classes. In Germany the hospitals receive even the rich classes… there is also a system for the middle classes.' In 1919, the vast majority of Germans, as well as 40% of the British population was covered by state medical insurance (with private insurance added in, a majority of the British population was insured). Prior to the 1928 medical insurance law, only 6% of the French population, all indigent, was covered by state programmes. Only a small handful were covered by private insurance, which was undeveloped in France.[6] As of 1893, French hospitals were within the reach of the urban poor,

[4] R. Tomlinson, 'The disappearance of France, 1896–1940: French politics and the birth rate', *Historical Journal*, 28 (1985), pp. 405–15; F. Thébaud, 'Le ministère de l'hygiène, de l'assistance et de la prévoyance sociales', *REB*, 1920, pp. 1–3; S. Pedersen, *Family, dependence and the origins of the welfare state: Britain and France, 1914–1945* (Cambridge, 1993); M. L. Roberts, *Civilization without sexes: reconstructing gender in postwar France, 1917–1927* (Chicago, 1994); M.-M. Huss, 'Pronatalism in the inter-war period in France', *Journal of Contemporary History*, 25 (1990), pp. 39–68.

[5] Grinda, quoted in *RH*, 1920, p. 65.

[6] V. Berridge, 'Health and medicine', in F. M. L. Thompson, ed., *The Cambridge social history of Britain, 1750–1950*, III (Cambridge, 1990), p. 222. The rough figure of 6% for France has been

but they were not an option for the middle class. 'Our conception of [public] assistance, in France', said Herriot, 'dictates that our hospitals are invariably poorhouses or charities.' French hospitals remained, on the eve of the First World War, the 'maisons des pauvres'. More than in England or Germany, French hospitals had a 'differentiating impact', in that they preserved social distinctions between the classes.[7]

In the five years before the war, Herriot, inspired by a fact-finding mission to the leading hospitals of Germany, England, and Scandinavia, had pressured the Hospices Civils de Lyon to broaden its vision and change the very nature of the hospital. As one administrator recalled after the war, the hospital board itself had been opposed to Herriot's meddling, believing that the hospital was, 'by definition', only for the poor, and charging that the expansion of paying beds to cater to the middle class would detract from the hospital's essentially 'charitable mission'.[8] The 'maison des pauvres' must remain just that, an institution devoted solely to the poor, an institution which perpetuated hierarchical social relations between doctor and patient and which enabled civic elites to project a positive image of their class.

Outside of Paris, French hospitals in 1914 were mired in the past, two decades behind their German, American, and British counterparts, which from the 1880s had begun 'to be transformed into … expensive scientific, clinical, highly mechanised, research organisation[s]'. The task was somewhat easier in Britain, given that most hospitals which existed in 1880 had been built since the beginning of the century. But in France, the deadweight of the past was a problem. At least 1,224 of the 1,557 hospitals and hospices standing in late nineteenth-century France had been established before 1790. Many were situated in city centres, with limited opportunities for expansion or renovation. Many occupied buildings dating back to the seventeenth century or earlier.[9]

To be sure, Paris was still a vibrant centre of medical research, but the 'Paris school' was no longer predominant by the late nineteenth century, and the fruits of Parisian research were not in any case spread across the country, let alone to all Parisian hospitals. France had only three sanitoria in 1901; Switzerland had six and Germany had eighty. The failure of France to combat tuberculosis effectively was generally regarded as a national disgrace. Relatively few professionally trained nurses existed outside Parisian hospitals.

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calculated as follows: 2·2 million people were covered, out of a population of roughly 37 million. See M. Guaguery, 'Les assurances sociales et les établissements hospitaliers', *RH*, 1928, p. 381.

[7] B. Abel-Smith, *The hospitals, 1800–1948* (London, 1964), pp. 135–8; CML, 30 Dec. 1913. Berridge has made this observation with regard to British hospitals, but it seems just as applicable to the French case, 'Health and medicine', p. 203.

[8] E. Delore, *Nos hôpitaux de demain* (Lyon, 1917), p. 32.

[9] F. B. Smith, *The people's health, 1830–1910* (New York, 1979), p. 259. L. Lallemand, *Etude sur la nomination des commissions administratives et des établissements de bienfaisance* (Paris, 1887). Other impediments to medicalization lay in the attitudes of French people themselves, many of whom were still peasants in 1914, wedded to traditional folk medicine. E. B. Ackerman, *Health care in the Parisian countryside, 1800–1914* (New Brunswick, NJ, 1990), p. 164.

Doctors were very thinly spread across rural France, as were hospitals (they existed in only 1,200 of 36,000 communes). Above all, the hospitals remained burdened with 'social cases' as opposed to medical patients.[10] Not only was this the result of tradition and local inertia, but the central state itself was committed to this state of affairs, reprimanding the odd hospital commission which admitted paying patients into an institution which, the Ministry of the Interior reminded French hospital administrators in 1913, 'was created for the indigent'. An 1899 Ministry of Interior regulation forbade hospitals from treating the well-to-do except under exceptional circumstances (accidents, epidemics) and reaffirmed the hospital's mission: to serve the indigent. In 1907, a critic noted that 'the hospital remains … the place of refuge *par excellence* of the sick indigent'. The turning point in the history of French hospitals is the First World War, after which they began to cater to a broader public and to concentrate on medical, as opposed to social, care.[11]

II

As the board of directors of the Paris social welfare agency, Assistance Publique, recalled: 'the war led to an extraordinary development in surgery, underscored the need for new hospital equipment and revealed the necessity of improving our operation rooms, labs and clinics'.[12] By putting pressure on existing services, the war threw problems and deficiencies into relief. Above all, it was the financial burdens of caring for military and civilian victims of the war which tested French hospitals. The massive state-run Service de la Santé Militaire set up hundreds of its own temporary hospitals, as did the Red Cross, municipal councils (Lyon set up thirty), and scores of private charities, but the state also imposed upon municipal hospitals to take in soldiers. In keeping with a long French tradition, the state never fully reimbursed most hospitals for military-related expenses, sending them into debt. Major advances in medical care did, however, take place: orthopaedics and radiology blossomed into sophisticated specialties and surgery in general progressed. Inevitably, this rapid accumulation of knowledge would bring forth new needs, new popular desires, and new problems of funding. The American example, driven home during the war by the American Red Cross's infant health campaign and by the Rockefeller mission's anti-tuberculosis campaign, impelled the French to modernize their hospitals, and abetted the post-war 'separation' of hygiene from pauperism and poor relief in the minds of the French. This, in turn, helped

[10] A. Fleury, *De l'Assistance Publique à Paris* (Paris, 1901), pp. 238–9; A. Mitchell, *The divided path: the German influence on social reform in France after 1870* (Chapel Hill, 1991); D. S. Barnes, *The making of a social disease: tuberculosis in nineteenth-century France* (Berkeley, 1995); T. B. Smith, 'The ideology of charity, the image of the English poor law, and debates over the right to assistance in France, 1830–1905', *Historical Journal*, 40 (1997), pp. 997–1032; Delore, *Nos hôpitaux de demain*, p. 9.

[11] From a 1913 report of the Inspection Générale des Services Administratifs, in *RH*, 1927, pp. 239–41; *RP*, 1920, p. 273; A. Picard, *Le bilan d'un siècle, 1801–1900*, VI (Paris, 1907), p. 59. For the British story, see J. M. Winter, *The Great War and the British people* (Cambridge, MA, 1986).

[12] AAP D-346/2, *Cent ans d'Assistance Publique à Paris* (Paris, 1949), p. xxi.

pave the way towards the opening up of the hospitals to middle-class patients.[13] Increased costs ensued.

Expenses at the Hôpital de la Pitié in Paris, for example, quintupled before the end of the war and the onset of rapid inflation. The Hôtel-Dieu had 9,553 entries in 1916, up from 7,118 in 1913. The total budget of Paris's Assistance Publique (AP) increased from 51·5 million francs in 1914 to 166·2 million in 1919. The municipal subvention to AP increased threefold during the war. Increased costs were brought on by expanded services: AP had 2,229 more permanent beds to fund in 1920 than in 1914, and several new services. More personnel were required, too.[14] More and more people were also being brought into contact with the social service bureaucracy. And more Parisian women were now giving birth in the hospital or under medical supervision at home, a policy accelerated during the war. Between 1899 and 1912, 53–58% of all Parisian births took place either in a *maternité*, in the hospital, or with the assistance of an AP midwife at home. By 1919, the figure was 79%. The war clearly led to an increasing medicalization of childbirth in Paris.[15] Parisians, then, did far more than simply cope with the added burdens of treating the war wounded and the displaced; during the war they raised their horizons, and set out on an ambitious programme of expansion and modernization that would set the tone for social policy during the 1920s. As early as 1915, Parisian social policy commentators called for the technocratic professionalization of assistance, presaging post-war debates.[16]

Most provincial cities, however, simply hoped to survive the war's burden. The hospitals of Tours, like those of other French cities, were strained by the war. The state's subsidies were inadequate; the hospice was in deficit from the start of the war, and the city was forced to borrow 200,000 francs in September 1914 to cover increased costs. But ultimately, new services were paid for not with loans but with new taxes: Tours's budget and *centime additionnel* (a local tax) both tripled between 1913 and 1922, largely as a result of increased assistance and hospital expenses.[17] This is a typical case. Across France, municipal councils increased their annual subventions to hospitals, but it was often not enough: the social policy journals during the period 1916–22 are replete with the desperate, public pleas of small town hospital administrators for financial assistance from the state.

The war also bankrupted large city hospitals, like the Hospices Civils de Lyon (HCL). Throughout France hospital commissions great and small were rendered dependent upon the three levels of government: municipal, de-

[13] A. Mignon, *La service de santé pendant la guerre, 1914–1918* (4 vols., Paris, 1926–7), iv, pp. 679–702; L. Bernard, *La défense de la santé publique pendant la guerre* (New Haven, 1929); L. Murard and P. Zylberman, 'L'autre guerre (1914–1918): la santé publique en France sous l'oeil de l'Amérique', *Revue historique*, 276 (1986), pp. 396–7.

[14] AAP D-306, AP-CMA, 1914, pp. 75, 77.

[15] AAP D-312, AP, *Compte-moral*, *Hôpital de la Pitié*, *Historique de l'année 1920*; AAP D-308, Hôtel-Dieu, *Historique de l'année 1916*, p. 2; AAP D-311, AP-CMA, 1919, pp. 7, 8, 9.

[16] H. Joly, *Contre les maux de la guerre: action publique et action privée* (Paris, 1915), p. 8.

[17] M. Lheritier, *Tours et la guerre* (New Haven, 1926), pp. 38–9.

partmental, and national. The HCL had to resort to loans to cover extra war-related expenses. Total war-related debts were over 8 million francs by 1919. The municipal council had to come to the HCL's rescue, and the price to be paid was a veritable municipalization of the hospital administrative board.[18] Hospitals across France became more dependent on public subsidies and a new hygiene ministry began to dictate how they should function. The war signals an important step in the transformation of the hospital from a charitable institution guided by the spirit of *noblesse oblige* into a new social institution, providing care as a sort of civic service.

