
Original Article

Class, territory, and inequality: Explaining differences in the framing of health inequalities as a policy problem in Belgium and France

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Abstract Inequalities in health status between social groups have been on the agenda as a problem for policymakers in France and Belgium in recent years. But the constitutive arguments that French and Belgian policy elites use to frame the problem of health inequalities in public discourse – arguments about what health inequalities are, where they come from, and how they might be corrected – differ in ways that run counter to expectations based on the geography and sociology of health inequalities in the two countries. Belgian national policy documents steer clear of discussing the very large regional inequalities in health, focusing instead on differences between groups defined by socio-economic status. Meanwhile, French documents emphasize territorial inequalities over those linked to social class. Systematic content analysis of policy documents and interviews with over 50 health policy experts and actors in Belgium and France shed light on this puzzle. In both countries, political elites employ policy discourses about health inequalities that paper over the most salient and contentious political cleavages of the day. In doing so, they are constrained by historically rooted definitions of (in)equity, as well as nationally specific institutions of financing and redistribution.

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Introduction

Despite nearly universal access to affordable health care services in the rich democracies of Europe, there are systematic differences in the health status, morbidity and mortality of different groups within these nations. The World Health Organization (WHO) and the European Union (EU) have adopted the goal of equity between groups defined by their socioeconomic status (SES) as a major

objective for health policy. Many countries in the European Region of the WHO have enacted national plans to attempt to reduce the gap in health and well-being between better- and worse-off groups.

However, despite the dominant international framing of health inequalities that focuses on socioeconomic inequalities in health outcomes as the major policy problem, the framing of health inequalities at a domestic level – which social groups are highlighted as relevant for comparison, and the causal stories and moral judgments that those choices entail – varies across countries, and in ways that are not fully predicted by available epidemiologic data. This article analyzes which health inequalities have been singled out for attention in French and Belgian policy discourses since the 1980s, and why. I argue that in both countries, political elites attempt to shape policy discourses about health inequalities in ways that are bounded by historically rooted and nationally specific understandings of fairness and equity, but that also serve to articulate over the most salient and contentious political cleavages of the day.

In both France and Belgium there are significant health inequalities related to both SES and where people live. Health follows a distinct North–South gradient in Belgium, with the Flemish population on average enjoying significantly better health outcomes and lower mortality than in Brussels or Wallonia. In France, systematic differences in health status between regions of the country are harder to detect, although at smaller levels of spatial aggregation (for example, the neighborhood) there are distinct area effects. Meanwhile, higher-SES individuals enjoy better health than lower-SES individuals in both Belgium and France, but on most measures the gaps are somewhat larger in France than in Belgium. In sum, in Belgium it is territorial, and in France class, differences in health that are largest – and yet policy discourses about health inequality in Belgium and France do not reflect this scientific construction of reality. Belgian national policy documents steer well clear of any discussion of regional inequalities in health, focusing instead on SES differences. Meanwhile, French policy discourse is oriented equally toward the problem of territorial and SES inequalities, with the former often used as a metaphor for discussing the latter.

This article, then is organized around a puzzle: Why is it that the constitutive arguments that French and Belgian policy elites use to frame the issue of health inequalities in public discourse – arguments about what health inequalities are, where they come from, and how they might be corrected – are so different, and so counter to what one would expect based on the geography and sociology of health inequalities in the two countries? Studying variation in how national policy elites adopt and adapt the consensus framing of health inequalities propagated by the WHO serves to denaturalize health inequalities as a policy problem, and allows us to instead focus on the configurations of institutions, ideas and interests that shape contemporary definitions of inequality. Studying framing allows us, in the words of Vliegienthart and van Zoonen (2011), to ‘tie [...] problem definitions to an analysis of power’



(p. 108). Noticing that health inequalities are not just ‘out there’ to be measured, but rather actively constructed as concepts, encourages a deeper engagement with dimensions and causes of inequalities that might otherwise be missed. When we analyze a frame and its constituent parts in an attempt to understand why it has resonance, or when we observe policy actors wittingly or unwittingly framing the issue in ways that highlight or obscure certain facets of the problem, and empower or disempower different actors in the polity, we can more clearly see how certain aspects of inequality become salient and likely to serve as focal points around which policymakers may rally. Tracing how frames emerge can thus reveal which actors in a policy field possess sufficient material and symbolic resources to impose their framing of an issue, and show how social institutions channel those resources.

The first part of this article describes the dominant policy frame surrounding health inequalities within the international health policy field in Europe (that is, in the international research community and in international bodies like the WHO’s European regional office in Copenhagen and the European Union) as well as an alternative, territorial framing. In the second part of the article, qualitative content and discourse analysis of national policy documents demonstrates that while both frames – the SES frame that closely mirrors the dominant international frame; and the *territorial* frame – are present in both Belgium and France, their relative weight is markedly different in the two countries.

Finally, the third part of the article is devoted to explaining the varying presence of these different frames in France and Belgium. I argue first that there is a mismatch between the epidemiological facts on the ground and the dominant frames used to discuss health inequalities in France and Belgium. The remainder of the section draws on archival sources, secondary literature and on interviews with over 50 health policy experts and policymakers conducted between 2011 and 2014 in France and Belgium. My core claim is that variation in the domestic framing of health inequalities as a policy problem in Belgium and France, including the alacrity with which the dominant WHO frame has been adopted, is related to the structure and financing of the health care system and the degree of contestation over fiscal transfer mechanisms.

Dominant and Non-Dominant Framings of Health Inequality: SES and Territory

As a matter of epidemiology, the definition of health inequalities is simple: health inequalities are any differences between the aggregate health (measured as current health status, morbidity or mortality) of different population groups. Researchers and policymakers interested in a particular outcome (generally speaking, more equality) have sometimes used the term health *inequity* to pinpoint those inequalities that are problematic or unjust (for example, Whitehead, 1991).¹ However, health policy elites

at the international level in Europe often use the formally non-normative term ‘health inequalities’ as a synonym for the explicitly normative ‘health inequities’. The EU, for example, simply states that ‘Health inequalities are preventable and unjust differences in health status or in the distribution of health determinants between different population groups’ (www.health-inequalities.eu/HEALTH-EQUITY/EN/about_hi/glossary/). Following this usage, in this article the term health inequality denotes a policy ‘problem’ (Bardach, 1996) that has been identified as such at least partly because it is seen as inequitable.

In theory, any difference in health status, morbidity or mortality between any population group that is avoidable, preventable, or unjust could qualify as a health inequality. In practice, however, the dominant problem framing in international health policy circles since the 1990s has focused on a small number of social groupings when defining health inequality as a problem worthy of policy attention. The Whitehead definition and those that followed from it are ‘generally assumed to refer to socioeconomic differences in health’ (Braveman, 2014) – inequalities in health between groups defined by their income, wealth, occupation, or educational attainment. This definition of health inequalities as linked causally to socioeconomic inequality is often implicit. For example, the term ‘social inequalities’ (in both French and Belgian policy discourses, *inegalités sociales de [or en] santé*, abbreviated *ISS*) refers to inequalities in health that are linked to income, occupation, or education.

