8th ESPAnet Conference 2010
Social Policy and the Global Crisis: Consequences and Responses
Budapest 2-4 September 2010

11.1. European Public Health Care Systems and Institutional-Organisational Change

Alban DAVESNE, Sciences Po, Centre d'études européennes, 31 rue de Beaune 75 007 Paris, France
Phone: ++33 (0)6 71 96 39 87
Email: alban.davesne@sciences-po.org

Bruno PALIER, Sciences Po, Centre d'études européennes, 28 rue des Saints Pères 75007, Paris, France
Phone: ++33 (0)1 45 49 54 37
Email: bruno.palier@sciences-po.fr

The French health system: the never-ending struggle for cost-containment

Abstract:

For the last thirty years, the French national health insurance system has been struggling with mounting deficits and the financial imbalance of the Social Security has been the focal point of most of political attention in the field of health care. Together with some organizational and health-oriented changes, governments have thus successively implemented various cost-containment measures, in a bid to solve the financial difficulties of the public sickness insurance funds. Three stages could be highlighted in this continuous stream of reforms. The first phase consisted during the 70-80's in freezing Social Security tariffs in order to curb heath care expenses. It however did not work since professionals were able to increase activity to compensate for frozen tariffs. Hence governments turned to increasing co-payments for curbing public health care expenses. In the second phase starting in the early 90's the government negotiated with – and then imposed upon – health care practitioners to limit the cost of medical treatment without so much success as sanctions were not imposable on doctors. A third sequence emerged in the last decade with more structural attempts at increasing the control and regulatory capabilities of the State over the financing and the planning of the health care system. This paper sheds light on the past reforms and discusses new stakes for measuring the performance of the French health care system: while cost-containment and curbing public deficits have been the main rationale of the reforms, additional concerns about the quality – despite flattering international comparisons – and about the equity of the health insurance system have emerged, questioning more broadly the efficiency of the French 'regulatory health care state' in managing the financial sustainability, the quality, the responsiveness and the equality of the health care system.

The French health system: the never-ending struggle for cost-containment

1. Introduction

Like in many western countries, the financial resources of the French health insurance system have been first drastically restrained by the early 1970's economic downturn. Meanwhile, an extended access to universal medical care and the improvement of health technologies have contributed to steadily increase both total health expenditures and the share of public expenses devoted to health care. Health insurance funds have therefore been in deficit from 1969 to 1979, in 1981, 1986 and ever since 1990. First considered a technical issue, the funding of the health insurance system reached the formal political agenda in the mid-1970's, as part of almost annual saving plans which all aimed – and by and large failed – at bridging the deficit of the social security system. The politics of health care reform then became essentially a quest for cost-containment in the late 1980's. Despite the many saving plans, it appeared clearly that the institutional characteristics of the French health insurance system made it practically impossible to control the cost of health care. Indeed, Bismarckian institutional arrangements do not allow non-medical regulators (be it the State or health insurance funds) to set up budgetary limits to health expenditures, which could contribute grandly to curbing their uncontrolled upward trend (Hassenteufel and Palier 2007). The reimbursement of health care expenditures by the social security funds on an *ex post* basis means indeed that the government does not directly control health care expenditures. Moreover, doctors and patients enjoy a large freedom of establishment and choice, which ensures a good responsiveness of the health care system but adds to the costs of the system. Against this background, this paper analyses the reforms that led policy-makers to diversify the policy instruments and bring about deep cumulative organizational change *and a profound reorganization* of the health insurance system and health care institutions. We will trace why and how major regulatory changes have taken place in France in the last 20-30 years, and especially so since the mid 1990's. We will try to understand how far-reaching these institutional changes are and what are their distributional implications for health professionals, stakeholders and patients.

Building on neo-institutionalist theories of incremental change, we point out how the institutional features of the French health system determine the conflicts but also 'ambiguous agreements' over various cost-containment measures. From the onset, the French health insurance system was already an ambiguous synthesis of State control and autonomous regulation. The 1945 ordinances which created the health insurance system as we know it mark the end of the strong fragmentation of the previous health care insurances and *mutuelles* (mutual insurance companies)[1]. But in the new

[1] Ordonnance n° 45/2454 du 19 octobre 1945

system, state officials remain weak in the structure of social security funds; health care services are covered by the health insurance system but medical doctors are still independent and remain subject to competition among them. Today, the system is still highly fragmented and combines a strong hospital sector and dynamic private clinics. The ambulatory care is predominantly provided by private practitioners. These institutional arrangements encompass a wide range of hindrance for change and provide many actors with decisive veto possibilities, but they also contain the potential for incremental and cumulative change. By retracing three decades of health reforms, this paper shows how learning processes and conflicting 'change agents' (Mahoney and Thelen 2010, p.22) contributed to bring about institutional and organisational change within the health system. We see three main phases in the process of health care changes. After having implemented non structural financial plans aimed at freezing fees during the 1970s and 1980s, policy-makers tried to negotiate with the actors of the system the setting of capped health budgets in the early 1990s. The third sequence of reforms starting the late 1990's features an ambiguous combination of reinforced State control over health insurances and health care provision and an increased use of market and managerial policy instruments aimed at making the supply of health care services more cost-efficient.

2. The financial "rescuing" plans: increased resources and reduced coverage of the health insurance

Since the 1970's, health expenditures have been growing faster than the financial resources devoted to health insurance. Faced with an unprecedented deficit, the government decided to freeze the prices of health services as a means to cut the global health spending (2.1). In addition to setting authoritative limits to health prices, the government came up between 1975 and 1995 with no less than 18 saving plans in order to reduce the deficit of social security funds[2]. All these governmental plans followed a similar path, extending the financial resources devoted to health insurance on the one hand (2.2), and curbing the demand for health insurance benefits on the other. While increased social contribution was the main ingredient of the earlier plans, individual co-payments became in the 1980's a recurrent policy instrument aiming at curbing the demand for health care and drugs (2.3).