This occurred, at the most basic level, because the old spirit of *noblesse oblige* and the institutions that grew out of it were ill equipped to deal with the social problems born of total war. The traditional, private base to national hospital revenues (bequests, foundations, donations, *rentes* – endowment, in short) appears to have decreased from up to 70% of total revenues before the war to between 25% and 50% by the end of the 1930s.[19] Donations and bequests to hospitals amounted to a little more than 2% of their annual revenues in the mid-1930s (roughly 5 million francs out of 2·2 billion).[20] The state, the departments, and the communes had to step in to fill this gap. Central state spending on free hospital care (Assistance Médicale Gratuite or AMG) doubled in the 1930s. Whereas medical assistance accounted for 18·8% of total assistance expenses in 1913, it accounted for 32·1% of the total in 1935, showing how costs had risen and how priorities had shifted. But most of the brunt of this new spending was borne by the communes and the departments: in 1914, AP received 54% of its annual operating expenses from the municipal council but by 1920, 71·6% of its expenses were covered by the city of Paris. In smaller cities, the increase in the municipal subvention was often much greater.[21] The inter-war years were the high-water-mark of municipal social spending and activity.

By the war's end, inflation had taken its toll on hospital endowments. Their annual yields plummeted between 1912 and 1920. Many of the nation's hospices, like the Leprince in Paris, survived off small legacies, so they were adversely affected by the increase in the cost of living in the years after the war. AP's Hospice Debrousse in 1921 converted 200 of its 400 beds into 'assistance obligatoire' beds in order to get a steady stream of public monies flowing into its coffers. Otherwise it could not cope, since its endowment had dwindled. A sample of a few hundred hospital commissions from eighty-four departments studied by the ministry of labour reveals that revenues from hospital endowments declined from 30% of total revenues in 1912 to 15% in 1921. The first few years after the war were lean ones for many small hospitals; municipal

[18] *REB*, 1919, p. 1; HCL-CMA, 1915, p. 15; HCL-CMA, 1916, p. 15; HCL-CMA, 1918, p. 14; HCL-CMA, 1919, p. 18; HCL-D, 2 Oct. 1918; HCL-D, 1919, p. 457.

[19] D. Dessertine and O. Faure, 'Assistance traditionelle, assistance nouvelle: cout et financement: 1850–1940', in A. Gueslin and P. Guillaume, eds., *De la charité médiévale à la sécurité sociale* (Paris, 1992), p. 146.

[20] Statistique de la France, *Statistique annuelle des institutions d'assistance. Années 1934, 1935 et 1936* (Paris, 1941), p. xxiv.

[21] AAP, AP-CMA, 1919, p. 10.

and departmental subventions increased accordingly; by 1921 they exceeded 60% of total operating costs.[22] In short, the entire nature of hospital funding had changed due to the war. The balance had finally tipped towards public funding.

III

The war also saw the beginning of the erosion of the stigma attached to hospital care. As Dr Paul Boudin observed in an important 1920 report to the Société Internationale pour l'Etude des Questions d'Assistance,

> since the generalization of surgery, specialized examinations, x-rays, and since the war which brought so many wounded into the hospitals, the hospitals have lost their former renown as places of horror, solely devoted to indigents who go there to end their days. The bourgeoisie no longer fears [that it will] demean itself (*déroger*) by entering the hospital.[23]

This was a crucial development. At the most basic level, it occurred because total war exposed both middle-class soldiers and civilian victims of war (especially in the north), to institutions which they never would have considered entering in peacetime. Part of this was also a response to initiatives taken by hospital administrators themselves.

During the war, many cities created new services specifically designed to open up the hospitals to the middle classes. In 1916, for instance, Lyon created a service to aid large families and in the next year the municipal council worked with the Hospices Civils to expand the maternity ward at the Hôpital de la Charité. The commission in charge of this project was aware that it was presiding over an important change in the hospital's social mission: 'we are pleased that the [Hospices Civils] is expanding the maternity ward, which, more and more, provides services to the working class as well as to the middle class'.[24] This was the first instance in which both the hospitals and the municipality agreed that the hospitals ought to be opened up, en masse, to the middle classes. Bordeaux, Grenoble, and Annecy made similar efforts, establishing *maisons de santé*.[25] These local experiments born of wartime would provoke a nationwide debate during the 1920s within the hospital and social policy elite as to the proper mission of the hospital.

This debate began during the war in Lyon, as a commission was created in 1918 to study the very nature and purpose of the hospitals. The commission was particularly concerned with the alarming trend towards lower middle-class impoverishment and demands for hospital care and surgical operations. As Mayor Herriot observed,

[22] AAP D-314, AP-CMA, 1922, 'Note relative à l'Hospice Leprince en 1922', p. 345; AAP D-313, AP-CMA, Hospice Debrousse, 'Historique de l'année 1921', p. 285; Ministère du Travail, Statistique de la France, *Statistique générale des institutions d'assistance, années 1920–21* (Paris, 1923), p. xxvi.

[23] *RP*, 1920, pp. 270–1.

[24] CML, 26 Dec. 1916, 16 Oct. 1916, 7 May 1917.

[25] *CM*, 3 Jan. 1926, pp. 37–8. The process of opening up the hospitals to the middle classes had begun in Grenoble and Annecy in 1913, but accelerated during the war. CSAP 126, Annexe v, p. 139.

imagine the consequences of an operation which costs 400 to 500 francs in a worker's or petit bourgeois's family, which has an annual income of 2,500 to 3,000 francs; this is neither [a situation of] indigence nor is this a household which can afford the costs of a surgical operation.

To Herriot the solution was some sort of subsidized health care for the lower middle class and the working class, who had no legal right to health care at this time. He envisaged a *maison de santé municipale* which would charge fees on a sliding scale, according to one's resources, and as always, he had his foreign model to hold up as an example: in this case, Swiss semi-public clinics.[26] The war provided Herriot the opportunity finally to have his ideas taken seriously. After the war, precisely this sort of *maison de santé* emerged in a few dozen cities.

IV

One of the more significant consequences of the strains put upon hospitals during the war was that administrators were forced to formulate plans, surveys, and assessments of their inventories on an unprecedented scale. In 1917, Emile Delore, a member and future president of Lyon's hospital board, sketched, in *Nos hôpitaux de demain*, an overview of the Hospices Civils de Lyon in 1914 and again in 1917, and then he looked to the future of the HCL to recommend changes. Delore's book is significant in that it was the first ever written by a hospital administrator on the *future* of the hospital system; all previous work had been little more than antiquarian in nature, celebratory of Lyon's great hospital traditions. During the war, then, Delore felt compelled to take stock of the changes to the Hospices Civils wrought by the ordeal. He warned: 'it is easy to prove that for many years Lyon's hospital system has not responded to the needs of the population and has not kept up with advances in medicine'.[27] All the shortcomings were highlighted and magnified by the war. The testamentary base of the HCL's revenues no longer corresponded to the needs of modern hospital care. During the nineteenth century, when the hospitals had been static institutions, the conditions of wills did not hamper long-term planning for long-term planning simply did not exist. Since expenses and resources were relatively stable, the traditional revenue base, yielding low-interest but regular revenues, did not present a problem. It was now clear to Delore that private charity could not alone meet the demands of twentieth-century medical science. Prior to the war, Delore argued, this concern to 'not surpass the revenues from the endowment' had forced the Hospices Civils to engage in traditional methods of care which 'did not take the future into account'. He concluded that in order to survive, Lyon's hospitals, like all other French hospitals, would have to seek the state's regular assistance.

This was a fact which the municipal council's finance committee had admitted one year earlier. Reviewing the HCL's budget for 1916, it argued that it was time to put an end to the charitable nature of the Hospices's revenues:

[26] CML, 13 May 1918.

[27] Delore, *Nos hôpitaux de demain*, p. 5.

Until France's hospital system has been transformed and democratized by giving the hospitals and hospices a regular and rational revenue base beyond private charity, the deficits will only increase. This is a serious problem which deserves to be resolved without delay following the war. All our efforts must point toward this transformation; but it will ultimately be parliament's responsibility to help us with this task, in changing the laws which govern hospitalization in our country.[28]

As early as 1916, then, this sentiment existed, this type of legislative, national solution was envisaged. The war brought it out into the open. This marks a key turning point in Lyonnais and French attitudes towards the state.

V

The war's immediate effects were mixed: a significant expansion of hospital services in large cities like Paris, Bordeaux and Lyon, but a short-term decline in smaller cities and in those towns which had hospitals. Smaller cities like Dieppe lacked the tax base of large cities, and could not keep up with rising costs. In the short term, many smaller hospitals actually treated fewer patients immediately after the war.[29] But by bankrupting local hospitals, the war would, within a few years of its termination, inexorably draw the local and then the national state into this fiscal void. This, in turn, brought about various changes: the municipalization and professionalization of the hospitals, the erosion of the monopoly of hospital administration by traditional notables, and an increase in medical services. By roughly 1922, most hospitals had recovered and were treating more patients than before the war.

The greatest impetus to national social welfare development, of course, was the demographic loss incurred by the war itself. In addition to killing 1·4 million French, the war added several hundred thousand people to the list of those who could claim a legal right to medical and social assistance: 1 million invalided soldiers and civilians plus their 630,000 dependants, 680,000 widows, and 760,000 *orphans de père* who received assistance until their eighteenth birthday. These were people whose needs could not have been ignored, so in this sense the war broadened the field of central state social policy activity. Whether the French liked it or not, they, like the Germans and the British, were being forced to expand the state's social role. A law of 31 March 1919 created a national military pension scheme and by 1939, 10% of the French population received a war-related pension, representing 16% of national tax revenues.[30] Veterans, represented by a powerful new ministry, secured most-favoured status within the post-war state. Solidarity can be born of suffering as well as idealism.

[28] CML, 7 Feb. 1916.

[29] G. Lebas, 'La vie chère et les hospices et hôpitaux en province', *RH*, 1920, pp. 182–3, 203–4, 229–31.

[30] Guillaume, *Le rôle social*, p. 145; M. Huber, *La population française pendant la guerre* (New Haven, 1931); H. Jackson, 'L'impact de la guerre 1914–1918 sur la protection sociale', in Gueslin and Guillaume, eds., *De la charité médiévale à la securité sociale*, p. 118; A. Prost, *Les anciens combattants et la société française, 1914–1939* (3 vols., Paris, 1977).