Framing health inequalities as a public problem worthy of policy attention requires constructing ‘causal stories’ that explain the mechanisms by which bad outcomes occur and who is to blame for them (Stone, 1989, p. 282). The dominant causal story linked to SES frames is embodied in the concept of the ‘social determinants of health’ (SDOH),² which came into widespread use among social epidemiologists in the late 1990s and entered international policy discourse definitively in 2005 when the WHO convened a Commission on the SDOH, led by Sir Michael Marmot. The SDOH concept has been used differently by different actors, and even within the WHO its precise meaning has varied. However, variants on the SDOH story share an emphasis on socioeconomic inequalities in society as the most important source of inequalities in health.

While SES frames – which implicitly or explicitly define health inequalities as problematic because they are caused by socioeconomic inequalities – dominate international policy discourses, differences in health between social groups defined by their ethnicity or race; language; immigration status; gender; sexual orientation; disability status; age; neighborhood, region, or nation-state of residence; could all be considered as preventable and unjust (and certainly as ‘social’), depending on the circumstances. In fact, both international and domestic policies aimed at reducing health equity have targeted some such non-SES-related inequalities, particularly those related to gender and race/ethnicity, despite the dominant SES frame of the discourses out of which these policies arise.



Inequalities in health that are linked to where people live – from the neighborhood level up through the ‘global North/South’ – have also sometimes been addressed by international policy documents addressing health inequalities. In many of these instances, and frequently in national policy documents as well, place stands as a proxy for SES: either the SES of the individuals who reside there, or socioeconomic characteristics of the geographic context (for example, a high unemployment rate or a weak economy). I label these frames *territory-as-SES frames*, for they do not attempt to explain why people of low SES might gather in certain locales, or why some locales are more socioeconomically ‘deprived’ contexts (with worse consequences for health).

An alternate territorial framing of health inequalities defines geographic differences in health status within a polity as health inequalities that are important in their own right, above and beyond the correlation between territory and SES at the individual and/or aggregate level. This type of territorial framing of health inequalities has not been as prominent in the international research literature nor in the policy statements of international organizations as has the SES framing, but it has emerged from time to time – most recently with the work of the Oslo-Lancet commission on global health inequalities, which attributes global North–South health inequalities to political and economic processes embedded in international governance structures and markets (Ottersen *et al*, 2014). Yet such a *political territorial* framing of health inequalities could in many cases be amply justified – for example, by narratives emphasizing the inequitable allocation of common-pool resources, political privileging of some areas of the country over others for reasons of language or ethnicity, or ‘internal colonialism’ *à la* Hechter (1975). What sets these territorial frames apart from a territory-as-SES frame is the assertion of the former that health inequalities are a product of aspects of territoriality that go beyond the aggregate or contextual effects of SES.

Health Inequalities Frames in Belgium and France

Measurement and methods

In this article, I operationalize frames as discourses that employ certain key words, phrases and analytic tropes. Policy frames involve a definition of the social problem, a causal story about where that problem comes from, and a policy prescription – each of which may invoke a moral evaluation that determines who is responsible for causing and/or treating the problem (Stone, 1989; Entman, 1993; Verloo, 2005). These elements of a frame can be detected in texts like research publications, official reports, pamphlets, policy documents, minutes of meetings, parliamentary debates, or interview transcripts – in other words, any texts that contain the observations of the policy elites (academic researchers, policy advocates, bureaucrats and elected officials) who constitute the health policy field.

I use qualitative content analysis of a sample of two types of Belgian and French government publications to measure the presence of different health inequalities frames in policy discourses: central government reports and reports commissioned by the central government that are mainly concerned with the issue of health inequalities; and sections of government and government-sponsored serial reports on the state of the nation's health that specifically concern health inequalities.³ Government documents are a standard source of information about how health policy elites understand health inequalities at a definitional level and hence what policies are likely to be adopted in order to combat them (see especially Graham, 2004; Vallgård, 2007; Docteur and Berenson, 2014). The reports that national governments commission and produce are statements of belief about what health inequalities are, and why they are public problems. Freeman (2006) articulates clearly the rationale for choosing to analyze these documents: 'Government is a text-based medium, no less in public health than in other areas of public policy, and a feature of the politics of health equity across countries is that it turns on the production of a key text' (Freeman, 2006, p. 52). The process of producing government reports on health inequalities helps to build constituencies for particular ideas and policies within the policy elite, as contributors negotiate over common language; the documents themselves become 'a source of authority, a means by which influence is established and exerted, such that the production of the document may be thought of as a process of underwriting as much as writing' (Freeman, 2006, p. 54; see also Raphael, 2011).

No one type of text offers a complete view on how all actors in a policy field conceptualize the object of their work. Nevertheless, some documents are better choices than others for particular tasks. For this article I chose to analyze reports on health inequalities and sections of reports on the health status of the population because they alone offer sufficient detail over an extended time period to identify the constitutive claims that national policy-making elites make about health inequalities: what qualifies as a 'health inequality', and why?

Table 1 lists the documents coded systematically for this analysis. Semi-regular reports on the nation's health incorporating sections on health inequalities have been produced from 1995 onward in France, and from 1997 in Belgium. All numbers of these series were available on the Internet and were coded by the author. Identifying the universe of relevant one-off reports on health inequalities involved four stages: First, the epidemiological literature and the secondary literature on public health and health policy in the two countries were surveyed to construct a timeline including all mentioned government or government-sponsored publications. Second, health policy specialists were asked what reports they deemed to have been particularly important or influential. Third, Google searches for documents with the words '*santé*' and '*inégalité(s)*' or '*disparité(s)*' in the titles were conducted for those two countries in order to identify any further documents that might have been omitted based on my literature search. Finally, manual searches of the Websites of the national health ministries of Belgium and France, as well as all subsidiary organs linked on these

**Table 1:** National-level policy documents included in the qualitative analysis

| | Belgium | France |
|---|--|--|
| <i>Serial reports on health of the nation</i> | Institut Scientifique de Santé Publique Reports on the <i>Enquete de santé par interview</i> 1997, 2001, 2004, 2008, 2013 | DREES (Ministry of Social Affairs) <i>Etat de santé de la population en France</i> 2006, 2007, 2008, 2009–2010, 2011, 2015 Haute Conseil de la Santé Publique <i>La santé en France</i> 1994, 1996, 1994–1998, 2002 |
| <i>Reports on health inequalities</i> | Fondation Roi Baudouin. <i>Raccomandations politiques – inegalites en santé</i> 2007 Van Oyen <i>et al</i> <i>Les inegalites sociales de santé en Belgique.</i> 2010 Fondation Roi Baudouin. <i>Tackling Health Inequalities in Belgium. L'inégalité sociale en matière de santé reste tenace en Belgique</i> 2010 | Ministry of social affairs <i>Les inégalités devant la santé: rapport de mission</i> 1985 Haute Conseil de la Santé Publique <i>Allocation régionale des ressources et réduction des inégalités de santé</i> 1998 Haute Conseil de la Santé Publique <i>Les inégalités sociales de santé: sortir de la fatalite</i> 2009 IGAS (interministerial) <i>Les inégalités sociales de santé: déterminants sociaux et modèles d'action</i> 2011 |

ministries' Websites, were used to identify policy documents related to health inequalities.

These searches yielded a relatively short list of health inequalities reports for Belgium, and a much longer one for France. The final sample of documents to code for this analysis was selected purposively, to include major reports rather than occasional papers or documents contributory to larger reports; seminal reports from the early years of policy attention to health inequalities; the most recent available comprehensive reports; and those reports in between that were major statements on the issue. For Belgium, the final list of documents is the full census of reports produced by government or quasi-government organizations and devoted to the issue inequalities in health status. The sample of French documents is constituted by: the first-ever national government publication devoted to health inequalities, dating from 1985; both reports of the High Commission for Public Health dedicated to health inequalities (from 1998 to 2009); and the most recent (2011) comprehensive report on health inequalities, produced by the powerful Inspectorate General for Social Affairs.