2.1. Freezing social security tariffs

The traditional way of curbing the expenditures of the French health insurance system was to impose low prices on health care services and products. The *per diem* budget of hospitals increased only slightly, health practitioners had to comply with limited social security tariffs for ambulatory consultations and pharmaceutical prices were also kept low by an agreement between the State and the pharmaceutical industry. But this strategy focusing on low prices had a limited impact on global health expenses, since health professionals and pharmaceutical companies tended to compensate their lost income due to imposed tariff freezing by symmetrically increasing the number of medical acts and prescriptions. It led to longer stay at the hospital, multiplication of medical consultations and "false innovations" intended by the pharmaceutical industry at inducing drugs consumption.

2.2. Increasing the financial resources of the health system

Hence, the deficits of the health insurance funds have remained high in the mid 1970's. The government attempted to rescue the health insurance system by increasing the amount of social contributions (payroll taxes) devoted to funding health expenditures. The structure of the French health insurance system and the clear link between social contributions and health care benefits made it indeed easier for policy-makers to convince voters that social contributions should increase in order to absorb social security deficits. Social contributions were augmented by almost every

[2] Plan Durafour (1975), plan Barre (1976), plans Veil (1977 and 1978), plan Barrot (1979), plan Questiaux (1981), plans Bérégovoy (1982 and 1983), plan Dufoix (1985), plans Séguin (1986, 1986 and 1987), plans Evin (1988 and 1990), plan Bianco (1991), plan Veil (1993), plan Juppé (1995)

rescuing plan[3], and therefore grew faster than any other fiscal income in the 1980's. Their share went from 39% of all taxes in the 1970's to 46% in 1996 (Palier 2005).

2.3. Making users pay: privatizing health risk coverage

Besides increasing social contributions, the reduction of collective risk coverage has become a key cost-containment policy instrument in the 1980's. When facing financial hardships, reduced reimbursement rates ('*tickets modérateurs*') have been trusted by governments to reduce the financial burden on health insurance funds and to promote a better use of health care services by the patients. Beyond the savings directly related to the reduced reimbursement, state and national sickness fund officials expected on the long run patients to refrain from excessively consuming health care services. However, the effects of co-payments on the demand for health service have been partly compensated by the rise of supplementary health insurance as substitutes for social security schemes.

****

Faced with the deficit of the health insurance system in the 1970-1980's, the government multiplied financial rescuing plans combining increased resources and reduced risk coverage. As frozen social security tariffs provided an insufficient regulation of health services supply, the rescuing plans left tax payers and patients with the financial burden of bridging the social security deficit (respectively through the inception of new taxes devoted to funding health care and through individual co-payments). Increased social contributions have been used with greater caution since the mid 1990's, while co-payments are still key features of health insurance savings plans.

[3] Increased social contributions devoted to health insurance funds: 1975; 1976; 1978; 1979; 1981; 1986; 1987; 1991; 1995

3. Cost-containment through supply regulation: a national health budget for ambulatory and hospital care

With the general economic context of the 1990's and the commitment to respect the macro-economic convergence criteria set up by the Maastricht treaty in 1992, it became more difficult to increase payroll-taxes without harming the competitiveness of the country. Instead of social contributions, other fiscal instruments such as excise taxes on alcohol and tobacco or the 'general social contribution' tax (CSG: '*contribution sociale généralisée*) were redirected in the mid 1990's to fund health care expenses[4]. Since it was first devoted to financing health insurance funds in 1996, the share of the CSG increased steadily to cover 38 % of the health care resources. As the rise of health expenses could no longer be matched by frozen tariffs and co-payments, this institutional change of health insurance funding was complemented by structural attempts to control the budget devoted to health expenses. Capped budgeting had first been applied to hospital care in the 1980's (3.1), but cutting the resources devoted to the liberal ambulatory care proved to be much more complicated. The government first tried to negotiate medical restraint with health professional Unions, and then turned to a more authoritative regulation of the supply of health care as the deficit continued to grow deeper (3.2).

3.1. Setting hospital budgets and negotiating regional hospital restructuration

The post-war period is considered a "golden age" in many respects, but it seems particularly true for the expansion of the French hospital sector (Mordelet 2006, p.310). Since the famous 1958 reform creating elite public hospitals (CHU: *Centre hospitalo-universitaire*), the French hospital system has grown to become one of the most developed in the world. The number of beds increased by 55 000 units between 1970 and 1975. Although it declined in the 1990's, the number of hospital beds in France was still higher than in most OECD countries in 2008. This unprecedented modernization effort was supported by the steady economic growth of the "*trente glorieuses*" period, but the "fiscal imperative" (Freeman 2000, p.70) also affected the hospital sector. The ministry of health could apply regulatory changes to hospital care as early as in the mid 1980's because of the strong hold of the State on the sector.

Global budgets for hospitals

The socialist minister of social affairs Pierre Bérégovoy announced in November 1982 his intention to substitute the "*per diem"* funding system of hospital by a prospective global budget for public hospitals. The former funding system was a simple but inflationist method for financing hospital care which encouraged hospitals to extend the stay of their patients and multiply medical procedures (hospitals received a budget corresponding to the amount of patients multiplied by the number of days they spend in the premises of the hospital). A global budget, on the contrary, allows the State to

[4] Increased taxes (on alcohol and tobacco; pharmaceutical products; insurances; gambling; CDG): 1976; 1981; 1982; 1987; 1988; 1989; 1990; 1993; 1995; 1997 (LFSS 1997); 1997; 2004; 2008

steer hospital expenses and favours cost-containments measures, because it is the ministry of health which determines *a priori* the budget allocated by the social security funds to public hospitals. This important reform was implemented in 1983 for CHU hospitals and in 1984 for smaller public hospitals (it applied until 1995 – Pouvourville 2009, p.272). This measure seemed to have helped hospitals to lower their expenses: The share of public hospitals in the total health expenditures decreased from 41% in 1980 to 34% in 2000 (Tabuteau 2006, p.275). The average duration of a stay in French hospitals is among the lowest in all OECD countries (OECD 2009, p.99). But the global budget was criticized because it tended to discourage innovative management and shielded under-achieving public hospital by disconnecting the budget from the performance of each hospital. Meanwhile, private clinics (which account for the third of all acute beds and two third of surgery beds) continued to be financed on a fee-for-service basis, much like private ambulatory care.