There are few more potent symbols of this new sense of national solidarity than the Unions Hospitalières, associations of hospital commissions. The first of the regional associations was the Union Hospitalière du Sud–Est, founded by the Hospices Civils de Lyon and headquartered there. The brainchild of President Diederichs of the HCL, the Union's members were drawn from twenty-three departments in the south-east. In a May 1917 circular to hospital commissions in the south-east, he wrote:

> In addition to general questions which concern France as a whole, there are regional problems – financial, technical – which require a concerted co-ordination of our efforts to solve. From this point, we should concern ourselves with the *après-guerre* and work immediately towards the reorganization and the improvement of our hospitals' administration so that we may further extend their field of action.[31]

Not only was this a call to reorganize assistance, but also to 'extend' its scope.

The Union first met in Valence in March 1918, in the midst of wartime, in order to discuss the pooling of resources, and the centralization and rationalization of the delivery of medical services. Here was an unprecedented manifestation of geographic solidarity. By June 1918, fifty-three of the seventy-three hospital boards falling within the boundaries of the Union (from the Ain to the Bouches-du-Rhône to the Hérault) had joined. The goal of the Union was to 'centralize the means to improve assistance'.[32] It was formed to pool resources and share facilities at a time when hospitals were faced with unprecedented fiscal problems. On the one hand, provincial hospitals now wanted more money from the state, but they also feared an erosion of their autonomy in a new age of state subsidies, a trend everyone knew would only accelerate after the war.[33] The first Union promoted the establishment of five other regional Unions and later the National Federation of Hospitals, which held annual meetings in Paris. The remarkable transformation of provincial hospital commissions from intransigent defenders of localism before the war to advocates of regional and national reform is unthinkable without the war experience. It signals the closing of a centuries-long chapter in the history of local charitable activity and the advent of national-minded, or metropolitan, technocratic elites, with the interests of France as a whole in mind. This was essential to the success of social reform during the 1920s.

VI

In their recent book, Murard and Zylberman paint a picture of utter immobilism prior to the Great War; France was light years behind Germany and England in the realm of public health. Although, as they argue

[31] P. Pessemesse, 'Les Unions hospitalières et la Fédération hospitalière de France: leur action de 1918 à nos jours', *RHF*, 1937, p. 92; E. Brizon, 'L'origine de l'Union hospitalière du sud-est', *RH*, 31 May 1932, pp. 244–7.

[32] A journal was founded, the *Bulletin mensuel de l'Union hospitalière du sud-est* (later in 1918 renamed the *Revue des hôpitaux*, and, as of the mid-1930s, the *Revue hospitalière de France*), in order to disseminate information across the nation. *Bulletin mensuel*, May–June 1918, pp. 14–15.

[33] *RH*, May–June 1918, p. 15.

persuasively, 'total war inaugurated the era of partial solutions', in that the efforts of the Service de la Santé Militaire were, for the most part, limited to protecting the health of soldiers, we should not underestimate the general impetus the war gave to *étatisme* and the social reform movement.[34] Despite the financial setbacks occasioned by the war, it was the single most important impetus to reform to date. It provided the entire backdrop to, and framework for, post-war reform. It was the model held aloft, time and again, by the advocates of health care reform.

No sooner had the armistice been signed, than numerous calls for the complete reform of the nation's hospitals and assistance services appeared in influential journals such as the *Revue des hôpitaux*, the *Revue des établissements de bienfaisance*, and the *Revue philanthropique*, to name but a few. These calls for the overhaul of public assistance paralleled the plans for economic renovation which Richard Kuisel, Charles Maier, and others have examined, but we will see that social policy reformers were more successful in realizing their visions than the proponents of economic renovation were.[35]

To Gustave Gimbert, the president of Le Puy's hospital administration, the time was ripe for a complete transformation of the very nature of the French hospital. Writing in the hospital administration profession's leading journal, the *Revue des hôpitaux*, he called for an end to the 'maison des pauvres', run by 'men of wealth without professional training'. Despite the introduction of free medical assistance for the indigent in 1893 and attempts by the wealthier and larger cities to open up their hospitals to the middle classes during the war, most provincial hospitals remained in 1918 what they had been in 1818: refuges for the downtrodden. Gimbert argued, with reason, that only when hospitals were transformed into clean, spacious, and modern establishments, complete with the latest medical technology, would people change their attitudes towards them. They should become more specialized, scientific institutions, run by experts, not philanthropists. He called for the Taylorization of hospitals: 'modern industry, if we may be permitted such a comparison… has engineers and foremen to oversee the operation of its machines'. Gimbert and many others called for the establishment of a ministry of health. At stake was nothing less than the future of the race, the 'recovery' of France.[36]

To August Croze of the Hospices Civils de Lyon, the war had provided France with an opportunity to refashion the social contract and modernize the nation's social services. In a December 1918 article in the *Revue des hôpitaux* entitled 'The new dawn', he wrote:

[34] L. Murard and P. Zylberman, *L'hygiène dans la République: la santé publique en France, ou l'utopie contrariée, 1870–1918* (Paris, 1996), p. 547.

[35] C. S. Maier, *Recasting bourgeois Europe: stabilization in France, Germany, and Italy in the decade after World War I* (Princeton, 1975); R. F. Kuisel, *Ernest Mercier: French technocrat* (Berkeley, 1967), and *Capitalism and the state in modern France*; W. H. Schneider, *Quality and quantity: the quest for biological regeneration in twentieth-century France* (Cambridge, 1990).

[36] Gimbert, 'Pour la réforme de l'administration hospitalière', *RH*, Nov. 1918, pp. 22, 15; P. Alepée, 'Vers un ministère de l'hygiène', *RP* (1918), pp. 412–15.

The hour of victory has rung. The hour of victory, and, with it, the hour of repairs and reconstruction, the hour of unavoidable modifications in every branch of human and social activity. Public assistance cannot escape this necessity … it would be guilty if it were to settle back into its old ways and be blind to the new needs which demand its attention … Hospital administrations must break decisively with outdated methods and constricting limits, which, too often, paralyse their activities. Progress is incompatible with routine … The co-operation of all is necessary to achieve truly effective results. Above all, our efforts must not remain isolated, sterile: *l'union hospitalière fait la force*. May each of us bring his stone to the common work of rebuilding … may all the energy … liberated from the task of conducting war, be channelled with the same élan and the same power towards peacetime problems![37]

As the future minister of hygiene Paul Strauss proclaimed in the *Revue philanthropique* shortly before the armistice, after the war 'it will be the hour of reconstruction, in the industrial, commercial, economic and social sense'. The state cannot deny its role in this 'gigantic *œuvre de réparation française*'. Experts and technocrats (himself) would be needed to oversee this Herculean task.[38]

In the aftermath of the war, then, social reform took on the nature of a veritable crusade. Advocates of increased social spending employed the military metaphor to justify increased state intervention. As Dr Gustave Drouineau of the Conseil Supérieur de l'Assistance Publique (CSAP) argued, the state 'must fight against its internal enemies and achieve no less brilliant victories than those of our valiant and heroic soldiers'. He called for a centralization of all assistance services. In his 1920 book, *L'autre guerre: essais d'assistance et d'hygiène sociales, 1905–1920*, Georges Cahen of the Academy of Moral and Political Sciences called for a 'party of reconciliation' to govern post-war France, 'the party of social hygiene'. Cahen called for a 'sanitary crusade', adding that 'personal interests do not count when the *patrie* is threatened'. His 'new army' would fight internal enemies, 'for the *salut de la race*'. All forces must join in this 'other war', no price was too high to pay, not even the principle of democratic administration.[39]

So much for the rhetoric. What was achieved? Before the French got around to preserving life through medical means, they sought to do so with legislative solutions. The demographic losses of the war gave pronatalist groups such as the Alliance Nationale pour l'Accroissement de la Population Française a national audience. A consensus emerged over the need to suppress abortion and birth control and over the need to protect the family. On 31 July 1920 the chamber passed a law by 521 votes to 55 making both contraceptive propaganda and abortion illegal. A certain legislative *élan* can certainly be directly attributed to the war. As in England, the war gave rise to a new public health ministry: the ministry of hygiene, social assistance, and prevention, as well as the Conseil Supérieur de la Natalité, both created in 1920 (a separate

[37] *RH*, Dec. 1918, p. 4.

[38] *RP*, 1918, p. 336.

[39] G. Drouineau, 'Les œuvres philanthropiques de l'après-guerre', *RP*, 1919, p. 8; G. Cahen, *L'autre guerre* (Paris, 1920), pp. viii, 3–11, 159.

ministry of health emerged in 1930).[40] Natalist commissions were established in each department to report back to the Conseil Supérieur on local matters.

In addition to the emergence of a powerful and effective pronatalist movement after the war, the most important outcome of the war was the appearance in 1920 of a significant group of supporters of a national medical insurance bill, led by Deputy Edouard Grinda of Nice and the minister of labour Paul Jourdain of Alsace. Health insurance and old age pensions would not only bring the rest of France in line with Alsace and Lorraine, which re-entered France with their well-developed social assistance institutions intact and whose example was always at the forefront of reformers' rhetoric; it would also help to distinguish the French from other Europeans. As Aristide Briand took the floor in the chamber of deputies in March 1921 to introduce the government's social insurance bill, he declared: 'In its present form, this bill will place France at the head of all civilized countries in terms of social insurance'.[41] Arguments in support of medical insurance were also commonly grounded in the importance of preserving human capital, promoting efficiency, and stabilizing the social order. The social insurance bill called for sickness, retirement, and invalidity insurance, with supplemental benefits for maternity and death. It was to be funded by a 5% deduction from wages and a 5% contribution from employers too. The bill languished in the chamber until 1924, when it passed. It was then sent to the senate where further inquiries and debates over technicalities and costs delayed a vote until 1927. But well before this time, there was no doubt that some form of social insurance bill, centred around health insurance for workers, would emerge from the parliamentary labyrinth. The senate indeed approved the bill but sent it back to the chamber with many revisions. Finally it passed in 1928 after many of the contentious details had been ironed out. It was amended in 1930 to reduce employee/employer contributions to 4% (each) of salary. On what grounds did the French justify this unprecedented bill?

In a remarkable 530-page report to the chamber of deputies on behalf of the Commission d'Assurance et de Prévoyance Sociales (1923), Edouard Grinda succeeded in capturing the moral high ground in favour of the bill. Making frequent references to David Lloyd George and the 1911 National Insurance Act, Grinda matched Lloyd George's rhetorical mastery. Noting that the nineteenth century had witnessed the advent of large insurance companies

[40] A. H. Reggiani, 'Procreating France: the politics of demography, 1919–1945', *French Historical Studies*, 19 (1996), pp. 725–54; M. S. Quine, *Population politics in twentieth-century Europe* (London, 1996), pp. 65–6; J. H. Cole, '"There are only good mothers": the ideological work of women's fertility in France before World War I', *French Historical Studies*, 19 (1996), p. 671. See L. Murard and P. Zylberman, 'La Mission Rockefeller en France et la création du Comité national de défense contre la tuberculose (1917–1923)', *Revue d'histoire moderne et contemporaine*, 34 (1987), pp. 257–81.