All Belgian documents were available in both French and Dutch. To enable a more direct comparison of language with the documents from France, I coded the French-language versions of the Belgian documents.

To understand the origins of the different frames employed in Belgian and French policy documents, I employed a combination of process tracing methods (Collier, 2011; Bennett and Checkel, 2014) including reviews of secondary literature, archival research and semi-structured in-depth interviews with 52 purposively sampled French and Belgian health policy experts and practitioners from 2011 to 2014 (see Lynch, 2013 for a discussion of the inferential logic behind purposive sampling designs). Respondents were drawn from the full range of academic specialties involved with health inequalities research (epidemiology, demography, economics, public health and social medicine) and from government and non-governmental bodies with an interest in health equity (for example, National ministries of health and social welfare, Sub-national actors and agencies responsible for health policy, political parties, social insurance bodies, labor unions, organized representatives of medical professionals). In accordance with the University of Pennsylvania's Institutional Review Board, the identities of interviewees have been anonymized as far as possible. A list of anonymized sources is included with the references.

The dominant SES frame in Belgian policy documents

Despite a longstanding policy discourse that relates cross-regional difference in health care spending and health care consumption to cultural tastes and preferences, and despite the relatively late emergence of health status inequalities as a political problem in Belgium, Belgian policy documents frame inequalities in health status overwhelmingly as SES inequalities.



At a relatively early stage, scholars and health policy experts had identified regional differences in health care and mortality in Belgium as potentially troubling. Already in 1949 the problem of financial flows between regions resulting from differential use of social insurance benefits, including sickness insurance, had been raised (Trocllet, 1949). Nevertheless, health inequalities – defined as unfair inequalities in health status – emerged as a full-fledged political problem relatively late in Belgium. While the modern research tradition on health status inequalities in Belgium dates to 1982 (Lagasse and Namurois, 1982; see also Deboosere *et al.*, 2009), Belgian scholars and government representatives were not as active in European-level health policy circles during the 1990s as were policy elites from the United Kingdom, the Netherlands, or the Nordic countries.⁴

The first national health interview study was conducted in Belgium starting in 1997. Before that, information on the SES of social insurance subscribers could be inferred from employment status and matched to health care consumption, but the existence of multiple funds managed by the social partners rather than government meant that policymakers owned neither the data nor the policy problem. Once the national health interview survey data became available, however, the national government began publishing regular reports on health status in the country as a whole and in the three regions, and health inequalities began to take on more political import. Reports on the results of the national health interview studies were published for the 1997, 2001, 2004, 2008 and 2013 surveys. The surveys include a variety of health indicators, ranging from self-assessed health status to health-related behaviors to health care utilization. Because the survey is jointly funded by the regions, the sampling design is clustered to allow for inferences to both the regional and national levels. The survey also includes a measure of education – the highest qualification obtained by the reference person in the household or his or her spouse – to allow for systematic comparisons by SES.

Despite the potential for equal emphasis on territorial and socioeconomic inequalities given the structure of the health interview survey, the reports quite clearly frame health inequalities in SES terms. One of the stated purposes of the survey program is to allow for ‘analysis of social (in)equalities in health and in access to health care’ (*analyse des (in)égalités sociales en matière de santé et de l’accessibilité des soins de santé*), where ‘social’ is implicitly defined as socioeconomic. Each report contains a separate section on ‘social inequalities in health’ that summarizes the indicators for which there are significant differences between education groups. There is no such summary section (or stated purpose) for geographic inequalities – and in fact, in the summary reports for each survey there were no instances in which the (many) large differences in health status, health behaviors and health care utilization were labeled as ‘inequalities’, and only one instance in which a territorial difference was described as a ‘disparity’.

The earlier reports contained few graphics, and hence it is not surprising to see an absence of maps or other geographic representations of inequality. By 2008 the

reports began to include more charts and figures, some of which showed differences between regions as well as educational groups for some indicators. The presence or absence of a table or chart illustrating an inequality seems not to be a guide to the size or importance accorded to that inequality in these documents; nevertheless, it is striking to compare the complete absence of maps in these publications with the analogous French population health reports.

There are only three extant reports at the national level on health inequalities in Belgium, none of them issued by the government. The first national-level report devoted specifically to health inequalities in Belgium appeared in 2007, and was produced by the non-partisan King Baudouin Foundation (KBF). The KBF is funded and sponsored by the royal family and run as an independent, not-for-profit organization acting in the national interest. The stated aim of the 2007 report was to convince leaders at all levels of government in Belgium to put the issue of health inequalities on the policy and political agenda. The second report was a 2010 summary of findings from the research program ‘Tackling Health Inequalities in Belgium’ (TAHIB), which was funded by the Belgian Science Policy Office and led by Herman Van Oyen, an epidemiologist and researcher in the national government public health agency who also led the team that developed the national health interview survey. The third document is a report-*cum*-press release issued by the KBF in 2010 in order to translate the results of the 2010 TAHIB report for a policy audience.

In all three of these reports, socioeconomic inequalities are the overwhelming focus. In the first KBF report, there is no mention of the fact that health status differs widely between Belgium’s regions and communities, nor even of the existence of geographic variation in health care utilization. The TAHIB report makes occasional reference to the possibility of differences in health that correspond to geographic locale, but the overall conception of health inequalities remains resolutely non-territorial. For example, Chapter 6 of the report discusses contextual effects on health in theoretical terms, and cites public policies as a cause of these contextual effects: ‘In effect, certain geographic zones could be disfavored [*défavorisées*] in terms of public education, health, or social services, in particular in countries in which financing of investments in human capital is organized at a local level’ (p. 95). But while this precise setup is clearly the case for Belgium, regional differences in Belgium are not once in the report mentioned as a source of health inequalities.

Similarly, Chapter 9, on the health status of informal caregivers, explains contextual effects by way of a parallel example (at the regional level) from the domain of the labor market: ‘For example, if the economy of our region is such that there is a surplus of available labor, we risk being unemployed’ (p. 165). The report’s authors go on to argue that ‘If we are interested in “contextual” influences on health, we need to be able to compare groups of people who are exposed to different types of contexts’ (p. 166). But this discussion sets up a cross-national comparison, with the United Kingdom, rather than a cross-regional one, within Belgium.



In fact, while neighborhood (*quartier*) appears at least as a hypothetical cause of health in the TAHIB report, mainly in the sense of territory-as-SES, the regions and communities are never mentioned in relation to the health status of their populations, and region of residence is not ever an axis of comparison. The report contains numerous figures and tables that demonstrate SES inequalities in health outcomes, but there are no such figures showing regional differences. The 2010 KBF report parallels the TAHIB report in mentioning ‘socially-determined environmental factors’ such as environmental nuisances, or living in a milieu that is economically precarious or has weak social capital (p. 6), but *not* mentioning regional differences in health status or health care within Belgium.

The conceptualization of health inequalities in Belgian policy documents mirrors quite precisely the dominant WHO consensus framing. In addition to presenting mainly SES inequalities in health, the KBF reports devote considerable space to explaining to policymakers concepts that are central to the SDOH approach, including laying out a rationale for linking health behaviors to socioeconomic inequalities rather than to personal choice or moral failure, and presenting the concept of the social gradient in health.