Negotiated regional planning

In addition to a fixed budget for hospitals, the government tried to restructure the planning of hospital care on the French territory (the '*carte sanitaire*' created in 1970). The 1991 reform allowed the ministry of health to coordinate the supply of regional public and private inpatient care through regional contracts (SROS: *Schémas régionaux d'organisation sanitaire'*) setting objectives agreed upon by local stakeholders and organize the provision[5]. Agreements were signed in order to rationalize the supply of hospital care. Regional hospital planning was intended to contribute to cost-containment policies by allowing to rationalize the supply of hospital beds (the global number of beds decreased by 16 % during the 1990's – Palier 2010) and encourage a territorial restructuring of inpatient care according to need health care needs (elderly care and long term care). Despite the improvements brought by the SROS, negotiated planning of hospital care is still thwarted by the autonomy of hospitals and local politics (local authorities often oppose restructuring). In 1996, the government then turned to the creation of regional hospital agencies in order to make regional planning of hospital care more efficient.

3.2. Towards a capped budget for ambulatory care

Regulating the supply and the cost of ambulatory care in a health insurance system is a much more complicated task, especially so in France where the principles of the '*médecine libérale*' laid down in the 1927 charter of medical professions (freedom to choose doctors, freedom of prescription, fee-for-service payment) are considered by a large majority of medical doctors as "*holy and inalienable*" (Hassenteufel 2009).

The minister of social affairs tried to impose a 'global volume envelope' during the 1980 conventional negotiation. The general aim was to link the growth of ambulatory care expenditures to the general economic growth. The national sickness fund (CNAM) was left with the uneasy task to enforce this new supervision of doctors' activities. It "sold" It to medical Unions in exchange for the creation of a '*secteur* 2' allowing medical doctors to decide freely the level of the fees they would charge. But

[5] Loi n° 91-748 du 31 juillet 1991 portant réforme hospitalière

while this part of the deal was actually implemented, the biggest medical Union (CSMF) thwarted the implementation of a 'global volume envelope'[6].

The ministry of health subsequently tried to circumvent the inflationist logic of frozen tariffs by trying to impose more binding cost containment measures. In 1991, the left wing government led by Michel Rocard introduced the concept of 'medicalized restrain' (*maîtrise médicalisée des dépenses*). This means that the objective of reducing the supply of health care had to be based on the medical evaluation of therapeutic activities. During the conventional negotiations, the government wanted to introduce a limit on medical expenses for each health professional, but this measure was only accepted by non-medical professionals (nurses and massor-kinesipathists). Failing to control the budget devoted to ambulatory care, the government could only release medical guidelines on best therapeutic practices (RMO: *références médicales opposables*). This mechanism was first included in the new convention that the sickness fund and medical doctors' Unions signed in October 1993, but no thorough sanction mechanism came to support its implementation.

In November 1995, Alain Juppé announced a deeper reform of social security schemes, including a dramatic restructuration of the financing and organization of the health system. An effective implementation of medical conventions in the ambulatory sector was the cornerstone of this reform. The first objective of the Juppé plan was to reinforce the legitimacy of the capped health budget. A constitutional revision adopted in February 1996 allowed the Parliament to determine every year the resources devoted to the social security funds (annual bill on social security budget – LFSS: *Loi de financement de la Sécurité sociale*) and to set up capped budget for health insurance expenditures for the year to come (national health spending objectives – ONDAM: *Objectif national des dépenses de l'assurance maladie*). Health insurance funds then negotiate conventions with health practitioners on the basis of these objectives set by the Parliament. The health insurance funds and the medical professionals remain in charge of negotiating the conventions, but an ordinance released in April 1996 prompted the State to take over and set national health spending objectives if the social partners are unable to come up with an agreement within 65 days (abandoned by the 2004 "Douste-Blazy" reform).

In order to get liberal practitioners to comply with the national spending objectives, the Juppé plan introduced potential sanctions against practitioners who would disregard the spending objectives (the sanctions were to be taken by the social partners and then by the State according to the 1999 *loi de financement de la Sécurité sociale*). This initiative triggered a massive strike of medical students (*les internes*) during the spring of 1997 and doctors led a successful juridical battle against penalties. The sanction mechanism has been severely watered down in 2000 by a Council of State ruling (*Conseil d'État*) which denied the government the right to force health professionals to pay a fine to social security funds. The socialist government led by Lionel Jospin thus gave up the attempts at enforcing the capped health budget in 2000.

Instead, socialist health ministers Martine Aubry and Elisabeth Guigou tried to revive a "frozen tariffs" strategy in 2000-2002 and held the ambulatory care tariffs unchanged during this period. But

[6] Only the FMF Union – representing mostly specialists from large cities (those most favored by the sector 2) – accepted this system

it again triggered massive protests among health practitioners (for instance a strike day called "journée sans toubib" on February 15th, 2002). Following Jacques Chirac's 2002 election pledge, the next right wing government allowed doctors to charge up to €20 for a consultation. After another general practitioners' strike, President Nicolas Sarkozy announced in April 2010 that the consultation will be charged €23 at the end of the year 2010. The price of drugs has also been partly liberalized in 2003, under the pressure of drug lobbyist concerned about the declining profitability of the medicine industry (Paris 2009, p.220-223).