[41] No sooner than June 1919, the conservative opponent of social insurance, La Réforme Sociale, and its ally the Société d'Economie Charitable, organized a conference to highlight the pitfalls of accepting the Alsatian model into the hexagon, *RS*, 1 July 1919, pp. 7–11. Another conference took place in November, *RS*, 1–16 Nov. 1919, pp. 253–83. Briand is quoted in *JE*, Oct. 1921, p. 146.

covering fire, drought, harvest failure, floods, and accident insurance, Grinda asked why it was that, 'by some strange anomaly, our labour force – the most precious, indispensable [component] of our capital, is not insured!'. Grinda presented his bill as 'a law in our national interest which will serve to protect the future of the race, improve its health, bolster the quality and quantity of our manpower, spread the benefits of hygiene, and secure social peace'. There was no doubt in Grinda's mind that health insurance was owed to French workers in the aftermath of wartime sacrifices. He began his report: 'Give to the great phalanx of workers the [medical] care, the ambulances, the hospitals they demand; for us this is the most urgent of duties.'[42] A people's war must be rewarded with a people's peace.

VII

Meanwhile, as the medical insurance bill slowly weaved its way through the maze of parliamentary committees and bounced back and forth between the chamber and the senate during the mid-1920s, the victim of seemingly countless modifications and filibusters, French reformers got on with business at the local level. Local experiments and debates determined the final shape of the 1928 medical insurance law. This story is absent in the historical literature, perhaps because it was simply assumed that nothing could have changed until the medical insurance bill was passed. In fact, a lot was achieved well before the passage of the 1928 law, much of it the product of remarkable local initiative.

The central state was also very active. Despite the argument that prior to the creation of the ministry of health in 1930 'the hospitals were not yet one of the major concerns of the government', during the 1920s hospitals were in fact one of the key concerns of successive governments.[43] Consequently, health policy became more and more standardized and centralized. As early as October 1920, the government had laid out its goals in a circular to prefects: our 'hospital policy' consists of 'equipping the hospitals in the *chef-lieux* of each department with the latest scientific advances'. State subsidies followed, earmarked for certain services, such as tuberculosis, radiology, surgery, and cancer research. Major urban hospitals located in regional centres were favoured, much to the dismay of the hospital administrations of smaller cities. Not since the Revolution had a French government committed itself to a national 'health policy'. The goal was to concentrate on well-endowed institutions. In May 1922, another ministry of hygiene circular instructed prefects to abide by the following guidelines as they distributed state subsidies: 'It is absolutely indispensable that there exist in each department a hospital complex equipped with the most modern surgical equipment, with operating

[42] AAP C-864, Chambre des Députés, no. 5505, Annexe au procès-verbal de la séance du 31 janvier 1923. *Rapport fait au nom de la Commission d'assurance et de prévoyance sociales … sur les assurances sociales*, ed. M. Edouard Grinda (Paris, 1923), pp. 7, 104, 2. The same alarming rhetoric is evident in AAP C-865, Sénat, no. 435, Annexe du procès-verbal de la séance du 8 juillet 1925, *Rapport fait au nom de la Commission de l'hygiène, de l'assistance … sur les assurances sociales*, ed. M. Chauveau (Paris, 1925), passim.

[43] Imbert, *Histoire des hôpitaux en France*, p. 302.

rooms, radiology services, radioscopy, radiotherapy services, and bacteriological laboratories.'[44] Although the state was not yet directly managing affairs at the local level, it was now setting the general tone of hospital policy and regulating the internal rhythms of hospitals as never before, laying out the ground rules for the hiring, promotion, and disciplining of personnel and administrators, much to the dismay of some local notables.[45]

But the reformist impetus came from both Parisian technocrats and from the provinces; the CSAP was bombarded with requests from provincial hospital and welfare committees asking for a national pooling of hospital and assistance resources.[46] In the 1920s, the provinces requested over 500 million francs worth of state subventions for renovation and modernization projects (they received roughly four-fifths of this sum). As new medical technologies sent expenses on an upward spiral, small provincial hospitals, largely funded by small private bequests, could not keep up. The state would have to step in. Although for obvious reasons the provinces stopped short of calling for an outright nationalization of hospitals, there were some legislators (Edouard Grinda) and policy experts (Gustave Gimbert from Le Puy) who called for just this, but few had forgotten the rash nationalization of hospitals during the Revolution. This was an ideal for the post-Second-World War era. In the meantime, however, the first steps toward the implementation of national standards for hospitals were taken.[47] Hundreds of ministry of hygiene circulars and CSAP regulations changed the way hospitals did business, starting the process of chipping away at localism.

Typical were the CSAP directives of 31 July 1921 and 31 January 1922. They required all hospitals receiving public monies to standardize their procedures governing internships. They also reorganized the local hospital commissions, allowing women to participate and increasing municipal input. Hospital boards were now required to meet at least once a month (it had not been uncommon for many small boards to meet only once a year), all patients were now required to be visited by a doctor at least once per day, and doctors were now required to give their opinion regarding any major changes in hospital policy and regarding any plans for new construction. The CSAP and the ministry of the interior were, in short, medicalizing the hospitals, transforming them from refuges into medical institutions.

Not everyone was pleased with post-war governments' policies, however. Throughout the 1920s, successive governments sought to build up the major

[44] Both circulars quoted in *RH*, 1922, p. 345.

[45] For example, the CSAP regulation of June 1929 which set out new guidelines for hospital secondary personnel (recruitment, advancement, discipline of), CSAP 133 (1929), 'Statut-modèle des fonctionnaires hospitaliers', Annexe I, pp. 77–81, and the regulations which governed hospital administrators, ibid., pp. 107–9. On opposition to this reform, see CSAP 134 (1930), 'Assurances sociales et hôpitaux', pp. 35–9, and CSAP 133, pp. 42–5.

[46] G. Cros-Mayrevieille, 'L'état des établissements hospitaliers', *RP*, 1921, pp. 44–77.

[47] M. L. Nicaud, the Inspecteur Départemental de l'Assistance Publique of the Marne, proposed the nationalization of hospitals in 1920, *REB*, 1920, p. 193; minister of hygiene to prefects, 13 Oct. 1920, in *REB*, 1921, pp. 132–3.

urban hospitals, even if this meant neglecting smaller remote ones. Many hospital administrators from poorer regions, like the Tarn-et-Garonne, protested.[48] By 1921, J.-L. Breton, the new minister of hygiene, assistance, and social insurance, had tired of the numerous requests he received from bankrupt provincial hospital boards whose regular revenues, derived from charitable bequests and their endowments, were no longer sufficient. Breton instructed the prefects to concentrate their efforts on building up the resources of the large, wealthy hospitals situated in major urban centres, for 'a rational distribution of our medical establishments'.[49] At a time when technological advances were rapidly increasing the cost of doing business, France could not, he rightly concluded, afford to spread scarce resources too widely. 'We must', Breton instructed the prefects in a circular, 'concentrate the state's resources on those establishments which are capable of providing the population the [type of] services which it deserves and expects, instead of scattering our subventions like dust.'[50] Breton's successor, Paul Strauss, went one step further, ordering the prefects in May 1922 to conduct a complete inventory of hospital equipment and resources so that hospitals could be classified according to type (major surgical/diagnostic/research centres and all others) in order to determine which ones would receive special state subsidies for new equipment and so that a national hospital strategy could be drawn up. The next month, Strauss issued a circular calling for an official inventory of all health care institutions, public and private.[51] Although future critics like Paul Garnal of the Hospices Civils de Cahors would decry the continuing lack of national co-ordination of hospital resources, this inventory aided future ministers, armed with roughly 30 million francs per year in subventions for hospitals (and an allocation of 350 million francs for hospital construction and renovations in 1932), in their efforts to build up major hospitals.[52] Strauss's crowning achievement was the creation of state-funded regional cancer research and treatment centres in 1923–4 in Bordeaux, Caen, Lille, Lyon, Montpellier, Nantes, Reims, Rennes, Strasbourg, and Toulouse. Other new state-funded institutions were: venereal disease dispensaries in cities larger than 10,000 people, anti-tubercular dispensaries and sanitoria. These institutions all grew out of wartime public health concerns and legislation (the Bourgeois Law of 1916, the Honnorat Law of 1919) but most were actually built during the early 1920s. By the early 1930s, the ministry of health had an annual operating budget of 1·3 billion francs; by 1939 it had increased to over 1·6 billion.[53]

[48] *RH*, 1922, pp. 352–3.

[49] Circular of 15 Oct. 1920, in *RH*, 1922, p. 197.

[50] 'Le Ministre de l'Hygiène… à MM. les préfets', *REB*, 1921, pp. 132–3.

[51] Circular of 9 June 1922, *RP*, p. 289.

[52] M. Sarraz-Bournet, 'Travaux hospitaliers', *REB*, 1931, pp. 53–66, and 'Esquisse d'une politique hospitalière', *REB*, 1932, pp. 259–71. Garnal was a tireless critic of French health policy (or, as he claimed, the lack thereof). For example, 'L'hydre aux cent têtes', *RH*, 28 Feb. 1934, pp. 51–7.

[53] *RH*, 31 Oct. 1932, p. 544; *REB*, 1939, p. 119. On the evolution of the ministry, see M. Bargeton and A. Ziegler, 'Historique des ministères sociaux', *Revue française des affaires sociales*, special edn (1971).

Like the British, the French were beginning to formulate (if not completely realize) a regional and even national approach to hospital issues, and the fiscal difficulties facing cities and hospital commissions across the country provided the opening in which the state could drive its centralizing wedge. If the state did not have as much control over hospitals as some were calling for, it was still issuing hundreds of circulars each year laying out the guidelines under which doctors and hospital administrators across the nation had to do business. And if the funding was lacking (in the eyes of some), there was indeed a slow but quiet process of standardization going on. The annual *Bulletin du ministère de la santé publique*, for instance, contains decrees, circulars, new public heath laws, and regulations governing the administration of hospitals, and the conduct of the medical profession. The 1938 bulletin consists of over 500 pages of material. Here was a very active ministry.[54] Government subsidies, which before the war had often been refused by communities jealous of their autonomy, were now welcomed, but the money now came with strings attached. As a result, French hospitals were being transformed from private philanthropic institutions (subject to loose governmental supervision) which may or may not have received communal or state funding, into public institutions.

VIII

This process was particularly pronounced in Paris. Hospital reforms in the capital got more attention than those in Nancy, which were arguably more important (as of 1924 all Nancy residents were eligible for free medical consultations and free surgery).[55] Paris's co-ordinated social services administration, Assistance Publique (established in 1849) today presides over Europe's largest sub-national health and welfare service. It was only during the 1920s and 1930s, however, that AP raised several Parisian hospitals and social services to world-class status. This was the result of a conscious and concerted effort to catch up to the Americans, the British, and the Germans. It was fundamentally a question of money.