The territorial frame in French policy documents

In notable contrast to Belgium, discussion of health inequalities in France at least since the 1990s has had a strong territorial emphasis, and has only sporadically adopted the SES-centered language of the WHO consensus. This is surprising in light of France’s long tradition of social epidemiology, which one might expect to make SES inequalities more salient for French policy elites (in fact, one of the founding fathers of social epidemiology, Louis-René Villerme, was a Frenchman, who studied differential morbidity and mortality in France in the early 1800s). In the mid-1950s, the French national statistics agency (INSEE) began collecting data on mortality by both socio-professional category (for example, farmers, blue-collar workers, self-employed professionals, managers) and place of residence. These data were published and available to researchers beginning in 1965. Yet, while French reports on health inequalities taken as an aggregate discuss both differences in health status across SES groups and parts of the country as ‘inequalities’, the territorial frame is far more prominent than in Belgium.

Beginning in the 1990s, two serial publications reported regularly on population health in France, and contained sections dedicated to health inequalities. The High Council for Public Health (Haute Conseil de la Santé Publique, or HCSP), charged with contributing to public health planning by advising the government on prevention, health risks and health care system performance, published a series of reports on *La santé en France*, in 1994, 1996, 1998 and 2002.⁵ Throughout the reports there are references to both socioeconomic and territorial inequalities,

the latter often conceptualized in terms of differences in health status between regions.

The first of these reports outlines four main objectives for health policy in the medium term, the last of which is *Réduire les inégalités face à la santé* (p. 209). Both *l'inégalité entre les catégories sociales les plus favorisées et les moins favorisées* and *l'inégalité entre les régions* are to be targeted (p. 209). The remaining reports are similar in their joint emphasis on SES and territorial inequalities. Unlike in Belgium, where the reports on the national health interview surveys contained narrative and tabular breakdowns by region but minimal graphical representation of regional differences in health, all of the *Santé en France* reports feature maps: 2 in 1994, 12 in 1996, 4 in the 1994–1998 report and 11 in 2002.

The new public health law of 2004 in France specified 100 public health objectives, 2 of which included reducing health inequalities, to be achieved by 2008. These objectives necessitated systematic monitoring and data collection, which was undertaken by the *Direction de la recherche, des études, de l'évaluation et des statistiques* (DREES), a research organ attached to the Ministry of health and social affairs, and published in a series of reports on *L'état de santé de la population en France* in 2006, 2007, 2008, 2009–10, 2011, and 2015. As required by the 2004 law, these reports address the issue of SES health inequalities in independent sections and as an issue cutting across other indicators. However, territorial inequalities also figure prominently: the 2007 report notes in the introduction that there are important *disparités géographiques* as well as *disparités sociales* in France (p. 14), and the 2008, 2009–2010 and 2011 reports title the sub-section on inequalities in the summary *Des disparités sociales et territoriales persistent*. The 2015 summary report (published as a separate document) has a section devoted to *nombreuses disparités*, with subsections on both 'social' (SES) and 'territorial' inequalities. While these reports generally reserve the plural noun *inégalités* to refer to SES inequalities, the adjectival and adverbial forms of inequality and inequity appear repeatedly in reference to large-scale (including regional) territorial differences.

As with the HCSP reports, so too are the DREES reports liberally sprinkled with multi-shaded maps showing the diversity of health outcomes, health behaviors and health care utilization across French regions. The 2007 report had 7 (sets of) maps; in 2008 there were 10, in 2009–2010 there were 14, in 2011 there were 9; and the 2015 report contained 50 (sets of) maps. All of these maps showed differences between regions and, in some cases, also differences between provinces within *Île-de-France*, the region in which Paris is located.

One-off French government reports on health inequalities are similarly attentive to the territorial dimension of the problem. The first such report in the modern era seems to have been *Les inégalités devant la santé*, authored in 1985 by Sylvie Le Roux at the request of the newly appointed Communist Health Minister Jaques Ralite. The report details the health consequences of hard, lightly regulated labor in France's countryside, factories, fisheries and office buildings. But despite the pervasive



emphasis on work as a driver of health inequalities (27 of the 31 tables and charts show SES inequalities in health, mainly related to occupation), the report is nevertheless deeply territorialized in its structure: The first chapter, dedicated to inequalities in access to care, is divided into two sections – the first on ‘geographic inequalities’, the second on ‘sociological factors’. The second chapter, on inequalities in health and mortality, is divided into three sections, the first on ‘regional inequalities’, the second on ‘social inequalities’, and the third devoted to health in ‘the rural world [*le monde rural*]’. The report contains five maps detailing health care service provision and mortality by region.

The next major government report to include a discussion of health inequalities in France was *Santé 2010* (also known as the Soubie report, after its lead author), commissioned by the *Commissaire general du plan* in 1991. While it was not itself a report on health inequalities, one of the four working groups, Atelier 2, was dedicated to the subject of *Les inégalités sociales de santé*. The report of Atelier 2 notes that despite a generally equitable health care system, certain gaps (*écarts*) in health persist, first among which is *Des situations territoriales contrastées de mortalité, de densités d’offre de soins et de niveaux de dépenses de santé* (p. 103). The report mentions disparities between socio-professional groups, but the text’s main concern, is with regional variation in health care spending, which is argued to be unjust given regional variation in health status and health care needs.

The HCSP’s 1998 report *Allocation régionale des ressources et réduction des inégalités de santé* was written in response to changes in the health care financing system that were prompted by the Soubie report. As such, the report is really about health care financing and not about inequalities in health *per se*, but it is the first HCSP report that uses the term health inequality in the title. The report begins by noting that there are large differences in both health and health care supply between the regions, with the North of France generally disfavored on both counts. The report concludes that the best way to reduce inequalities in health status between regions would not be through health care spending, but by *une politique régionale* that devotes supplemental resources to disfavored regions (p. 23). Appendix II of the report is dedicated to indicators of health and health care needs. These are conveyed via a series of 11 maps, plus 2 tables showing the best- and worst-off regions. This report shows more clearly than any other the importance of territorial (regional) inequalities in French policy discourse about health inequalities.

The next HCSP report on health inequalities, *Les inégalités sociales de santé: Sortir de la fatalité*, came more than a decade later and is explicitly addressed to ‘social’ (that is, SES) rather than territorial inequalities in health. The report characterizes territorial inequalities as linked to social inequalities in health, arguing that ‘The geographic environment constitutes one of the determinants of health. Social inequalities in the occupation of territory can be clearly identified in France, so it is natural to reflect on [these inequalities] jointly’ (p. 22). It goes on to state that

‘The territorial, local, or regional dimension is extremely important for the question of social health inequalities [...] As we have emphasized, territorial and social inequalities are intricately tied to one another’ (p. 75). The territorial analysis recommended and carried out in part in the report is at a finer-grained level than much previous government analysis in France – at the level of the community or neighborhood rather than whole regions. And unlike earlier reports, this one casts territorial inequalities primarily as containers for SES inequalities (SES inequalities are ‘anchored’ in *les territoires* [p. 76, p. 92]). In other words, the frame is more territory-as-SES than political territorial, as it was in the previous reports.

But if this report shifts the connotation of territorial inequality closer to SES inequality by focusing on the socioeconomic composition and context of geographic designations, it does not entirely abandon the French discursive tradition of treating territorial inequalities as important in their own right. The report culminates with a series of propositions, the first of which is to insert into the new public health law the objective of reducing social inequalities in health. The HCSP recommends the following formulation of the objective:

Objectif général : réduire les inégalités sociales et territoriales de santé.