****

The Juppé plan culminated a sequence of health care reforms which started in the late 1980's. The inability of earlier financial rescuing plans to curb the deficit of the health insurance funds indeed opened in the early 1990's a political opportunity for "subversive change agents" (Mahoney and Thelen 2010). A coalition composed with high level public servants and centre-left Trade Unions (CFDT) promoted a far-reaching structural reform of the health system. Through concepts such as "medical restrain", this reformist coalition distanced itself from both the purely financial approach of the ministry of finances and the professional freedom of medical doctors. Although the aim of the reforms was still cost-containment, additional concerns about the quality of the health insurance system emerged as motives for institutional change through managerialisation and technocratisation (Hassenteufel and Palier 2005). This strategy was however clearly in contradiction with the principles of liberal medicine, its funding based on a fee-for-service and its professional self-regulation. The implementation of a capped budget for ambulatory care has therefore been fiercely contested by the main medical Unions eager to increase social security tariff and expand the scope of the free tariff sector. Hence, in the absence of a credible sanction mechanism against excessive spending, the attempts at controlling national health budgets have had rather limited effects so far. Neither the annual objectives voted by the Parliament nor the negotiated conventions signed by health insurance funds and social partners have consistently been respected year after year (*see table 1*).

4. Cost-containment through organisational change: fostering managed competition and increasing the regulatory capabilities of the State

A third stream of reforms emerged in the second half of the 1990's and unfolded during the 2000's, featuring structural attempts at increasing the managerial efficiency of health care on the one hand (4.1) and at reinforcing the control and regulatory capabilities of the State over the financing and the planning of the health care system on the other hand (4.2). Previous unsuccessful attempts at curbing social security deficits were indeed attributed by the ministry of health and sickness fund officials to the absence of strong incentives or sanctions mechanisms on health professionals and patients. An increased control by the state and more efficient modes of management are seen by a coalition led by ministry officials in charge of social security supervision (DSS: *direction de la sécurité sociale*), the French audit office (*Cour des Comptes*) and the CNAM as a prerequisite for curbing the social security deficit. But contrary to the attempted reforms of the mid 1990's, the main concern of the government is to appease the tensions which upset liberal health professionals. The autonomy of ambulatory health professionals was thus left almost unchanged by the far reaching regulatory changes which have been implemented since 2002. In the waiting for potential financial savings brought by the institutional changes, cost-containment policies continue to rely on patients' co-payments, thus having important social impacts (4.3).

4.1. Managerial reorganisation of health care through rationalisation of actors' freedom

Compared to national health services, health insurance systems grant greater freedom of choice for the patients and a greater freedom of establishment for liberal health professionals. This ensures a good responsiveness of health care services but this comes at a high financial cost for the health insurance funds and creates territorial inequalities. Hence, many experts have long recommended that the free movement and the freedom of establishment within the health system should be better controlled. The expected benefits of such a regulation are twofold: it would help reduce the cost of health care by controlling medical consumption (and sometimes even abuses) and it would increase the quality of care by improving the coordination of health care services. Although rationalisation instrument have been implemented, the incentives for private health practitioners to provide a more coordinated and prevention-oriented care are still at their early stages. So far, "managerialisation" has gone the furthest in the hospital sector where the State is stronger, while managerial control by the State and the sickness funds of the liberal ambulatory sector remains limited.

Rationalizing patients' choice

The 1995 and 2004 reforms set up new policy instruments in order to better monitor ambulatory care. As it is difficult to confront the professional autonomy of private health care providers, policy-makers turned to restricting patients' mobility within the health system. Some patients are indeed suspected to take advantage of the free choice of providers and request several examinations for a same condition. This weakly documented behaviour is often referred to in the public discourse as "medical nomadism". A convention signed in 1997 by the national sickness fund (CNAMts) and a

general practitioners' Union (MG France) first encouraged patients to choose a general practitioner as their 'referring doctor' to be entrusted with the monitoring of their medical records and to act as a gatekeeper into the health care system. The 2004 reform went one step further and the law is now providing that all patients older than 16 years old must register to a '*médecin traitant*' whom they must consult before any specialist intervention. This 'treating doctor' is most of the time a general practitioner (GP), but could be a specialist in some cases. The first aim of this new pathway for patients is to make savings by avoiding redundant consultations, but it is also trusted to bring medical benefits to patients though a better follow up of their treatments. This measure has been successfully implemented: since 2006, 80% of the insured persons reported their gatekeeper to the national health insurance (Palier 2010). In order to enforce this new system, the government introduced in 2007 a 50% co-payment fee for patients who would disregard the 'coordinated medical pathway' and did not refer to their treating GP before requiring further medical care (*parcours de soins coordonné*). The implementation of such new practices represents a restriction on the freedom of choice, which constitutes a cornerstone of the French liberal medicine, but it was fashioned in a way that it would benefit general practitioners. Potential sanctions are once again directed on patients (increased co-payment) and not on health professionals who even benefit from this new regulation. Indeed, GPs reinforce their central position in the primary care system and specialists are allowed to apply higher charges if patients are not referred by their GP.

The ministry of health also launched in 2004 a system of medical files in order to provide an individual database (DMP – *dossier medical personnel*) on patient's history which could be used by practitioners throughout the health system. Despite the repeated public statements made by the minister of health on the benefits of such device, both for limiting global health consumption and improving patients' health, the DMP system has still not been implemented[7]. This could be explained by the important financial investments needed, the technical and ethical difficulties inherent to such a database, but also by the hostility of many general practitioners towards any device with would affect their professional autonomy.

Rationalizing health care providers' freedom: the key issue of medical demography

The State has only limited possibilities to control the quantitative supply of the liberal ambulatory care and thereby avoid induced over-consumption of medical care. One of the way achieve this is to allow only a limited number of students to start a medical career. A *Numerus Clausus* regulation was introduced in 1978 and contributed to limit the global supply of ambulatory care (although France is still above the OECD average with 3.4 GPs per 1000 inhabitants – OECD 2008). But it did not help to regulate when and where liberal health professionals could establish their activities. In the past years, there has been growing concerns about the lack of general practitioners in certain rural areas and unattractive regions, while Paris and the Côte-d'Azur area are over-medicalized (Cour des comptes 2007, p.192). Despite massive demonstrations by "*internes*" (medical students), the 2009 Bachelot reform managed to impose to medical students a contract by which those who received a funding for their medical studies would have to serve in under-equipped areas ('*contrat d'engagement de service public*').

[7] Assemblée Nationale, « Rapport d'information sur le dossier médical personnel », 29 janvier 2008

Remuneration of liberal practitioners: how to combine lower cost and better public health?