Money had, of course, been sorely lacking prior to the war, as the French went to extraordinary lengths to avoid imposing an income tax and other taxes on themselves. But after the war, the dyke was breached: total state revenues (at all levels of government) increased from 5·14 billion francs in 1913 to 10·1 billion in 1919 to 30·37 billion in 1924. Government revenues rose from between 10 and 12% of GNP in 1913 to 15 and 18% in 1924. In addition to the income tax introduced during the war, cities gained more freedom to increase property and professional taxes. Many cities, including Paris, took advantage of this to build up their hospital and social services.[56] The process

[54] *Bulletin de la Ministère de la santé publique: textes officiels concernant la protection de la santé publique* (2 vols., Paris, 1938).

[55] On the Nancy reforms, see M. Gauguery, *Les hospices civils de Nancy* (Nancy, 1930), and *RH*, 1922, pp. 382–5.

[56] Maier, *Recasting bourgeois Europe*. pp. 467–9; AP-CS, 12 June 1924, p. 628.

required a significant amount of political will: as Henri Rouselle addressed the Paris municipal council in 1924, 'despite the economic difficulties we are experiencing, we cannot wait any longer to bring about some indispensable improvements to our hospital services and to attend to the financial matters required for their execution'.[57]

In December 1925, the Paris municipal council approved Assistance Publique's programme of 'grands travaux', responding with a municipal tax increase of 6 *centimes additionnels* for a period of ten years. The Paris municipal council gave AP 150,000,000 francs in 1925 and 350,000,000 francs in 1932. In 1921, AP provided Parisians 2·3 million medical consultations in the city's hospitals and clinics; by 1935, almost twice as many consultations (4·5 million) were provided. This was the greatest leap in access to medical care to date and it would not have been possible without the larger public monies being spent.[58] AP's child welfare bureau expanded rapidly during the 1920s and 30s. By 1937, the city supported 28,000 children in one way or another, at an expense of 70 million francs, or one tenth of the total AP budget. In that year, besides the children, the numbers of people aided by the Paris AP were: 51,282 elderly indigent (under the 1905 law); 44,470 hospitalized; 28,000 children; 9,123 pregnant women; and 5,992 large families.[59] Eight Parisian hospitals, including the Bichat, were completely renovated and reconstructed in 1927–9 alone and the twelve-storey-high, 1,100-bed Hôpital Beaujon was built between 1933 and 1935, using municipal and state revenues. Ten other hospitals, including the Claude-Bernard, were enlarged and several sanitoria were constructed. Between 1920 and 1929, AP added 9,000 beds to its hospitals.[60] Starting in 1929, AP, the general council of the Seine, and the municipal council of Paris embarked on a plan to add 4,000 new hospital beds to the departmental total (outside Paris). New hospitals were begun in Garches and in Rosny. Old institutions such as the Charité in Paris were closed. This project cost over 300 million francs. It was a remarkable success in every sense: political, technical, financial, medical, social.

All of this building and spending added up to a significant medicalization of the Seine. In 1920, there were 20,076 beds under AP control (13,139 'medical', 5,061 'surgical', and 1,876 'maternity'). That year 257,809 patients were treated. By 1936, there were 29,082 beds under AP control (18,423 'medical', 7,556 'surgical', 3,103 'maternity'). In 1935, 336,126 people were treated. Over 80,000 more people were treated in the hospitals in 1935 than in 1920.

[57] BMO-CMP, 31 Dec. 1924, p. 5483.

[58] *REB*, June 1934, p. 219; BMO-CMP, 20 Dec. 1925. On Parisian hospitals and child welfare in the inter-war years, see F. B. Burkhard, 'Henriette Valet's *Madame 60bis*: French social realities and literary politics in the 1930s', *French Historical Studies*, 18 (1993), pp. 503–23, and his paper given at the American Historical Association's 1997 meeting, New York City, 'Delivering babies: the Assistance Publique of Paris and the administration of maternity services, 1919–1939'. I. Gaussen, 'Principes de fonctionnement de l'assistance publique en France', *RHF*, Apr. 1938, p. 169.

[59] AAP, *Administration générale de l'Assistance Publique de Paris, 1920–1937* (Paris, 1937), p. 8.

[60] Burkhard, 'Delivering babies', p. 6.

Whereas 42·4% of births took place at home in 1920, only 16% did in 1931 and 7·7% in 1939, thanks to the efforts of AP. This was the largest and quickest expansion in medical care to date, and the administrators of AP were well aware that they were presiding over an important project of social reform.[61] Indeed, they prided themselves on this. Looking back over the progress made since the Great War, AP had a keen sense of what the hospitals were like before and after that great cataclysm. AP publications, brochures, and reports of the 1920s and 1930s are replete with references to the 'Ancien Régime' (i.e. before the war) and the new regime they were constructing:

> The hospital is no longer the isolated institution of yesteryear, cut off from the life of the city, which took in the sick only at the most advanced stage of his illness, only to dismiss him, losing all further contact with him, as soon as his presence was no longer necessary; it is no longer a place where… we would attend to the illness in the man without considering the man who is ill. The hospital tends, more and more, to become not only a medical centre, but also a centre of prophylactic and sanitary activity, more and more the hospital seeks to remake the entire man, to become 'an enterprise of social recuperation'.[62]

The development of external consultations, specialized clinics, specialized medical practices, public hygiene education campaigns, family education and visiting programmes ('La Semaine Sociale'), and preventive medicine all set apart AP's post-war activity from the 'Ancien Régime' and helped to 'remake' Parisians.[63]

Other cities, like Nancy under Alfred Krug's stewardship, witnessed improvements of a similar order. Five new hospitals were completed by 1926, adding 1,400 new beds to the city's capacity. During the 1920s and again in the 1930s, the budget of Lyon's hospital system doubled in real terms. Millions of francs were invested in modern operating facilities and clinics, x-ray technology, isolation wards, maternity wards, cancer research, better kitchens, and more comfortable ward rooms, and so on.[64] Medicine expenses more than doubled during the 1930s. In 1914, there were 5,200 beds in Lyon's hospital system; by 1933, there were 8,200, thanks in large part to the completion of the enormous, new Hôpital Grange Blanche (made possible, in part, by a 42 million franc donation from the Rockefeller Foundation). The Grange-Blanche was in many ways the very antithesis of the old Hôtel-Dieu. Rather than one large building, it consisted of twenty-one smaller pavilions, with specialized services and laboratories housed in each. New gynaecological, dermatological,

[61] Paris had only 20,000 beds, and not, as C. Rollet claims, 30,000, in its hospital system at the outbreak of the First World War, 'The "other war" 1: protecting public health', in J. M. Winter and J.-L. Robert, eds., *Capital cities at war: Paris, London, Berlin 1914–1919* (Cambridge, 1997), p. 423; Burkhard, 'Delivering babies', p. 8; *Administration générale de l'Assistance Publique de Paris, 1920–1937*, pp. 12–13.

[62] *Administration générale de l'Assistance Publique de Paris, 1920–1937*, p. 185.

[63] P.-F. Armand-Delille, *Le Service Social dans les collectivités contemporaines* (Paris, 1929); Reynolds, *France between the wars*, ch. 6; A. Del Re, *Les femmes et l'état providence: les politiques sociales en France dans les années trente* (Paris, 1994).

[64] *RH*, 1926, p. 3; P. Delore, *Tendances de la médecine contemporaine* (Paris, 1936).

and ophthalmological clinics were built, symbolizing the specialized nature of inter-war medicine.[65] The architects of the new hospital hoped that this new type of design would distance the Grange-Blanche from the popular image of the hospital – the old, decrepit Hôtel-Dieu, the ignominious death trap. These efforts, and similar hospital renovation projects in cities across France, succeeded in expanding the hospitals' clientele, as the middle classes began to seek the comforts of modern, specialized medicine. New hospitals built in the 1930s usually contained a large number of private rooms, and every effort was made to make new and renovated hospitals as aesthetically pleasant as possible.[66] Across the nation, from Dijon to Cahors, cities converted old ward rooms into smaller rooms of two, four, six, and eight beds by erecting permanent partition walls.[67] One of the most innovative hospital commissions of the inter-war years was that of Montpellier, which constructed an avant-garde 'Hôpital de Cliniques', literally a hospital made up of clinics (ophthalmology, urology, dermatology, otorhino-laryngologie, 'clinique des maladies nerveuses'), during the period 1930–40. Each clinic contained 100 beds, for a total of 500. There were rooms designed for all classes, containing one, two, four, six and eight beds, with separate wings for men and women. There was a radiology department, operating rooms, examining rooms, and labs. Here was a true hospital 'à l'américain',[68] one which was still deemed to be modern enough in 1969 to be celebrated in a pamphlet on French hospitals published by the Ministre des Affaires Sociales.[69]

In addition to the modernization of old public hospitals and the construction of new ones like Montpellier's, hundreds of small private clinics were built between the wars in response to popular demand. Much of the impetus to specialized and modern medicine, then, came from the people themselves. For wealthier people, the clinic was the answer. For some workers, mutualism was the answer: during the 1930s, mutual aid societies created medical clinics, including surgical ones, for their adherents. The first one opened in Montpellier in 1910, then Marseille in 1926, Bordeaux in 1930, Nimes in 1932, Saint-Etienne in 1933 and Lyon in 1935. By 1938, 800,000 *mutualistes* were covered, and were eligible to enter these types of surgical clinics. In 1938 they performed 17,851 surgical interventions (mostly minor ones, such as hernia operations) and provided 204,000 *journées* of hospitalization. According to Faure and Dessertine, this type of clinic was the prototype for the post-Second World War modern hospital.[70]

[65] M. Garden, *Histoire économique d'une grande entreprise de santé: le budget des Hospices Civils de Lyon 1800–1976* (Lyon, 1980). By 1939, 4,000 of France's 27,700 doctors were specialists, and the dental profession increased from 3,600 in 1921 to 9,100 in 1937, P. Theil, *Le corps médical devant la médecine sociale* (Paris, 1943), pp. 207–8.

[66] For example, *RHF*, 1936, pp. 602–29.

[67] M. Fréjacques, 'L'evolution hospitalière', *RH*, 31 Apr. 1931, pp. 139, 142.

[68] 'Aux Hospices de Montpellier: construction d'un Hôpital de Cliniques', *RH*, 30 Apr. 1930, pp. 158–68.

[69] AAP C-1085, M. Schumann, Ministre d'Etat, Ministre des Affairs Sociales, *Les hôpitaux en France* (Paris, 1969), p. 44.

[70] Guillaume, *Le rôle social*, pp. 224–5; O. Faure and D. Dessertine, *La médecine entre libéralisme et solidarités (1850–1914)* (Paris, 1994).