Objectifs spécifiques:

- réduire le gradient social et territorial des états de santé en agissant sur l’ensemble des déterminants de la santé ;
- réduire les obstacles financiers à l’accès aux soins. (p. 13)

Indicators are to be collected by socio-economic category, *déclinés par zones géographiques*. (p. 13) The HCSP also proposes to develop a geographic indicator of deprivation *pour suivre le lien entre développement territorial et santé* (p. 14). This primary recommendation of the report is in line with the then-state-of-the-art epidemiological focus on small-area variation as a proxy for SES. But at the same time, the suggested language for the objective seems designed to leverage the ambiguity in the language of ‘territory’ to link into longstanding political concern in France with inequalities across larger-scale territorial aggregations, that is, regions.

The most recent major French report on health inequalities was prepared in 2011 by the Inspectorate General for Social Security (IGAS), and is once again nominally directed at social (SES) inequalities in health. *Les inégalités sociales de santé: déterminants sociaux et modèles d’action* reflects then current WHO language on health inequalities: social inequalities are defined as avoidable differences in health, they concern social justice, follow a gradient, require multisectoral action, are best addressed with proportionate universalism and so on. France is placed on Whitehead’s equity action spectrum, and the WHO Commission on the SDOH report is referenced as providing the most up-to-date model of causation (Table 2 [p. 14] in fact reproduces the WHO causal model diagram). With all of this wind-up, one

would expect the report to concern itself more or less exclusively with the socioeconomic inequalities that are the subject of the WHO's concern. Yet the introduction to the report states that 'Classically, three types of health inequalities can be distinguished: those between women and men, between socio-professional categories, or between territories' (p. 7). The report goes on to argue that 'public policies need to take into account the relationships that link social inequalities in health with other forms of inequality, above all territorial inequalities' (p. 22). The authors of this report understand and articulate the political consequences of choices about how they frame the causes of health inequalities – 'to act on the determinants of health implies in effect choices about economic and social regulation' (p. 12) – and have chosen a framing that resonates with longstanding concerns about regional inequalities in France.

Explaining the Frames

Why have policy elites in France and Belgium framed the problem of inequalities in health and health care so differently, with Belgians echoing the WHO consensus definition of health inequalities as rooted in socioeconomic inequalities, and the French embedding social inequalities in the territory? One possibility, predicted by the modernization theory model implicitly espoused by the WHO (Whitehead *et al*, 2014) and the EU (Judge *et al*, 2006), is that Belgium is simply farther along on the 'health equity action spectrum' than is France. A second is that the objective problem load that policy elites face corresponds more closely to a socioeconomic framing in Belgium, and to a regional framing in France. A third possibility is that class is a more *politically* salient political divide in Belgium, and territory more politically salient in France, and that it is the political rather than the 'objective' importance of these cleavages that pushes the framing of health inequalities in one direction or another. This last is the most obviously correct explanation, but it is a banal claim without further elaboration. In the final part of this section, I seek to clarify the institutional and ideational bases of the varying political salience of class and territorial cleavages as they relate to health inequalities.

The first possibility is relatively easy to refute. France is sometimes described as a 'bad pupil' (POL1, POL10 interviews) when it comes to internalizing WHO or EU policy models, while Belgian policy documents suggest that policy elites in that country have taken to heart the lessons taught by actors at the European level on the correct way to think and talk about health inequalities. However, it is not the case that Belgian policy elites recognize health inequalities as a policy problem while their French counterparts do not; the sheer volume of documentation relating to health inequalities demonstrates that there is no lack of interest in health equity on the part of the French. French discourse about health inequalities is simply, and systematically, *different* from the discourse in Belgium. The fact that French discourse about

health inequalities is, in its territorial focus, less consonant with the dominant discourse at the international level likely contributes to the impression that French policy elites have not yet fully recognized that health inequalities are an important policy problem.

Do existing patterns of mortality and SES by region in Belgium and France ‘naturally’ lead to the different frames that policy elites have employed in these two countries? Recognizing that no measurement or description of a problem load will ever be truly objective – the constructivist ontology and epistemology that underlies the present analysis insists that even relatively disinterested scholars inevitably frame a problem in the process of measuring it – we can still assess whether there is, generally speaking, a fit between the relative size of SES versus territorial inequalities and the framing of the problem.

First, consider the relative size of socioeconomic inequalities in France and Belgium. The most recent comparisons of socioeconomic inequalities in health mortality across European countries using comparable measures (Hernández-Quevedo *et al*, 2006, Eikemo *et al*, 2008, Mackenbach *et al*, 2008) have consistently found such inequalities to be larger in France than in Belgium. Furthermore, SES inequalities in health in France have tended to be at the high end compared with other west European countries, while Belgium has fared somewhat better in international comparisons. If the framing of health inequalities as a political problem were related in a straightforward way to the magnitude of an inequality, we would expect French policy elites to be more prone than those in Belgium to frame the problem of health in socioeconomic terms.

But the socioeconomic frame is not the only one available to policy elites. Health varies by geography as well as by SES. Working with data on the regional distribution of mortality and SES in France and Belgium, we can generate a set of expectations about how health inequalities ‘ought’ to be framed in the two countries. I have shown previously (Lynch, 2010) that (a) mortality overall and in the leading causes of preventable deaths in different age groups is somewhat more differentiated by region in Belgium and in France, but the extent of this difference depends on the causes of death considered; (b) a larger amount of the regional variation in mortality is explained, in a statistical sense, by regional-level indicators of socio-economic status in France than in Belgium; and (c) there is very significant variation in mortality across politically relevant macro-regions within Belgium (that is, Flanders versus Wallonia), but not in France.⁶ Hence, we would expect policy elites in Belgium to frame the problem of health inequalities in more territorial terms than is the case in France, where policy elites would have trouble constructing a political narrative to explain large-scale territorial differences.

To summarize, the relative size, overlap and political salience of socioeconomic and territorial inequalities in Belgium and France would suggest that, all other things being equal, health inequalities should be framed as primarily a matter of socio-economic inequality in France, and as a matter of territorial inequality in Belgium.



All other things are, however, rarely equal. Could the framing of health inequalities in France and Belgium correspond to the political, rather than the ‘objective’, salience of SES versus health inequalities in the two countries?

At first glance, this hypothesis seems implausible. One could hardly find a more striking example in Europe of politicized regional identity than Belgium, whereas class rhetoric is alive and well in France, thanks in part to a relatively robust socialist party that has continued to claim *égalité* and *fraternité* as core values, at least in rhetoric, at a time when other center-left parties in Europe have opted more decisively for (neo)*liberté*. If the political salience of SES versus territorial cleavages were linked directly to health inequalities frames, we would expect to see Belgian policy elites framing health inequalities in highly salient territorial terms, and French policy elites harnessing the political power of class-egalitarian discourses to foreground the issue of health inequalities.

The reality, however, is more complicated, and in ways that appear to have influenced the differing health inequality frames in Belgium and France. It is not so much the salience of territorial or class cleavages, but their meaning for politics and policymaking, that contribute to the framing of health inequalities. The regional cleavage in Belgium is linked conceptually to the social insurance system, which is the last remaining institution that binds the Belgian regions into a nation. The existential threat posed by a regional framing of health inequalities in Belgium means that for many political actors it seems preferable to avoid discussing regional inequalities in health at all. On the French side, while territory is not a strong basis for political mobilization, neither is class *per se*. French Socialists have, since the 1970s, emphasized ‘social exclusion’ over the class gradient, resulting in policy discourses that tend to target marginalized populations rather than acting on socioeconomic conditions more broadly. Territorial equality, on the other hand, is deeply rooted in French administrative culture and provides a basis for discussing socioeconomic inequalities that is appealing to both the Left and the Right, for different reasons.