Fee-for-service funding is, together with free choice of patients and free establishment of health providers, a keystone of the liberal health care system. Yet, this mode of health practitioners' funding has a strong inflationist bias and the sickness fund (CPAM) is experimenting new contracts with general practitioners in order to make ambulatory care more cost-effective. Based on British experiments, the CPAM is trying since 2009 to apply a funding system which would lead doctors to focus more on the qualitative dimension of care and on prevention. The '*Contrat d'amélioration des pratiques individuelles*' (CAPI) is being experimented. It guarantees a bonus funding (up to €7 per patient) to general practitioners whose patients reach various health- status indicators, such as the number of elderly vaccinated against the flue, breast cancer screening over 50 and follow up of long term diseases (diabetes and coronary problems). This experiment shows that the French health care system is progressively opening to new modes of health management which combine cost-containment and disease prevention. Prevention is indeed a good economic investment since it will avoid health care consumption in the longer run. The French health system is however still lagging behind Nordic countries in terms of prevention, precisely because of the curative bias of its ambulatory sector and the lack of coordination between health providers.

Managerialisation of hospital governance

Hospital politics have been very controversial in the early 2000's. The so called "crisis" of public hospitals escalated with the difficult implementation to the hospital workforce of the general law limiting working time in 2001 (35 hours a week). In 2001, the Jospin government promised the hospital medical Unions to hire 45 000 new doctors, but staff shortage remained a recurring problem for public hospitals. The sanitary crisis caused by a heat wave during the summer of 2003 put once again this issue on the public agenda[8]. This period of high tension has however deeper roots in structural managerial problems and in the many overlaps between public hospitals, clinics and private medical activities.

Since the first cost-containment policies implemented in the early 1980's, such as the global budget of hospitals, many hospital doctors have voiced their frustrations with the bureaucratic constraints and the general rise of 'managerialism' among public hospital directors (Pierru 2007, p.252). In 2003, a new plan labelled "hospital 2007" brought public hospitals one step closer to private business management, by introducing a new mode of remuneration based on the real activity of hospitals and their health performance (T2A: '*tarification à l'activité*'). The aim of this reform was to foster competition between hospitals by setting private and public hospitals on a level playing field, at least regarding the terms and conditions of remuneration. T2A rules apply to private clinics since October 2004, while public hospitals had until 2012 to progressively implement them. 35% of public hospitals had already implemented the T2A funding in 2007. The many protests this reform triggered prompted the government to postpone from 2012 to 2018 the deadline for achieving the public-private "convergence". The use of T2A as a managerial tool is criticized because it overlooks some of the specific missions of general interest of many public hospitals (emergency care and teaching

[8] http://www.vie-publique.fr/politiques-publiques/politique-hospitaliere/index/

activities) and could eventually lead public hospitals to emulate clinics and focus their activities on the most “profitable” health services (Palier 2005, p271).

Besides these key financing issues, the need for a new “governance of hospitals” has reached the formal political agenda. Hospital doctors and directors are indeed often struggling over the internal organization of hospitals and the autonomy of medical services. The director of hospitals usually consults medical advisory boards (CME: ‘*commission médicale d’établissement’*) when taking important decisions, but the discretionary powers of hospital directors have been reinforced by the 2009 reform, following Nicolas Sarkozy’s motto: “*there must be one person in charge*” (“*un patron et un seul à l’hôpital, le directeur*”, speech, 18 September 2008). While reinforcing hospital directors, the final version of the reform has been watered down by the Senate (the high chamber of the Parliament) and leaves medical matters in the hands of the medical board.

4.2. The creation of State agencies and new territorial organization of health care

The reinforced State intervention in the organization of the health insurance funds, its management and the provision of health care is the most striking change of the last decade. Growing from the seeds planted by the Juppé plan in 1995, the reforms of the 2000’s significantly increased the authority of the State on health care. In this respect, the major novelties of the reforms are the inception of an annual Parliamentary vote on the social security budget, the centralization of sickness fund steering through the creation of the UNCAM and the successive agency creations (regional hospital agencies and since July 2010 regional health agencies). Here the preferred mode of institutional change is layering (Streeck and Thelen 2005), as the creation of new institutions is expected to bring about a reorganisation of health care.

Increased State supervision over health insurance regulation

The power balance between the State and the social partners has been most explicitly altered by the Juppé Plan and the subsequent constitutional revision which introduced the annual Parliament vote on the national health spending objective (ONDAM). In addition to extending the influence of the State in the health insurance system with the vote in Parliament on these national health spending objectives, the health insurance reforms allow greater State interventions in the negotiation of conventions between doctors’ organizations and the health insurance funds. The creation of the national Union of sickness funds in 2004 is a key element of this new architecture (UNCAM: *Union nationale des caisses d’assurance maladie*). This institution is in charge of harmonizing and coordinating health policies between the national insurance (CNAMTS) and other funds. The government directly nominates the director of the UNCAM (who is also the director of the CNAMTS). Frédéric Van Roekeghem, a senior civil servant and former Director of the health minister’s cabinet, was appointed in 2004. His two most important tasks are to determine reimbursement rates and to lead conventional negotiations with the medical professionals, thus marginalizing the administrative board of the funds (chaired by social partners). These administrative boards have been turned by law into advisory boards on which users and parliamentarians are represented. High profile jobs within the health insurance funds have shifted from social partners to civil servants, both at national and at

local level. The institutional model behind this change is the one of state agency (Palier and Hassenteufel 2007).

The regulation of pharmaceutical products followed a similar pattern. The 1996 reform allowed for a tighter control over drug prescriptions and generalized the evaluation of therapies with the creation of a National Agency for Accreditation and Evaluation in Health (ANAES: '*Agence nationale d'accréditation et d'évaluation de la santé'*), recently incorporated within the new top authority on health (HAS: '*Haute Autorité de Santé'*). This agency releases opinions on the efficiency of drugs which could lead to de-reimbursement measures.