In real terms, national public hospital expenses quadrupled between 1902 and 1930. By 1936, national hospital expenses reached 4% of the state budget. Thanks in large part to increased state funding of medical schools, the number of doctors increased from 18,211 in 1906 to 20,364 in 1921 to 25,410 in 1931 and 27,700 in 1939. Nationwide, access to hospital care in public hospitals increased as follows (recall that the French population remained static). In 1912: 775,434 patients treated and 231,517 hospital beds available; in 1926, 896,253 patients and 249,379 beds; in 1932, 1,146,256 patients and 286,591 beds; and in 1939, 1,220,000 patients treated and 305,000 beds available.[71]

The big step took place between 1924 and 1928 – before the 1928 medical insurance law was passed. A quarter of a million more people were served by the hospitals at the end of that four-year period. Previously, it had taken over sixty years – from 1853 until 1911 – for a numerical increase of that order.[72] As hospitals began to take on the air of public institutions as opposed to private charities, they gained respectability among the middle classes. Scientific developments and the professionalization of hospital administration also helped to erode the traditional stigma surrounding hospitals. Nothing helped attract the middle classes more than the effort to wrap the hospitals in science. The hospital was seen by many reformers as a great social regenerator, and every effort was made to sell a new, positive image of it to the public.

IX

As the directors of the Parisian welfare administration recalled in a celebratory 1937 publication, during the second half of the 1920s, AP 'called upon modern methods [of management] in use in the industrial and commercial world; we have been inspired by the organizational and managerial methods [recently adopted by] large enterprises'.[73] Every effort was made in the aftermath of the war to make hospital administration a more attractive career to talented young men and women. French social policy experts set out to transform the administration of hospitals from a philanthropic activity, a pastime, a service performed out of *noblesse oblige* or out of political ambition, into a science performed by experts. And they largely succeeded in the big cities. After the war, salaried hospital administrators with regular pay scales became the norm. A retirement fund for employees was set up in 1921 by the member-hospitals of the Union Hospitalière du Nord-Est. Other hospitals followed suit.[74] Several hospitals in major cities were reorganized along bureaucratic, organizational lines, with new managerial positions and titles, pensions, and better pay. The old local-based, notable-administered hospital commissions were gradually replaced by salaried experts (especially in the larger cities) who now advertised

[71] P. Montel, *Etude sur les prix de journée des établissements hospitaliers* (Avignon, 1936), p. 10; Theil, *Le corps médical*, pp. 127–9, 207–8; Statistique Générale de la France, *Statistique annuelle des institutions d'assistance. Année 1932* (Paris, 1935), p. xxvii.

[72] M. Rochaix, *Essai sur l'évolution des questions hospitalières de la fin de l'ancien régime à nos jours* (Paris, 1959), p. 159.

[73] *Administration générale de l'Assistance Publique de Paris, 1920–1937*, p. 9.

[74] *RH*, 1921, pp. 362–3.

their skills in the national social policy journals and travelled from city to city in order to ply their trade, though in many smaller cities the hospitals continued to be run by the local business and legal notability.[75] The age of the hospital expert had, however, begun, and the age of the amateur philanthropist-administrator was coming to an end. Little record of the old notables' opposition to this questioning of their capacity to operate modern medical facilities can be found, perhaps because these men realized that they were, alas, in the words of their critics, yesterday's men.

The professionalization of nursing at the national level, too, a process underway in a few cities prior to 1914, can be directly attributed to the war. The heightened post-war concern for saving as much human capital as possible, no matter what age, put a higher premium on efficient and competent medical assistants. Yet another rationale for the professionalization of nursing was that this would, Minister Paul Strauss hoped, render the vocation more appealing to 'young women who are seeking salaried jobs'. Nursing would channel the ambitions of the 'new woman' into a safe outlet.[76] In 1922, nurses were recognized as professionals (as they were in Germany too). The following year, national standards for nursing schools were set by the CSAP. Accordingly, the nursing population more than doubled during the inter-war years. Significantly, the old concerns to eliminate the *religieuses* from all French hospitals faded as reformers realized that they would have to enlist all possible labour power in support of the nation's public health crusade.[77] Still, the general trend was to increase the number of lay nurses.

More lay nurses, of course, meant more wages to pay. Social medicine came with a high price. More doctors and more support staff were also required to serve an expanding clientele. Coupled with inflation, costly new surgical and radiology equipment, an increased emphasis on pharmaceuticals, and the higher labour costs brought on by the eight-hour work day law passed in 1919, French hospitals faced alarming increases in their operating budgets during the 1920s and 1930s. The Taylorization of some hospitals was, among other things, a response to this. There were 43,000 public hospital employees in 1912, 51,000 in 1921, and over 100,000 by 1939. Rising personnel expenses were also

[75] For example, 'Demande d'emploi', *RH*, 1922, p. 344.

[76] K. Schultheiss, '"La véritable médecine des femmes": Anna Hamilton and the politics of nursing reform in Bordeaux, 1900–1914', *French Historical Studies*, 19 (1995), pp. 183–214; M. F. Collière and E. Diebolt, *Pour une histoire des soins et des professions soignantes* (Paris, 1988); P. Strauss, 'Bulletin', *RP*, 1921, pp. 99–100. During the war, volunteer nurses were, Margaret Darrow argues, 'targets of as much criticism as praise'. M. H. Darrow, 'French volunteer nursing and the myth of war experience in world war I', *American Historical Review*, 101 (1996), p. 83.

[77] In 1908, there were 13,956 lay nurses and 12,362 *religieuses* in France; by 1939, there were 28,818 nurses and 13,719 *religieuses*. There were, by contrast, 110,039 nurses in Britain in 1921. Berridge, 'Health and medicine', p. 184. See also F. Thébaud, *Quand nos grand-mères donnaient la vie : la maternité en France dans l'entre-deux-guerres* (Lyon, 1986), pp. 39, 47–8; Y. Knibiehler *et al.*, *Cornettes et blouses blanches : les infirmières dans la société française, 1880–1980* (Paris, 1984). During the inter-war years, the Fédération National des Unions Hospitalières de France regularly saluted the thousands of *religieuses* who still worked in French hospitals. Of course, there remained tensions between those who believed that the hospital was no place for the *religieuses*, but the sisters stayed: their cheap labour was still too useful.

brought on by increased professionalization and specialization, and the need to provide better wages in order to attract talented people. From Lille to Lyon to Le Puy, hospitals struggled to shoulder this heavy burden. Medical and surgical expenses in Lyon doubled between 1921 and 1932, and doubled again by 1939, from 33 francs to 69 francs per day for each hospitalized person. In Lille, whereas the daily cost of medical care was 22 francs in 1935, it was 42 in 1939.[78]

As costs rose in both public hospitals and private clinics (which might charge 80 francs per day) and as the site of medical practice increasingly became situated in the hospital, more and more members of the lower middle class were unable to gain access to medical care. Rising costs led to calls for insurance to cover those who could not afford to cope with the new costs associated with technological advances. A heated debate raged within French medical and social policy circles throughout the 1920s–30s over whether or not traditional hospitals and hospices should admit paying patients (*malades payants*).

X

This debate was brought on by the rise in the cost of living after the war. Increases in the cost of medical care were coupled with a decline in the standard of living of the lower middle class. Runaway inflation of over 400%, the ruining of lower-middle-class savings and fixed incomes, the problem of reinserting unemployed demobilized soldiers into the workforce, industrial and agricultural stagnation, labour unrest: the inventory of post-war misery stretched far and wide, spelling hard times for millions of French citizens, including many who had never before known misery. The erosion of lower-middle-class economic power was not, of course, a singularly French problem. The problem was far more acute in Weimar Germany.[79] Jurgen Kocka and many others have chronicled this phenomenon. The broad-reaching social reforms of the early Weimar governments attest to the 'democratization' of poverty and risk, so to speak, in Germany. In the end, misery and hardship, the spread of insecurity, bred solidarity in France too. In the post-war debates over whether or not French hospitals should be opened to the middle class and over the medical insurance bill, many made the argument that the law was being passed for the economic victims of the war.[80]

Hospital care was extended by several municipalities during the mid-1920s, even before the 1928 law, on the grounds that the war had created 'nouvelles pauvres', victims of war-induced inflation. By 1925, twenty-six departments

[78] Ministère du Travail, Statistique Générale de la France, *Statistique des institutions d'assistance. Années 1920–21* (Paris, 1923), p. xxvi; Theil, *Le corps médical*, p. 129; AML, 742/wp/41, prix des journées d'hospitalisation; AML 742/wp/41, HCL to mayor, 13 Apr. 1921; HCL-D, 6 Apr. 1921; *REB*, 1934, p. 354.

[79] Becker and Berstein, *Victoire et frustrations*, p. 150; L. Chaptal, 'L'assistance aux personnes dites "de condition moyenne"', *RP*, 1928, p. 821.

[80] See, for example, AAP C-865, *Rapport…par M. Chauveau*, p. 4; *RP*, 1925, pp. 50–7; *RP*, 1929, p. 259; and CSAP 127, séance of 25 June 1925. This concern was raised by Isidore Monteunis in *RH*, 1923, pp. 380–1, and by Léonie Chaptal in *RP*, 1928, pp. 817–51.

(more than one quarter of the total) were providing financial support to hospitals which provided 'demi-assistance' to members of the *petit bourgeoisie* and the respectable working class who could not afford to pay their bills in full.[81] These new poor included shopkeepers, artisans, skilled workers, small pensioners, or those who could neither afford a medical visit nor a stay in a private clinic. Increased misery, then, bred solidarity on a cross-class basis. As a member of the CSAP declared, 'surgery had made real progress, but who profits from it today except a small portion of the citizenry? One has to be very rich or very poor to benefit from it.'[82]

E. Morin, the director of the Le Havre hospital administration, noted in 1924 that the war had impoverished many of Le Havre's *petit commerçants*, small independent owners who had never sought assistance of any sort in the past. A 'new category of assisted' was emerging, the pensioners on fixed incomes and smallholders who could no longer afford a doctor's visit. The solution adopted in Le Havre was to admit these people, who qualified for no type of state assistance, to the hospital on a reduced fee basis. This helped (partly) to offset the stigma attached to charity medicine. Morin noted that this could not continue forever, since the Hospices were absorbing the cost. He called for a broadening of the 1893 law (providing free medical assistance to indigents) to the lower middle class. Even though some members of the middle class were coming forward to ask for help, he was concerned that there were many 'new poor' who were too ashamed to enter the hospital. They 'hide their suffering to the point that… their situation would not have been known to the administration… if third parties… or concerned neighbours had not informed us'.[83] Similar evidence can be found in Dunkirk, where the Union Hospitalière du Nord-Est had created small *maisons de retraites* (retirement homes) for the new poor and provided them with access to medical services. AP in Paris, too, attempted to help these 'new poor' before the state stepped in. Here we can see the grassroots support for the extension of medical assistance.[84] Lyon, Bordeaux, Nancy, and many other cities responded to this type of problem by giving municipal pensions to the elderly 'new poor' and by opening up special wings for them in their hospitals. Importantly, (partially) free services were being accorded to people who, in the entire history of French hospitals, had never sought medical assistance outside the home.