Why Belgian HI policy discourse is focused on SES rather than regional inequalities

While differences in health status at the regional level may be reported in Belgian policy documents, they are almost never characterized as ‘inequalities’, and the SES framing of disparities is thus paramount. As one interviewee put it, ‘No one in Belgium takes a different approach from Marmot and the social determinants of health’ (FLA6 interview). Some of the most prominent Belgian researchers of socioeconomic inequalities in health have also examined spatial inequalities within Belgium, and it has been noted that there are not only marked correlations between deprivation and poor health at the small-area level, but also a ‘group effect’ in which

Belgians of the same SES have different levels of health depending on which region they reside in (see for example, Deboosere and Gadeyne, 2002). Nevertheless, the only counter to the dominant SES framing of health inequalities in Belgian politics has come from Flemish nationalists, who argue that regional inequalities in health *care* spending are a major injustice in the health sphere because they require Flemish citizens to pay for unnecessary or wasteful care consumed by French-speaking Belgians. Why, given stark regional inequalities in health, is the discourse surrounding health inequalities in Belgium so firmly focused on SES inequalities? And why is it that Flemish, rather than French-speaking political leaders, have been the ones to mount a challenge to that frame?

One important reason has to do with the devolution of economic policy competences to the regions in 1980. When responsibility for economic management passed from the national to the regional governments, unemployment, poverty and economic performance of the regions were no longer Belgian problems, but regional problems. In this context, the overlap between socioeconomic and health deprivation in Wallonia relative to Flanders ceased to be understood as an issue of injustice between regions tied together in a common national project.

While national government policies through the 1970s clearly contributed to differential patterns of economic development between Belgian regions, until the 1960s Wallonia was a more prosperous region than Flanders. One interviewee pointed out that since much of the economic development that allowed Flanders to pull ahead of Wallonia as a center for growth, income and employment occurred after devolution in 1980, Walloons do not blame the Flemish or the ‘center’ for current economic conditions in Wallonia. If anything, they point out that Flanders has adapted more successfully to the post-industrial economy. And when socioeconomic inequalities are not conceived of as unfair, the health inequalities that derive from them are not understood to be inequitable, either (WAL1 interview).

In this context, it makes little sense for French-speaking politicians or policy-makers to emphasize the regional aspect of health inequalities, despite the fact that these overlap quite strongly with the SES gradient in Belgium. Unlike in France, where regional variation in health care and health status were construed as evidence of the failure of the French state to protect different areas of the country equally (as in the *Santé 2020* report, or the 1998 HCSP report on regional inequalities), in Belgium there is no expectation that there would be equal social conditions in the two regions. As a Walloon health official explained:

You use the term inequity when something is not fair. And we can't identify what's unfair in Wallonia versus Flanders, except the general socioeconomic situation. And we (well, I mean capitalists) are more or less responsible for this situation. We know it's linked to the social and economic situation, but it's our problem. We are saying it's not normal, we estimate lives lost to inequality. But we can't really say it's unfair. (WAL1 interview)



Framing the issue of health inequalities in regional terms would emphasize the failure of Walloon and Bruxellois politicians to provide better management of the economy. Hence, when French-speaking politicians in Belgium make an issue of health inequalities, they tend to discuss them in regionally neutral terms, focusing on SES as the key determinant, and on health care access and health promotion as the primary policy responses. As a former official of the King Baudouin Foundation noted, French-speaking socialists have avoided making commitments to reduce health inequalities ‘because they also have their own political strategies and they wouldn’t stress negative things too much’ (NAT1 interview).

A second reason for the SES framing of health inequalities in Belgium, despite stark regional differences in health status and mortality, is related to financing of the health care system. Belgium has the highest proportion of general revenue financing of any Bismarckian health care system in the OECD, and in contrast to economic policy, health insurance in Belgium has remained centralized. This combination of high levels of state financing and centralized administration means that the health insurance system carries out substantial fiscal transfers between regions. But fiscal transfer mechanisms between regions are highly contested in this unstable federation – and indeed, Flemish nationalists complained beginning in the 1990s of transfers carried out surreptitiously via the social insurance system to subsidize ‘excessive’ medical consumption in the French-speaking part of the country.

At the level of the public and political discourse, and sometimes even within the public health policy and research communities, these complaints are justified by stereotypes of French-speaking patients as prone to excessive care-seeking and poor health behaviors, and French-speaking providers as enmeshed in an inefficient and ineffective culture of medicine. Also important, though, for the (ill)legitimacy of these fiscal transfers, the Belgian social security system is based on a norm of interpersonal, not inter-regional solidarity: higher earners subsidize the benefits of lower earners and former-earners, but the transfers between regions that are implied by this system are not explicit or transparent. There is thus a marked contrast between the actual flow of money in the system, which has a strong regional dimension, and the publicly stated logic of the system, which is based on inter-personal solidarity. This contrast has been exploited by political actors who are keen to see the social insurance system – which many argue is the last thing holding Belgium together as a country – dismantled.

This negative social transfer discourse linked to the health care system is not about health outcomes *per se*, of course. But most Belgians (like most French) automatically think of health care when the topic of health inequalities arises.⁷ Furthermore, the two issues are linked by the discourse, which pushed French-speaking policy makers and researchers to justify the differences in medical care spending as ‘objective’ or ‘justified’ by the greater medical need in Brussels and Wallonia.⁸ A 1993 law altered some aspects of the financing of social insurance, introducing a risk-adjustment scheme to account for differences in the case-mix

across different social insurance funds. Despite these reforms, however, some Flemish nationalists continue to balk at the inter-regional transfers carried out via the social security system – even if their discourse has now shifted slightly, away from the injustice of transfers *per se*, and toward complaints about the inefficiency of the French-speaking medical care ‘culture’ and the poor health behaviors of French-speaking Belgians (FLA3 interview).

The social security system thus remains at the center of political debates over further decentralization of Belgium, and debates about the legitimacy of higher medical costs in the South remain at the center of the social security debate. Under these conditions, French-speaking policy elites, who are generally more keen than their Flemish colleagues to retain both the social insurance system and Belgian national unity, have little incentive to frame regional ‘differences’ in health as ‘inequalities’. As one public health official said:

You have to understand that the problem is basically money. We have a national health insurance. And Flemish nationalists say, “We are paying for the Walloons.” So the French-speaking politicians don’t talk too much about that, because that’s a way to focus on an issue that will be interpreted in Flanders as a problem because it’s about money. And [the Flemish politicians] avoid even calling it an inequality, because it’s opening a debate where money will come into it. (WAL1 interview)

Similarly, when asked why his party did not try to stimulate a broader discussion of regional inequalities in health that go above and beyond SES inequalities, a Walloon health policy advisor to the Socialist minister explained, ‘You have to take a political view ... It’s a subject that is difficult to open without entering into a larger debate’ about federalism (WAL2 interview).