Territorial coordination of hospital and health care services

The emergence of health regulatory capabilities is also at work with the creation of regional agencies for hospital care (ARH: *Agences régionales de l'hospitalisation*) in April 1996. The ARH were in charge of the budgets and planning the regional supply of health care (SROS)[9]. Since the 2003 plan "*Hôpital 2007*", the regional agencies fostered the creation of regional health networks in order to improve the coordination between outpatient and inpatient care (CHT: *communautés hospitalières de territoire*). The agencies are in charge of distributing budgets between hospitals, based on an evaluation of the performance of every hospital. Three types of care are identified on each territory: local care (primary care), main hospitals (including surgery and specialized care units) and specialized hospitals (CHU and regional hospitals)[10]. Local hospital mergers and unit restructuring are encouraged in order to make the coordinated care system more efficient overall and less redundant in term of specializations. As a result of this rationalization of the territorial supply of hospital care, local surgery units which were not able to perform more than 1500 procedures annually were to be closed, for obvious cost saving reasons, but also because such small units are considered not routinized enough to keep up with the best quality and safety standards. The government was planning on closing 54 of such surgery units but local governments opposed it strongly and the publication of the application decree has been postponed *sine die* in august 2010. The recently created regional health agencies (ARS: '*Agences Régionales de Santé'*[11]) further embody the commitment of the ministry of health to improving the territorial coordination of hospital and health care services. One of the expected outcomes of this reform is to give a great authority to the regional health agencies directors, who would represent the State (they are nominated by the Ministry of health) and coordinate health policies in the regions, especially as far as health services planning and access to care are concerned.

Although it is too soon to analyse the organizational outcomes of the creation of regional health agencies, it is – at least on paper – an important element of the general strategy of reinforcing the

[9] Ordonnance n° 96-346 relative à la réforme de l'hospitalisation publique et privée (JO du 25 avril 1996)

[10] Rapport Vallancien « Réflexions et propositions sur la gouvernance hospitalière et le poste de président du directoire »

[11] ARS started to operate in July 2010. They are in charge of driving the regional hospital planning (former attribution of the ARH), of the coordination between public and private health institutions, and to determine the funding of health providers

authority of the State on the regulation of both hospital and ambulatory care. But beyond the apparent consensus on the need for organizational change and better regulation, there are still important uncertainties on how actors will respond to this new institutional arrangement. For instance, the newly created ARS overlap by design with some of the planning competencies of the sickness funds. In the ambulatory sector likewise, the collective bargaining between the sickness fund and medical Unions is under tighter supervision by the State since 1996 (the State takes over when social partners are not able to reach an agreement). The legitimacy and ability of social partners to manage the sickness fund has thus been weakened. Likewise, the appointment by the minister of health of the national sickness fund director shows a clear sign of "*étatisation*" of health care regulation (Hassenteufel and Palier 2007).

4.3. The privatization of health risks as a rationalizating instrument

Besides these processes of institutional change, and in the waiting for their potential financial effects, cost-sharing measures are still being implemented in order to cope with the deficit. These privatization reforms are very gradual and routinized policy changes, but their cumulative effect on the access to health care is noteworthy.

Co-payments for ambulatory and hospital care

Cost-sharing measures have been regularly applied to ambulatory care since the 1980's. In 2010, the legal reimbursement rate of ambulatory care amounts to 70 % of the standard social security tariff, but since the 2004 reform, a 40% fee affects to patients who did not follow the 'coordinated pathway' (*see above*). The national sickness fund decided in august 2008 to increase this co-payment measure up to 50% of social security tariffs. After a failed attempt in 1979-1981, the 2004 health insurance reform set up an extra €1 out-of-pocket fee called '*ticket modérateur d'ordre public*' which cannot be covered by any voluntary health insurance fund. While most doctors apply the standard social security tariff, the introduction of the so-called '*secteur 2*' in 1980 created a *de facto* co-payment for patients whose doctor applies free tariffs (read higher tariffs). They are still reimbursed on the basis of social security tariffs (70% out of €22) regardless the actual price of the consultation. As Richard Freeman puts it, "*the expansion of sector 2 provision in France by definition brings with it extra billing*" (Freeman 2000, p.72). The government also introduced co-payment for hospital care (*forfait hospitalier*) in January 1983, which has been regularly revalorized since (20 Francs per day in 1983, 50 FRF in 1991, 70 FRF in 1995). The government decided in 2004 to apply an annual €1 increase to the '*forfait hospitalier'* in order to save each year €0.3 billion. Out-of-pocket payments jumped from €13 per day in 2004 to €18 in 2010. Patients pay in average 20% of hospital costs, but co-payments remain lower than those applying to drugs and ambulatory care.

Reduced reimbursement rates on medicines

The average reimbursement for drugs is about 75% according to the national sickness fund. This figure has been stable for the last decade and is slightly better than in 1995, despite the de-reimbursement of inefficient drugs. Since 1999, an expert Committee (CTM – *Commission de Transparence du Médicament*) is in charge of advising the minister of health to determine the rate of

reimbursement for medicines[12]. These reimbursement rates been severely lowered in 2004 and now vary from 100%, 65%, 35% and 15% according to the medical efficiency of the drugs (SMR: '*Service Médical Rendu'*). In April 2003 the minister in charge of health decided to cut the reimbursement rate from 65 to 35 % for 617 medicines (vignette bleue: '*service médical modéré*'). In March 2006, 152 medicinal products have even been removed from the reimbursement list altogether. Finally, 191 medicines whose medical usefulness is limited are now only reimbursed up to 15% since April 2010 (vignette orange: '*service médical faible ou insuffisant*'). The sickness signed in July 2004 an agreement with two pharmacist Unions (UNPF and USPO) aiming at promoting the use of generic medicines by applying penalties to patients who could refuse to use them.