Nancy, Bordeaux, and Lyon were, of course, richer than most other French cities, and there were scores of cities which identified this problem but could not cope with it. Ultimately, the solution was to ask for the central state to step in and to pressure parliament to pass the medical insurance bill. As M. Laborie of the Hospices Civils de Toulouse declared in a 1926 radio address in Toulouse on 'The social role of the hospital': 'The profound economic changes have gravely afflicted the middle classes; and a large number of artisans, clerks, *petits commercants*, and above all intellectuals with unstable resources find themselves

[81] CSAP 127, séance of 25 June 1925, p. 50.
[82] Ibid., p. 52.
[83] E. Morin, 'Essai d'assistance partielle aux Hospices du Havre', *RP*, 1924, pp. 57–9.
[84] *Administration générale de l'Assistance Publique, 1920–1937*, pp. 172–3.

forced to seeking relief from public institutions when sickness or old age [impoverishes them].' Dr Charles Gosselin echoed this theme in *Le concours médical*:

> An illness is more and more a costly affair. And more and more people want to protect themselves from this risk. A greater concern for health and well-being has penetrated the general population. This is a trend which has been evident for a long time, but the upheaval of war has accelerated it. We can no longer claim that medicine is only for the poor.

And as the general council of the Bouches-du-Rhône declared in a resolution presented to the Conseil Supérieur de l'Assistance Publique in 1926: 'May the *petits rentiers* and the *petits retraités* benefit from certain provisions of the social assistance laws [the free medical assistance law dating from 1893], notably hospitalization.'[85] By the mid-1920s, a concerted chorus of advocates of medical insurance had emerged.

As we have seen, the war experience began to change attitudes toward the public hospital, and the working class began to make greater use of it. Private clinics and hospitals sprung up during the 1920s to cater to the wealthy and the upper middle class. But for those squeezed between the labouring class and the upper middle class, there was often no alternative to the hospital. Private clinics and municipal *maisons de santé* did not exist outside of large cities, and in the provinces only the larger hospitals could afford new medical equipment like X-ray machines. The small-town provincial petty bourgeoisie, then, had nowhere to go but the Hôtel-Dieu or hospice, but as non-indigents they were not always welcome.[86] Nor could they afford to travel to a large city and pay for a private clinic's services. As medical technology advanced, large portions of French society feared they were being squeezed out of the opportunity to enjoy the fruits of progress. A national debate ensued at all the social policy forums about how to deal with the non-indigent who were now demanding access to hospital care.[87]

By the middle of 1921, the forces of conservatism had won the day. In a time of limited resources, they argued, the public hospital should continue to cater almost exclusively to the indigent. The CSAP had declared in a *règlement-modèle* of June 1921 that the hospital should continue to concentrate on the indigent population, but several cities disregarded this. The reformers did not give up, and in 1925 the CSAP heard an important report by M. Verdet-Kleber, the vice-president of the Hospices Civils d'Avignon, on 'assistance aux classes moyennes'. Momentum was again building in favour of spreading hospital care to wider segments of society. From 1926, public hospitals were permitted to provide surgery and other care to 'demi-payant' pensioners, or those whose

[85] M. Laborie, 'Le rôle social des hôpitaux', *RH*, 1926, p. 6; Dr Ch. Gosselin, 'Médecine sociale', *CM*, 22 Aug. 1926, pp. 2184–7; CSAP 129 (1926), Annexe 1, Conseil Général des Bouches-du-Rhône, voeu, p. 57.

[86] *RP*, 1920, pp. 270–81; Fréjacques, 'L'évolution hospitalière', p. 138.

[87] CSAP 116 (1920), 'Règlement-modèle des hôpitaux et hospices'; *RP*, 1920, pp. 270–81; *REB*, 1921, pp. 58–61; *RH*, 1922, pp. 338–9, 58–61; *RH*, 1924, pp. 46–50.

resources were too great to be aided under the terms of the 1905 law (assisting the elderly indigent) yet who were also unable to afford medical care. By the mid-1920s, then, a certain momentum had built up in favour of the idea of 'relieving the misery of the middle class'.[88] This lies at the heart of the origins of the ambitious 1928 law and can explain its success.

XI

Many opposed the extension of hospital care to the middle class on the ground that the hospital should remain the 'maison des pauvres', a charity devoted to soothing the misfortune of the poor.[89] Some critics argued that mandatory payroll deductions would 'violate individual property'; others argued that the bill would spell financial ruin for France, still others repeated the timeworn argument that laws targeting particular groups were 'class-based law[s] which only affect that part of the population which [they] seeks to protect'. There was also the inevitable association of mandatory social legislation with Prussian authoritarianism. Many doctors, in particular, believed that the traditional charitable nature of medicine would be destroyed by health insurance, and of course they were correct in this belief.[90] Still others, like the editors of *Le concours médical* and the author/doctor Georges Duhamel, opposed the law since it seemed to herald modern commercial, even American-style hospitals. The law also seemed to threaten the French doctor's traditional independent status. As Duhamel stated: 'L'acte médical est par essence un *acte singulier*, c'est-à-dire acte d'homme à homme.'[91] Some Catholics opposed the bill on the grounds that the state was seeking to usurp a traditional charitable service, but compared to their efforts in fighting against 'legal charity' prior to the war, their opposition was faint. This is surprising, since so much was at stake. By democratizing hospital care and medical assistance, the French were chipping away at a class-based society, in that they were eliminating one of the most visible symbols of inequality between the classes: the 'maison des pauvres'. More importantly, the 1928 law threatened, like nothing had before, the very idea of private charity, and, by extension, the church's social role.

[88] CSAP 126 (1925), Annexe v, 'Rapport sur l'assistance aux classes moyennes', p. 139.

[89] Although opposition to the law came from all sides of the political spectrum, most of it came from the liberal political economy journals and newspapers (*Le temps*, *Revue d'économie politique*) and from Catholic conservatives (*La réforme sociale*, *Revue catholique des institutions et du droit*). The *Journal des économistes* was joined by *La réforme sociale*, the *Revue politique et parlementaire*, several other conservative and liberal political journals, and medical journals like *Le concours médical*, in opposing the medical insurance bill on a weekly and monthly basis. *Le temps* ran articles almost on a daily basis opposing it; the *Société d'économie charitable* held conferences and meetings to oppose it.

[90] On *Le temps*'s opposition, see S. D. Carls, *Louis Loucheur and the shaping of modern France, 1916–1931* (Baton Rouge, 1993), pp. 282–9. R. Hubert, 'La loi des assurance sociales et ses diverses répercussions', *JE*, Oct. 1928, p. 133; T. Rothe, 'Les assurances sociales', *RS*, Dec. 1923, p. 838. See E. Villey's articles in the *REP*, 1921, pp. 496–503, 1923, pp. 375–83, 1924, pp. 556–74; Dr J. Vanverts, 'Le projet de loi sur les assurance sociales et l'exercise de la médecine', *RPP*, 129 (1926), pp. 250–9; Dr T. Gallet, *L'assistance publique à l'hôpital: ce qu'elle est. Ce qu'elle devrait être* (Paris, 1934).

[91] G. Duhamel, *Les excès de l'étatisme et les résponsabilités de la médecine* (Paris, 1935), p. 6.

XII

But it had become clear to more and more people that the church and private charity could no longer pretend to be sufficient to the task. Charitable care could not compete with the x-ray machine. It was precisely because health care expenses were increasing that health insurance was introduced, as a way to pool resources and spread costs, a way to democratize access to expensive new medical care. The same phenomenon occurred in the United States and Britain during the 1930s, but there it was through the spread of private health insurance, which helped the American and British middle class cope with rising medical costs. A private route was not feasible in France, given its extraordinarily underdeveloped private insurance industry.[92]

The social insurance bill passed in April 1928 and was put into effect in 1930. It immediately extended hospital insurance to one third of the French population, or roughly 13 million people. Originally, all those with salaries under 15,000 francs were required to pay into the programme, but in 1930 this was raised to 18,000 francs in the major urban centres (the 15,000 francs limit remained outside the big cities). In 1935, more and more people were brought into the fold as the barrier was pushed up to include all those earning less than 25,000 francs in urban and industrial centres (the lower threshold, for the rest of France, was raised to 21,000 francs). In 1938, the threshold was again raised to 30,000 francs (for all) and to 42,000 francs in 1942, at which point much of the middle class was covered too. By the beginning of the Second World War, over 20 million Frenchmen and women had medical insurance – over 50% of the entire population. Where medical insurance is concerned, France was now on a par with Britain, if not ahead, given that workers' dependants were also covered by the bill – a glaring omission in the 1911 National Insurance Act. The 1928 law shows that the Third Republic was capable of fundamentally important domestic reforms.

Although the new programme was a far cry from universal health insurance, it must be emphasized that only about 6% of the population (2.2 million people) had ever qualified for state-funded health care (the 1893 law, the 1905 law in aid of the elderly indigent, and the *femmes en couches* – pregnant women – programme) before 1914.[93] Coverage began after the sixth day of illness, and lasted for up to six months. It covered 80% of medical costs, 85% of pharmaceutical costs, and 50% of lost wages. Many hospitals picked up the rest of the costs for those patients who could not cover the remainder. After six months, the insured were entitled to invalidity pay of up to 40% of wages. It also provided death benefits consisting of a lump payment of 20% of the deceased's annual earnings, and a pension from age sixty, for up to thirty years, of 40% of earnings. In the event of unemployment, the monthly dues would be

[92] See R. Stevens, *In sickness and in wealth: American hospitals in the twentieth century* (New York, 1989); P. Starr, *The social transformation of American medicine* (New York, 1982); S. Cherry, *Medical services and the hospitals in Britain, 1860–1939* (Cambridge, 1996), p. 57. As late as 1943, no more than 100,000 people had private medical insurance, Theil, *Le corps médical*, p. 102.

[93] Gauguery, 'Les assurances sociales', p. 381.

covered for up to three months and the unemployed were covered with medical insurance for six months after the loss of their job (there was no unemployment insurance per se). Finally, it provided maternity benefits and reimbursed 80% of hospital costs associated with childbirth and 85% of medicine costs.[94]

Here was without doubt the most important piece of social legislation in the history of France to that date.[95] The 1928 law represented a key intellectual breakthrough, since it extended assistance to the non-indigent. Assistance was transformed into 'assurance' – or, into what Georges Rondel called 'bourgeois assistance'. Prior to this time, this would have seemed an oxymoron, since the very essence of bourgeois existence had always been 'independence', the ability to provide for oneself, free from charity, aristocratic patronage, outside help of any kind.[96] More than any social programme to date, this new service signalled the end of traditional charitable practice.

What else lies behind this landmark law? Increasingly, social scientists are drawing our attention to the instrumental motives of the supporters of social insurance. Europe – including Scandinavia – moved towards solidaristic social programmes because the middle class, and even farmers, felt the need to protect itself from risk, and feared that it would be left out of programmes which might benefit only the urban poor.[97] The 1928 law underscores the essentially middle-class nature of modern social policies: as the inspector general of public assistance asked the readers of the *Revue hospitalière de France* in 1937, shortly before the government expanded the scope of the 1928 law to include even more people, 'Will the middle class alone remain excluded from the hospital?'[98] Solidarity was born of economic insecurity, and workers and the Confédération Général du Travail were among the chief advocates of medical insurance throughout the 1920s. Health insurance seemed like the logical way to pool risk.[99] Like similar British social insurance programmes, the law passed because its sponsors emphasized that it was a programme of 'insurance', not 'assistance'.