In sum, the SES frame meets the needs of both Flemish and French-speaking political elites. On the Flemish side, the focus on SES inequalities serves to de-emphasize the important regional gaps in health, well-being and life expectancy, which might otherwise serve as the basis for greater claims on Flemish solidarity. On the French-speaking side, avoiding a discussion of the regionalized nature of SES health inequalities may sidestep uncomfortable questions about who is responsible for the economic decline in Wallonia, and the exclusion of many Bruxelloises from the fruits of the capital region’s dynamism.

Why French HI policy discourse is focused on territory as the lens through which to view SES inequalities

The framing of health inequalities as a policy problem in France is, as we have seen, quite different from that in Belgium. Instead of an SES frame designed to mute the issue of territorial inequalities, the French frame casts territory as a primary axis of

inequality. How can we explain this difference between the policy frames in the two countries?

One explanation for the strongly territorial frame in France could be that, as in Belgium, French policymakers are more concerned with health care than with health, and health care is inherently territorial because it depends on providers and facilities that are located in particular places. Beginning in the 1990s, as restrictions on the number of new medical graduates introduced in the 1980s (the so-called *numerus clausus*) took effect, medical demography – the unequal distribution of doctors over the territory – emerged as a prominent theme in media coverage of health policy. As the overall numbers of doctors declined, the idea of the medical ‘deserts’ (*déserts médicaux*) came into common parlance. More recently still, in the 2000s, the territorial differentiation of *dépassement* – the practice of doctors charging fees above those reimbursed by the national insurance – has become a newsworthy topic, with stories of patients being unable to find a single doctor in their area willing to accept the regular fees (POL15 interview). These differences in health care supply feed a sense that the important inequalities in health in France are linked to health care, and to territory – and hence, in the words of a senior health advisor, violate a ‘strong principle’, ‘shared by all people’, that ‘health [care] has to be the same everywhere in the country’ (POL15 interview). This ‘strong principle’ undoubtedly contributed to the presentation of the 2009 law that regionalized the health care system in terms of health equity – particularly, geographic equity in access to care.⁹

But where does this strong principle come from? And what do French policy elites really mean when they say territory? *Territoire* is a concept weighted with multiple meanings in France. As one French expert put it, territory has ‘a political, social, historical thickness about it. It has a state dimension; i.e. it’s also about institutions, political systems, political networks, political exchange. It’s also about history. So it’s a very thick notion, but at the same time hard to define clearly’ (RES3 interview). Territory is a metaphor, then, but for what?

One of the primary valences of territory in France is equality. The equation of state policy with territorial uniformity is deeply rooted in France. A key threat to inequality and national cohesion in French political discourse, dating back to the realm of Louis XIV and gaining full expression during WWII, is the lack of access in France’s ‘deserts’ to the amenities and privileges of the Parisian way of life. The juxtaposition between Paris and less well-served parts of the country entered mainstream policy thinking with Gravier’s, 1947 book *Paris et le Désert Français*. Gravier argued that since the Napoleonic Period, more and more power had been concentrated in Paris to the detriment of the rest of France. Gravier’s ideas were influential in the post-World War II period and led to his appointment as head of the *Commissariat général au Plan* (Baudouï, 1999). The determination to remove the disparities implied in the concept of *déserts* became a cornerstone of post-War French planning. A consequence of this idea is that for French policymakers, territory

becomes ‘a metaphor to focus on the issue of policy implementation’, in the words of a political scientist specialized in regional politics (RES18 interview).

If territory is a resonant metaphor for inequality in France, a number of respondents also expressed the view that framing health inequalities in territorial terms is at least in part a way to avoid talking directly about class inequality. One geographer noted an ‘irony that the centralized state that we inherited from the revolution made it possible to extract data from throughout the territory, and hence to consider geographic inequalities; while at the same time French history makes attention to SES inequalities unwelcome’ (RES6 interview). He explained that France has a long history of strong social and class conflict, from the Revolution through the strikes of 1936 and 1968, and that politicians of all colors feared reawakening those societal conflicts by bringing too much attention to the issue of class inequalities (RES6 interview). One result of this history may be that class discourse is relatively weak in French politics: A number of respondents opined that the French Left prefers to discuss exclusion than class inequality, and the right would rather avoid the issue of inequality altogether (RES15, RES1, RES7, POL10).

However, the main reason my interviewees offered for favoring a territorial frame over an SES frame is, as the head of a medical practitioners’ union succinctly put it, ‘Politicians are avoiding the ISS problem’ (POL8 interview). A pioneering epidemiologist of cancer in the 1970s and 1980s noted that at that time policymakers were happy to ‘compare two spaces, but you don’t compare people between social classes’. Policymakers ‘had the data about differences between social class but they didn’t use it, they didn’t work with this question. The director [of the regional health observatory] said to a colleague of mine, *c’est inutile! C’est trop explosif!*’ (It’s a bad idea; it’s too explosive!) (RES1 interview). Another respondent said the reason for the lack of public discussion of SES inequalities in health is ‘rather obvious. It’s a disturbing issue. We all know that’ (RES6 interview).

Yet numerous researchers have been engaged in recent years in fine-grained geographic analyses of mortality and morbidity that often seems to serve as little more than a proxy for SES inequalities. One high-level researcher characterized much of the work on small-area variations in health as ‘a purely ecological mapping that is directly interpreted in terms of individual conditions’ (RES7 interview). Keller (2013) describes a similar tendency in the part of French policy researchers trying to understand patterns of mortality in the 2003 heat wave: ‘These are sophisticated studies. [...] They draw exhaustively on geographical information systems data and involve careful digital modeling, yet they [...] go no farther than mapping a spatial correlation between death and economics’ (Keller, 2013, p. 313). How can we explain this shift from political-territorial to territorial-as-SES frames in French discourses about health inequality?

Increasing socio-spatial segregation in France over the last 30 years has made small-scale geographic analyses useful as a way to make inferences about the effects of both SES and ethnicity on outcomes including health (RES 7 interview). At the

same time, French law prohibits collecting individual-level data on ethnicity, and French norms make it at least as politically sensitive to discuss ethnic differences as class differences. Small-area analyses such as those contained in the most recent reports on health inequalities may simply be a doubly encoded way of referencing ethnic inequalities without appearing to talk about them.

A simpler explanation, though, is that despite the constraints in French politics on openly discussing class inequality, in the last 10 years in France there has actually been growing acceptance of the idea that ‘social’ inequalities in health are a legitimate policy problem. Health Minister Marisol Touraine authored an article in *The Lancet* in March 2014 advocating more policy attention in France to ISS, and the *Stratégie Nationale de Santé* announced by the government in 2014 established a transversal working group on social health inequalities. This shift in the policy frame can be dated to different landmark events: Many interviewees mentioned that the issue of life expectancy by social class first rose to the attention of non-specialists during pension reform debates in 2004 (RES12, RES13, POL18, POL4, RES5 interviews),¹⁰ while others note the influence of the 2009 HCSP report itself, and still others attributed the recent shift toward a more SES-focused frame to influence from the WHO and EU (RES1, RES8, POL7 interviews). Most proximately, however, intense fiscal pressure since 2008 has led national-level political leaders to show a greater interest than ever before in preventive health, which is less expensive than health care, and can be cast as a measure to reduce SES health inequalities (POL1, POL7, POL15, RES7).

Conclusion

Health inequalities policy frames in both Belgium and France have been influenced by developments at the international level, to different extents (more in Belgium, less in France) and with different timing (earlier in Belgium, later in France.) The alacrity with which the normative international problem definition adopted by WHO Europe and the EU has been embraced in the two countries seems to depend on the structure and financing of the health care system, and the degree of contestation over fiscal transfer mechanisms, as well as by historically rooted conceptions of equity that are linked to both geography and class.