"Franchises médicales": co-payment 2.0

The 2008 social security financing plan also introduced a new co-payment measure called "*franchises médicales*". It is a 50 cents fee applying to drugs, paramedical and medical acts and thus concerning almost all health expenses. A €2 fee even applies to health transportation[13]. The cumulated amount of these fees cannot exceed €50 per person and per year, but this new co-payment measure nevertheless triggered many protests. For patients' organizations, "*Franchises médicales*" have indeed become a symbol of an increasingly unequal health system which puts a growing financial burden on patients. The government announced that the savings brought by the "*franchises médicales"* are about €850 million each year, which covers less than the half of the annual cost of the 2005 and 2007 consultation tariff increases granted to medical doctor (which cost €2.2 billion according to the French audit office annual report for 2008, p.102). In order to justify these measures, the minister of health announced that the funds collected would be specifically used to finance Alzheimer, palliative care and cancer programs, and that it would not affect long term patients (ALD: *affections de longue durée*).

The polemic about the "*franchises médicales*" unveils a deeper trend within the French health insurance system. In 2008, 16% of the population suffers from an acute or long term disease and are fully covered by a special social security allowance. Overall, 60% of health care expenses are devoted to the treatment of heavy and long term conditions, and they account for most of the increase of global health costs. Meanwhile, the basic health insurance coverage of primary and ambulatory care declined in the past decade to an average reimbursement rate of 65% in 2008 (*see table 2*). So far, acute and long term care have remained well covered by the basic health insurance, but co-payments measures are contributing to the "silent privatization" (Hassenteufel 2001) of "smaller risks".

Co-payments have adverse social impacts in terms of access to care and health inequalities, which are not entirely compensated by the successive extensions of universal health protection. In complement to the general health insurance system, the Jospin government instituted in 1999 a fully

---

[12] Décret n° 99-915 du 27 octobre 1999 relatif aux médicaments remboursables et modifiant le code de la Sécurité Sociale

[13] Loi n° 2007-1786 du 19 décembre 2007 de financement de la sécurité sociale pour 2008 http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000017726554&dateTexte=

universal health coverage (CMU: *Couverture Médicale Universelle*), targeting people who lawfully live in France but who are not ensured, for instance due to their specific employment status (about 1.4 million people benefited from a basic CMU coverage in 2006). If the worse-off are theoretically covered by the CMU system, patients who do not have a complementary health insurance took the biggest hit of co-payment. Since 2004, complementary CMU funding is provided to these insured people who cannot afford any complementary insurance (40 % of the population in the 1970’s, 25 % in the 1980’s and 15 % in the end of the 1990’s – Destais 2003, p. 132). However, it is estimated that the access to health care is often denied by practitioners to the beneficiaries of the CMU scheme (41% of specialists and 39% of dentists in 2006 – European Commission, 2008).

****

A new health system is unfolding in the late 2000’s. Deep structural change occurred in the last decade, allowing the State to better control the management and the organisation of health care services in France. The question still remains whether the government will be able or willing to enforce its new regulatory tools and to turn them into effective and lasting cost-containment measures. The autonomy of liberal medical practitioners remains indeed a strong limitation to the rationalization process of health care supply, and meanwhile, patients affected by “small risks” are asked to carry the costs of cost-containment.

5. Conclusion

For the last three decades, reforms of the French health system have mainly been directed at reducing the deficit of the health insurance system. Thirty years of health insurance reforms merely slowed down the rise of health expenditures. It grew from 7.6 in 1980 to 9.4% of the gross domestic product in 1994. It then stabilized in the early 2000's and went back on the rise since 2001 (now reaching 11% of the GDP). The deficit of the health insurance funds followed the same trend, reaching 13.6 billion in 2004. It went down to 4.4 billion in 2008 and increased again up to 9.4 billion in 2009. Although comparisons on health expenditures are uneasy, French health expenditures are still among the highest in the OECD (The average health expenditure in France was $3601 per inhabitant in 2007, more than the average of OECD countries – OECD "health at a glance" 2009, p.161) and the consumption of drugs in France is among the highest in the world (Haut Conseil 2004, p. 88-89). But the health spending per inhabitant increases slower than most of OECD countries since 1997 (2.5% per year in average, against 4.1 in average for all OECD countries)

Despite its uneven results, the strife for limiting health expenses and the health insurance deficit has been the focal point of the numerous reforms which have been implemented. We pointed out three main streams of reforms which correspond to main three periods in the politics of health care reform in France since the 1970's. Financial plans increasing the funding for health insurances and attempts at reducing the demand for health services have been implemented since the 1990's. These regulatory instruments have been partly supplanted in the 1990's by supply-oriented regulatory reforms, first through negotiation and then through law. A third sequence started in the early 2000's, after the difficult implementation of the Juppé plan in the second half of the 1990's. This period is marked by strong territorial and managerial re-organizational reforms of the health care system, as well as renewed co-payment measures.

Dramatized announcement of new deficit highs have certainly created a favourable political context for important changes and could explain partly the timing of the reforms (deficits peaks occurred in the early 1990's, just before the Juppé plan, and since 2001). But how to explain the different contents of the institutional changes implemented during the two latter sequences? Although the inspiration of the reforms often originated from abroad (as for instance the concept of 'managed care' invented in the United States in the 1970's or the recommendations of international organizations), their implementation is triggered by a combination of learning from failed reforms and the power struggle between "change actors" (Mahoney and Thelen 2010). An "elite of welfare" emerged in the late 1980's and constructed a shared diagnosis about the need to reinforce the State control and to pay more attention to managerial efficiency in the provision of health care (Hassenteufel *et al.* 1999). The institutional specificities of the French health insurance system and the key role of liberal doctors in the system make the implementation of these regulatory changes arduous. While comforting the diagnosis about the need for clearer State competencies and managerial control over health policies, the third stream of reform marks the return of a more conciliatory attitude towards medical professionals. Instead of confronting their autonomy, the reforms focus on patients' responsibility and on the partial privatization of health risks.