The new law had important ramifications for the relationship between doctors, patients, and hospitals.[100] Health insurance, by transforming hospital care from a gift, for which one owed deference and gratitude to doctors and

[94] The law is printed in the *Journal officiel*, 12 Apr. 1928, and was reproduced in several periodicals.

[95] Susan Pedersen points to this law as well as the 1932 law which forced companies to affiliate with a family allowance Caisse as being the two most important pieces of inter-war social legislation, but stops short of concluding which of the two laws was the most significant, *Family, dependence*, p. 372. As of 1938, only 6·5 million workers and 3·9 children were covered by the 1932 law.

[96] G. Rondel, 'L'assistance bourgeoise', *RP*, 1926, pp. 152–4.

[97] P. Baldwin, *The politics of social solidarity: class bases of the European welfare state, 1875–1975* (Cambridge, 1990), p. 293.

[98] M. Sarraz-Bournet, 'L'établissement d'un plan d'organisation hospitalière', *RHF*, 1937, p. 145.

[99] A. Rey, Confédération général du travail, *Les assurances sociales* (Paris, 1924); Société Internationale pour l'Etude des Questions d'Assistance, *Rapport présenté par M. le Dr. P. Boudin sur l'admission des malades payants dans les hôpitaux*, 29 May 1920, in *RP*, 1920, p. 281.

[100] AML 742/wp/43, Caisse d'Assurance Sociale (Rhône) to Hospices Civils de Lyon, 8 Feb. 1935.

hospital notables, into a sort of commodity, owed to the 'insured' as a result of monthly pay deductions, forever changed the medical triangle. Doctors, patients, and institutions were now on an entirely new footing. Patients could now choose their doctor – they had been unable to do so as indigents. And there is some evidence that the regional insurance funds created by the new law were now dictating policy to hospitals. For example, in 1935, the Rhône's Caisses d'Assurance Sociales issued an important report to the Hospices Civils de Lyon, calling for the HCL radically to alter its way of dealing with patients. Ward rooms were too large, the Caisses argued, and patients needed more of the amenities of smaller private clinics: 'public hospitals must adapt to new conditions' and needs, 'lest they … are supplanted by more ingenious private institutions, more conscious of the well-being of their patients (or, more accurately, of their clients)'. The hospitals were warned by the Caisses: 'The [old] framework has cracked; between the "indigent" and the well-to-do patient sits a large part of the population.' Patients, then, had been transformed into 'clients'.[101] No sooner had the 1928 law been passed, cities modified construction programmes under way to make room for special wards for the *assurés sociaux*, who would be spared the indignity of being housed in wards. Social insurance, as a contributory scheme, seemed to hospital administrators, like M. Fréjacques of the Hospice Civils de Dijon, to herald a new approach to the nature of the hospital. Since the *assurés* had paid into a programme, they ought to have some sort of right – such as the right to a smaller, more private room. Regional Caisses put pressure on hospitals to do just this, yet they also put pressures on hospitals to reduce costs, so that their reimbursements would be lower.[102]

The *maisons des pauvres* were being transformed into bureaucratic organizations responsible to Parisian bureaucrats and regional insurance funds.[103] The inter-war period is notable for the bureaucratization of health care provision and assistance regulations, a process accelerated by the war. Bureaucracy and regulations were, and are, fundamentally a response to rising costs, growing complexity of activity, and a growing number of obligations to fulfil. The Hôtel-Dieu of Lyon treated 12,767 people in 1914 but 25,535 in 1930.[104] As more and more people entered the hospitals and for shorter stays (15·6 days on average in 1930 as opposed to 21 days in 1914, due to the shift toward medical care as opposed to the provision of shelter to the destitute), stricter rules and guidelines were needed to manage this human traffic. Notables could no longer

[101] AML 742/wp/43, 'Les assurances sociales et les hôpitaux publics', p. 1.

[102] Fréjacques, 'L'évolution hospitalière', pp. 138–9. For a discussion of this practice, see CSAP 134 (1930), 'Application de la loi du 5 avril 1928, relative aux assurances sociales', Rapport, pp. 94–105. For example, 'L'application des assurances sociales dans les hôpitaux', in AAP AP-CMA, *Exercise 1936* (Montévrain, 1938), pp. 79–83. Conflicts between hospitals and the regional Caisses were legion: P. Garnal, 'L'hospitalisation des assurés sociaux et le devoir social des hôpitaux', *RH*, Mar. 1931, pp. 146–51.

[103] The hospices are another matter: until the 1970s, if not beyond, they remained dumping grounds for the country's social outcasts, the uninsured, and the marginalized.

[104] E. Brizon, *Les Hospices Civils de Lyon et leur activité actuelle, 1918–1930* (Lyon, 1932).

pull strings to have 'their' local poor, their 'protected' admitted to the hospitals; regional insurance funds, the municipal council, and Parisian ministries now dictated policy. In several ways, then, the changes taking place in the funding, administration, and the use of the hospitals during the inter-war years were fundamental. The hospital was being transformed into a health factory. Arguments in favour of preserving the *maison des pauvres* against the onslaught of modern social medicine were no match for those who argued that the fruits of modern technology had to be extended as far as possible, to be democratized. Perhaps this can explain the relatively muted opposition, compared with the carefully orchestrated campaigns against the 1893 and 1905 social legislation.[105]

XIII

How did the people who entered hospitals feel about them? The evidence is patchy, but if admissions statistics are a gauge of people's attitudes toward hospitals then they were becoming more popular. Lyon's hospitalized population doubled between 1918 and 1930. In a report to the First National Conference of Hospitals in 1937, two doctors from Niort revealed that in the thirty-three urban hospitals which they studied, the number of those admitted under the terms of the 1928 medical insurance law increased from 36,494 in 1932 to 45,157 in 1936.[106] There is some other evidence which suggests that as the hospitals lost their stigma and became available to wider portions of the population, more and more people began to use them on their own terms. In 1935, a mayor's aide in Lyon reported that 'in 1920, emergency hospitalizations were the exception… Today they have become the rule.'[107] Whereas during the nineteenth century the hospital had been used primarily by sick and tired workers to recuperate from an unemployment-induced illness, or by other workers deprived of neighbourhood support networks, by the 1930s, the hospital was increasingly being used by the middle class for emergency medical conditions.[108] Hard times during the 1920s and 1930s deprived people of resources which, in better times, would have allowed them to pay for their own medical services. By extending economic insecurity and risk to a wider spectrum of the population, post-war economic problems forced people who in the 1910s would never have imagined resorting to a public institution to begin to take advantage of them. For more and more people, it was no longer a badge of shame to enter the hospital.

The inter-war years, then, saw the realization of Edouard Herriot's pre-war vision of medical assistance for all classes.[109] As the prefect of the Rhône noted in his 1930 report on the department's medical assistance programme, 'the constant increase in the number of people receiving hospital care is due to the oft-noted need to ensure that the sick benefit from new scientific procedures and therapies made possible by recent discoveries'. These advances in

[105] Smith, 'The ideology of charity'.
[106] *RHF*, Oct. 1937, p. 562.
[107] AML 742/wp/43, Assurances Sociales, Mairie de Lyon, 'Rapport, 30 Nov. 1935'.
[108] Cited in AML 742/wp/43, 'Rapport, 30 Nov. 1935'.
[109] CGR, 1930, v. 2, p. 445.

medicine, he continued, have 'been made available to those who suffer' regardless of class or status.[110] How could the hospitals deny cancer treatment or surgical interventions to people on the basis that they were not poor enough? In the end, it was technology which attracted the middle class to the hospital.

XIV

Although the process was by no means complete prior to the outbreak of the Second World War, French health care administrators had made great advances in broadening access to hospitals during the inter-war years. While this article has only briefly discussed the issue of public demand for hospital care, this was no doubt an important variable in the equation, and one which calls for more research. From the late 1920s until the beginning of the war, there occurred a steady rise in the proportion of paying patients (including those covered by state programmes), from 14·5% of the total hospitalized population in 1900 to 25·4% in 1920 to 76·0% in 1936.[111] By 1936, then, only 24% of the hospitalized were the beneficiaries of charity. Only thirty years earlier, in most hospitals 85–95% of patients had been the recipients of charitable care.

The 'maison des pauvres' stood on a very shaky foundation by 1940, one which crumbled soon after German tanks rolled onto French soil. The next year, the Vichy government paved the way for post-war reforms, decreeing that all public hospitals be opened up to all French citizens, including private paying patients, regardless of income. The law of 21 December 1941, which has been called 'a decisive turning point' in the history of French hospitals, also reformed hospital commissions, bringing them under the firm grip of prefects and the Secrétaire d'Etat à la Santé.[112] In 1942–3, the 1941 law was put into practice and plans were made to centralize all hospital resources and to set up regional hospital centres – here was another post-war project adumbrated under Vichy. The law of 17 May 1943 further medicalized the hospitals and increased doctors' managerial roles within them, continuing inter-war trends. Most Vichy hospital legislation remained in place after the Liberation, and politicians were not ashamed to admit that Vichy had provided the French with their 'hospital charter'.[113] The legacy of Vichy's hospital reforms was confirmed by the 15 June 1945 *ordonnance*, which retained the essentials of the 1941 law and the 1943 reforms which transferred more control of hospital boards to doctors and prefects, reducing the power of local hospital notables lacking formal training.

When during the 1940s and 1950s the French gained wider access to hospital

[110] Ibid.

[111] *RHF*, Oct. 1937, pp. 582–3.

[112] P. Comet, *L'hôpital public* (Paris, 1965), p. 14; Theil, *Le corps médical*, pp. 121–31; *RHF*, Apr. 1943, pp. 132–5; *RHF*, June 1943, pp. 246–51; J. Deprun, 'Comment est née la nouvelle "charte hospitalière"', *REB*, Nov. 1943, pp. 245–8; H. Thoillier, *L'hôpital francais* (Paris, 1943); Imbert, *Les hôpitaux en France*, and 'La réforme hospitalière', *Droit social* (1958), pp. 496–505.

[113] AAP C-1085, *Les hôpitaux en France*, pp. 23–4; P. Durand, *La politique contemporaine de sécurité sociale* (Paris, 1953), p. 457.

care as a right of citizenship, the road had already been surveyed and accepted by many as the logical route to follow. All that remained to be done was to complete it. To be sure, after one of the darkest chapters in French history came to an end, the implementation of a near-comprehensive national medical insurance system was one of the ways in which the French could relegitimize their social and political order. But the success of the reformers of 1945–6 is inconceivable without the important advances made during the inter-war and Vichy years.