Most public health scholars and activists would make a conceptual distinction between the problems of health care and health outcomes. But as we have seen, the structure of the health *care* and health *insurance* systems plays a critical role in framing debates about health *status* inequalities. Even in countries like Belgium and France, where citizens enjoy near-universal access to health care and barriers to health care are not the main cause of inequalities in health status, most politicians, policymakers and members of the public do not make a distinction between health and health care – least of all when it comes to discussing health

inequalities. So discussion of health inequalities is inevitably linked to discussions of health care.

For this reason, the institutions that govern health care administration affect how health inequalities are framed. In Belgium the significant public funding of a social insurance health system with regionally concentrated funds sheds a bright light, for politicians and policy specialists, if not for the general public, on the extent to which the social insurance system carries out transfers between regions. In a contested federation such as Belgium's, drawing more public attention to these transfer mechanisms poses an existential political threat. Belgian policy and political elites who would like to see their country remain united are hence loath to bring up the issue of *either* regional differences in health status or regional differences in health care spending, for fear that would reopen the debate about decentralizing the social insurance system, which many regard as the last remaining institution holding Belgium together as a country. Under such circumstances politicians may adopt the international consensus framing of health inequalities, emphasizing SES, to avoid discussions of regional inequality that highlight the fragile nature of the social compact between regions.

In France, socioeconomic inequality in health status has until quite recently been much less prominent a policy problem than the issue of territorial inequalities in access to health care providers. At the same time, social insurance funds in France do not have strong regional identities, and the social insurance system is very weakly understood as an instrument for inter-regional fiscal redistribution. Even many of the experts I interviewed did not know how funds for health care and prevention were allocated among regions, and several respondents remarked that it was simply a political non-issue (POL18, POL11, RES18). The territorialized frame of health inequalities in France thus draws on a longstanding but depoliticized perception of territorial inequality between center and periphery in France, rather than on a highly salient regional cleavage as in Belgium. This territorial frame in France has survived pressure from international organizations like the WHO and the EU and from international networks of researchers to reframe the issue in terms of socioeconomic inequalities, in part because the notion of territory is flexible enough to be able to absorb SES differences, and in part perhaps because politicians on both the Left and Right in France have been content to use the metaphor of territory as a way of avoiding more difficult conversations about class inequality. Only with the recent fiscal contraction have money-saving prevention policies linked to social inequalities in health been actively promoted by the French government.

Existing state institutions affect the framing of inequality as a political problem in Belgium and France. This phenomenon is unlikely to be limited to these two countries. With regard to health inequalities, we might hypothesize based on these two case studies that where fiscal transfer mechanisms are highly contested, and state financing of the health care system is substantial, as in Belgium (but also, potentially, in Italy, Canada and pre-devolution UK), politicians are likely to adopt the

international consensus framing of health inequalities, emphasizing SES to avoid discussions of regional inequality that highlight the fragile nature of the social compact between regions. Where contestation over inter-regional fiscal transfers is limited and where central state revenues take a back seat to insurance financing, as in France (but also perhaps in Germany and in the United States before the Affordable Care Act), there is likely to be less concern about the national government's role as a redistributor in the health care system. Under these circumstances of relatively low contestation over fiscal transfers and low state spending in the health sector, autochthonous definitions of equity (territorialized, as in France and Germany, or racialized, as in the United States) can more easily frame the health equity debate, and the international consensus problem definition that prioritizes reducing socio-economic inequalities may be slower to take root.

Notes

- 1 Whitehead's definition of health inequities as 'differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust' was put forth in the context of work on the WHO's Health For All strategy, in a discussion paper prepared by the Program on Health Policies and Promotion of the WHO Regional Office for Europe (EUR/ICP/RPD 414 7734r). The discussion paper was then reprinted in the *Health Promotion International* in 1991, and again in the *International Journal of Health Services* in 1992, and is the mostly widely used definition of health inequities, with 1924 Google scholar citations as of 28 May, 2015.
- 2 Tarlov (1996) is credited with 'the modern introduction of the term' SDOH (Raphael, 2011, p. 223).
- 3 In the book project from which this paper is drawn, I also analyze coverage of health inequalities in political speeches and national newspapers.
- 4 For example, Belgium did not participate in early EU health equity projects like the first phase of Closing the Gap in a Generation (2004–2007) or DETERMINE (2007–2011) (Gutierrez, 2010), nor does Belgium seem to have prepared a national action plan under the rubric of the WHO Health For All strategy.
- 5 I have also found references to two earlier reports titled *La Santé en France*, produced for the Ministry of Social Affairs in 1985 and 1989. These reports are not considered here because they are not part of the series produced by the HCSP beginning in 1994.
- 6 For a summary of methods and key findings relevant to Belgium and France, see the supplemental materials online at WEB ADDRESS.
- 7 I asked interviewees to say how they themselves, or, if they were researchers, how they thought policy-makers or the public, defined health inequalities. Ninety-one per cent of Belgian respondents said primarily in terms of access to health care.
- 8 This argument was bolstered by a widely publicized series of reports by a commission headed by French-speaking socialist Michel Jadot. There is still disagreement at a political level about whether the Jadot Commission reports proved that transfers were entirely justified, or only mostly justified. The controversy continues because some people argue that medical supply is an 'objective' (and hence 'legitimate') cause of spending differences, while others think that is under the control of sub-national entities and should not be used to adjust the spending data.
- 9 The *Loi Hôpital, patients, santé et territoires* was presented to Parliament in October of 2008 with the goal of ensuring 'l'accès de tous aux soins', and was framed rhetorically as a response to inequality. Title 1, Chapter 1, Article 1 of the law defines *la lutte contre l'exclusion sociale* (the fight against social

exclusion) as an essential function of the health system, and Health Minister Roselyne Bachelot's presentations of successive drafts of the *projet de loi* to the legislature cited inequalities in access to health care as the primary motivations for the legislation.

- 10 At the same time, an official of the organization whose working paper on differential mortality was widely cited during the debates lamented that 'what was preferred was to research which compensation was possible in the retirement schemes. If people work a hard job, they'll take their pension out before the others. But there wasn't a voice saying that we should help them to live longer!' (RES5 interview).

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Supplementary information accompanies this article on the *French Politics* website (www.palgrave-journals.com/fp)

Interviews conducted

(Interviews in bold font are cited in this paper)

Belgium

Government officials

BRU6, FLA2, FLA5, NAT3, **WAL2**

Medicine/public health, social insurance professionals

BRU2, FLA1, FLA6, NAT2, NAT4, NAT5, **WAL1**, WAL3

Researchers

BRU1, BRU4, BRU5, **FLA3**, NAT8, NAT7

Journalists, foundations

BRU3, FLA4, **NAT1**, NAT6

France

Government officials (political) and party personnel



POL1, POL7, POL14, POL15, POL17

Government official (civil servants)

POL3, POL4, POL5, POL6, POL12, POL16, POL18

Researchers employed in government

RES5, RES6, RES7, RES8, RES12, RES13, RES15, RES16, POL13

Medicine/public health, social insurance professionals

POL2, POL8, POL9, POL10, POL11

Academics

RES1, RES2, RES3, RES4, RES9, RES10, RES11, RES14, RES17, RES18, RES19

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