Hence, institutional and organisational change of the French health system could be summarized into three main categories of reforms than have been used differently during the three sequences: The most spectacular dimension of change is the redistribution of competencies among public actors (between the State and health insurance fund and between the State and hospitals). The territorial reorganisation of the French health system has undoubtedly accelerated in the past years, leading to a greater '*étatisation*' of health care regulation. This trend has a limit however, as no public regulator is yet able to enforce in the annual spending objectives set voted by the Parliament, especially in the ambulatory sector. The two other types of institutional change that we observed are the introduction of managed competition between health care providers and the partial privatization of health risks. Managerialisation and privatization both follow a micro-economic rationale of promoting the responsibility of actors and improving the efficiency of the system. The distribution of power between professionals and managers has shifted to the advantage of the later in public hospitals. Managerialisation is most noticeable with the development of tariffs based on the performance of health providers (T2A). Once again, it is much less obvious when it come to the management of ambulatory care supply, despite recent and still shy efforts to address issues such as medical demography and new experiments on performance-related funding of private practitioners. Instead, the distribution of health care costs between the State and the citizen has been consistently altered to the expense of the latter._Privatization of health risks occurs in terms of increased patient co-payment for a wide range of non acute health needs. Interestingly, privatization of risk is the only measure which has been used throughout the three sequences of health reforms, contrary to managerialisation and *étatisation* which date back from the second wave of reforms. This recurrent phenomenon could be explained by the need to find alternative ways to cut the deficit of the health insurance, as long as medical restrain cannot be fully implemented. An implicit political choice has thus been made over time: freedom and responsiveness of the health care system prevails over the principle of equal access to health care.

6. Tables

Table 1: National health spending – expected and actual annual deficits

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
National health spending objective (ONDAM)	+ 1.7%	+2.4%	+1.0%	+2.9%	+2.6%	+4.0%	+5.3%	+4.0%	+3.2%	+2.5%	+2.6%	+2.8%	+3.3%
Real variation	+1.5%	+4.0	+2.6%	+5.6%	+5.6%	+7.2%	+6.4%	+4.9%	+4%	+3.1	+4.2%	+3.3%	
Difference	-0.2	+1.6	+1.6	+2.7	+3.0	+3.2	+1.1	+0.9	+0.8	+0.6	+1.6	+0.5	

Sources: Commission des comptes de la Sécurité sociale, Cour des comptes

Table 2: Funding structure of health expenditures (in %)

	Hospital		Ambulatory		Medicine	
	200 care	200	care 200	200	200s	200
Social	092.	890.	06	86	065.	864.
Sta security	21.	61.	17.	15.	11.	81.
t Complementary health	14	5.	230.	270.	159.	126.
insurance		3	8	8	2	5
Household	2.	2.	10.	12.	14.	17.
s	7	8	9	5	2	5

Sources: Drees, 2009, comptes de la santé 2008

7. Bibliography

DESTAIS, Nathalie (2003), *Le système de santé, organisation et régulation*, Paris : LGDJ.

FREEMAN, Richard (1999), *The Politics of Health in Europe*, Manchester: Manchester University Press.

HASSENTEUFEL, Patrick (2001), « Liberalisation through the State. Why is the French Health System becoming so British? », *Public Policy and Administration*, vol. 16 (4), 2001, p.84-95

HASSENTEUFEL, Patrick et al. (2000), « La libéralisation des systèmes de protection maladie européens. Convergence, européanisation et adaptation nationale », *Politique européenne*, n° 2, September, p.29-48

HASSENTEUFEL, Patrick (2009), « Le rôle de l'Etat dans la régulation de l'assurance maladie. In : Traité d'économie et de gestion de la santé », Paris : Editions de Santé ; Paris : SciencesPo LesPresses, 2009

HASSENTEUFEL, Patrick, PALIER, Bruno (2005), « Les trompe-l'oeil de la "gouvernance" de l'assurance maladie : contrastes franco-allemands », Revue française d'administration publique, special issue « Les métamorphoses des politiques de santé », n° 113, pp. 13-27.

HASSENTEUFEL, Patrick, PALIER, Bruno (2007), "Comparing Health insurance Reforms in Bismarckian Countries towards Neo-Birsmarckian Health Care States?", Social Policy and Administration, "Comparing Welfare Reforms in Continental Europe?", December 2007, pp. 574-596.

MAHONEY, James, THELEN, Katleen (2010), *Explaining Institutional change*, Cambridge: Cambridge University Press.

MORDELET, Patrick (2008), *Gouvernance de l'hôpital et crise des systèmes de santé*, Presses de l'ENSP.

STREECK, Wolfgang, THELEN, Kathleen (dir.) (2005), *Beyond Continuity. Institutional Change in Advanced Political Economy*, Oxford, Oxford University Press.

PALIER, Bruno (2005), Gouverner la Sécurité sociale : les réformes du système français de protection sociale depuis 1945, Paris, Presses universitaires de France, Le lien social, 2d edition.

PALIER, Bruno (2010), *La réforme des systèmes de santé*, Paris : PUF, « Que sais-je ? », 5th edition.

PIERRU, Frédéric (2007), *Hippocrate malade de ses réformes*, Bellecombe-en-Bauges : Ed. du croquant

European Commission, *Joint Report on Social Protection and Social Inclusion 2009 - France*

IRDES, *La réforme de la santé en France 2003-2007,* *http://www.irdes.fr/EspaceDoc/DossiersBiblios/RefSystSante.pdf*

OECD report "Health at a glance 2009"; OECD Health Data 2010

Loi n° 2002-322 du 6 mars 2002 portant rénovation des rapports conventionnels entre les professions de santé libérales et les organismes d'assurance maladie

Loi n°2004-810 du 13 août 2004 relative à l'assurance maladie

Loi n°2005-1579 du 19 décembre 2005 de financement de la sécurité sociale pour 2006

Loi n°2006-1640 du 21 décembre 2006 de financement de la sécurité sociale pour 2007

Loi n° 2007-1786 du 19 décembre 2007 de financement de la sécurité sociale pour 2008

Loi n° 2008-1330 du 17 décembre 2008 de financement de la sécurité sociale pour 2009

Loi n° 2009-1646 du 24 décembre 2009 de financement de la sécurité sociale pour 2010

Loi n° 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires

Ordonnance n° 2010-177 du 23 février 2010 de coordination avec la loi n° 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires