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The search for the Holy Grail: combining decentralised planning and contracting mechanisms in the French health care system

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Summary

France has recently adopted one of the least market-oriented models for reforming its health care system, where competition does not feature at all prominently in the overall policy design.This country has a strong tradition of top-down public administration, and health professionals, trade unions and the general public are all uneasy about the idea of introducing market forces and privatising public health provision. The main reforms discussed in this article were based on planning, rationalisation, cost-containment, efficiency and equity. However, some embryonic changes and emerging practices can be detected which might seem to relate to the 'new public management' approach, and which could also serve as a basis for future market initiatives. Copyright © 2005 John Wiley & Sons, Ltd.

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The structure of the French health care system

The French health care system is largely based on a national health insurance system known as the 'Social Security' system. The principles of this system were set out in the Government Ordinance of 4 October 1945. The provisions of this Ordinance included national solidarity, the sharing of resources, equality of all in the face of illness, and free access to health care services. This resulted in universal coverage and uniform benefits, but funding was based on salary-related social contributions [1]. However, this insurance-based system has been gradually supplemented since 1991 by additional taxes such as the General Social Tax (CSG).

The principle of free access has meant that patients have had complete freedom to choose their health providers up to now, as shown in Figure 1. Physicians are free to choose their place of work and their type of practice. Furthermore, the public–private mix in the health care supply sustains the principle of pluralism: ambulatory care is mainly private, and is financed on a fee for service basis, whereas the public sector is mainly responsible for hospital care, since it accounts for two-thirds of the hospital beds.

The structure of the French health system and the main changes which have occurred in terms of funding and coverage over the last few decades will now be described. These changes include adopting a more economic approach, introducing potential incentives and taking the outcomes into account, as opposed to the former short-term accounting balance system. This new attitude underlies most of the measures included in the 1996 Ordinances – the so-called Juppé Plan, named after the Prime Minister at the time – reforming the French system of health care and health insurance funding.

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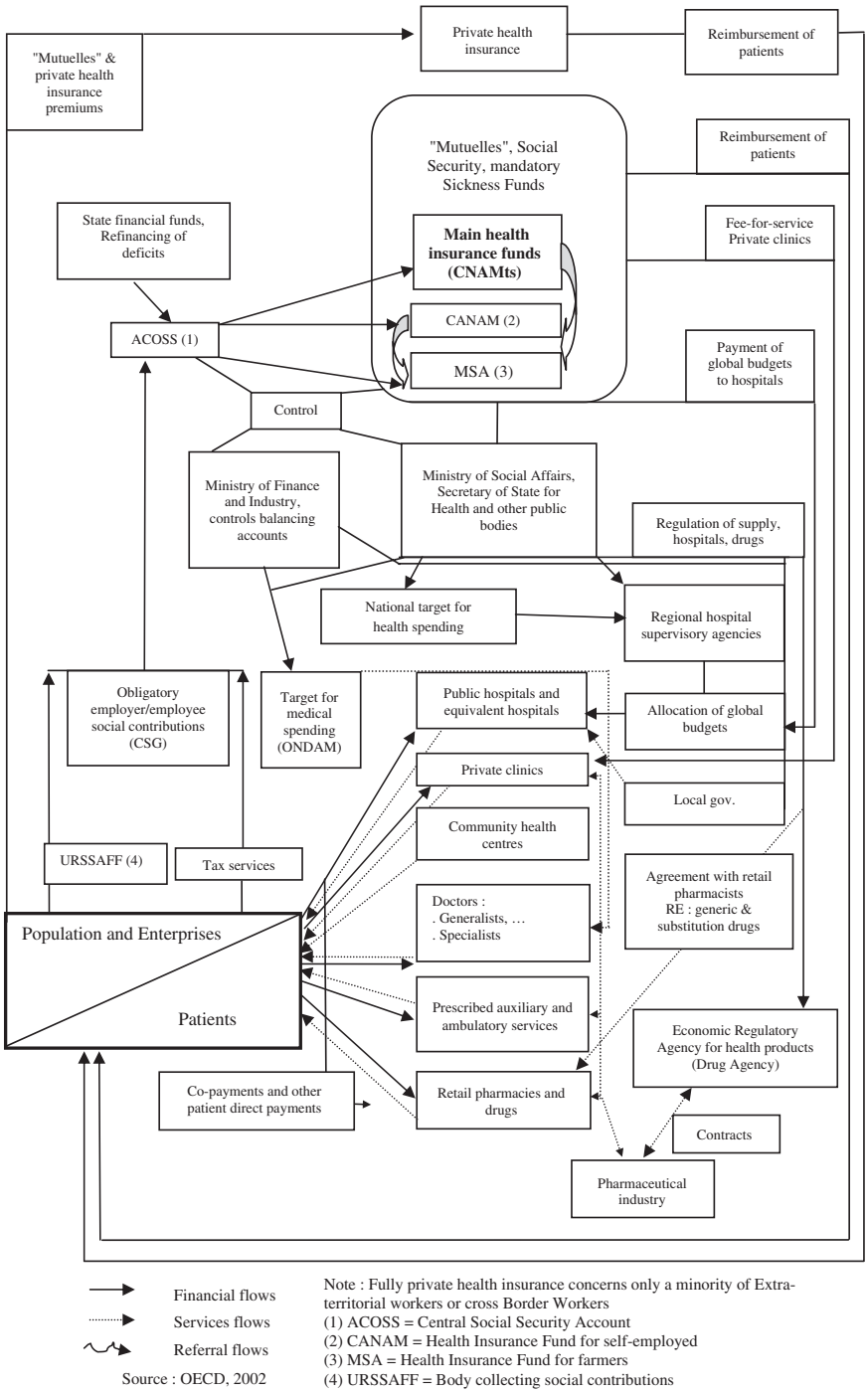


Figure 1. The French health care system, post 1996 reform

Sickness funds: key players – but no price competition

There are three main health insurance schemes and several smaller ones, which covered 99.8% of the French population in 1999. The remaining 0.2% were included in the statutory health insurance system only in 2000, when Universal Health Coverage (CMU) was introduced. Complementary health insurance, which is voluntary and provided by private insurers and mutual associations (Figure 1), and is mainly a third-party payment scheme, has expanded greatly over recent decades, involving about 85% of the population in 2000, and generally covers the co-payments in the basic statutory scheme.

The National Sickness Fund (CNAMTS) is the largest insurer and operates under what is called the 'General Social Security Scheme'. It covers all workers and pensioners, as well as the unemployed and their dependents, amounting in all to about 84% of the population. This organisation has a pyramidal structure, involving a national office, regional co-ordinating funds and local offices called primary funds. There are two other important health insurance schemes: the agricultural fund (MSA) and the fund for the self-employed (CANAM), covering 7 and 5% of the population, respectively. The primary funds of the three main schemes collaborate in a newly created institution, the Regional Union of Health Insurance Funds (URCAM), which monitors ambulatory care expenditure. In addition, sixteen specific funds cover workers in specialised occupations and their dependents. There is a long-standing tendency to depart from the traditional Bismarckian roots and to merge the specialised funds into the general one. One particularly noteworthy feature of statutory health insurance in France is the absence of market competition between the various sickness funds.

As can be seen from Figure 1, local bodies collect the General Social tax and employment-related social contributions. The money is then transferred to the National Social Security Agency Account, which manages and allocates resources to the sickness funds. Global and bilateral risk pooling occur, where the CNAMTS makes compensatory payments within the General Scheme in order to avoid disparities between the regional primary funds. The *ex post* demographic compensation mechanism used to adjust funding across health insurance schemes does not fully equalize risks [2]. In addition, the French State is bound to make up the recurrent deficits from which the National Health Insurance (NHI) suffers. Since the origin of this system, this weakness has threatened to undermine the power of the regulation system based on equal representation between employees and employers. However, this mechanism has also had positive effects, especially since it has protected the system as a whole from the private insurers wanting to enter the market. Furthermore, the system's habitual state of financial crisis enhances the key role which has always been played by the State, and the crisis has therefore never taken the form of a sudden event liable to result in a '*coup d'Etat*'.

Figure 1 also shows that the financial flows are relatively complex, since almost every segment of the health care system has its own resource allocation process. In addition, the regional level is now involved in the funding process and will become increasingly integrated. In fact, regional agencies and local state administrations are already dealing with hospitals, pharmacies, ambulatory care and private clinics. Their scope is still quite narrow, however, in comparison with that of the central state administration, although a project is being drawn up at the moment to reduce the co-ordination costs, as the result of which all these various bodies may possibly be merged into a single regional health agency.

Health policy: strengthening performance measurement

As far as the economic aspects of health policy are concerned, successive French governments have been attempting for the last 40 years to implement a variety of cost-containment initiatives known as plans, or '*plans de redressement*', most of which have been unsuccessful. The degree of governmental resolve has differed, as these plans were designed in at least two different economic contexts, before and after the mid-1970s.

Up to the mid-1970s, the main goal of health policy planning was to sustain general economic growth, facilitating what French economists called the '*déversement*' (a wide redistribution process) from the economic to the social side of society. In this 'Fordist system', all health policies were expected to mediate investment in human capital. Policies of this kind were costly as they inflated the demand and generated a huge public deficit. The

administration succeeded, however, in implementing this planning policy via special 'commissions', or 'organisations' such as the 'Commissariat General du Plan'. This Government agency ran a vast popular and administrative survey in order to draw up the main social and economic priorities for the following five-year period. This resulted in a large consensus, the effects of which were enhanced by economic growth.

The landscape changed at the end of the 1970s. The Government's Keynesian policy failed in the end to boost the economy. Short-term compromises on efficiency and equity replaced the 'plans'. Considerable efforts began to be made to reduce public health spending on hospitals and two main tools were adopted for this purpose. In 1979, a nationally defined growth rate was set, limiting expenditure on public hospitals, and in 1983, prospective global budgets were introduced. The 1990s took a more rationalising trend, as reflected in some institutional and instrumental changes, such as the creation of a Regional Hospital Agency (ARH) in each of the 26 French administrative regions and the implementation of a Diagnosis Related Groups (DRGs) system. This was a half-hearted attempt to include case-mix adjustment in prospective budgets. Quantified national targets limiting expenditure at private hospitals and ambulatory care were set in 1992 and 1993. Since the mid-1990s, national and regional 'agencies' have been the key institutions in the battle to improve health care performances in terms of quality, efficiency, safety, equity and outcomes.

In the case of France, unlike that of other European countries, there is no theoretical starting point or 'blueprint' such as the 'White paper' in the UK or the 'Dekker Report' in The Netherlands. However, some hints as to what future policy is likely to involve can be detected in the final chapter of a report drawn up in 1993 by some French health economists for the 'Commissariat General du Plan' [3], where the accent was on contracting and decentralisation. These two objectives were chosen with a view to modernising State intervention, based on the feeling that health expenditure could be contained and standards nevertheless maintained only on condition that the actors were directly involved. The latest efficiency objectives were therefore based on the involvement of local players in the decision-making process. This approach is congruent with the economic theory of bureaucracy, which states that whenever the level of decentralisation becomes an incentive to co-operate, the efficiency of the whole system will increase [4].

Health care funding: the shift from salary related contributions to an earmarked health tax

One key problem encountered by the French 'Social Security' system in the 1990s was the constant deficits, for which health care expenditure was mainly responsible. Most experts have argued that social contributions increase the labour costs and adversely affect employment [5]. The Juppé plan provided the starting-point for reforming the funding mechanisms. The financing source was shifted partially from payroll contributions to a general tax based on people's total income. The aims were first to widen the General Social Tax base, which was expected to compensate for the decrease in payroll tax which had occurred due to the high level of unemployment and to the dwindling active population, secondly, to contribute to reducing the public deficit, and thirdly, to improve both the consistency and the efficiency of the 'Social Security' system, thus making it fairer [6]. Since 1998, the earmarked General Social Tax levied on income at a rate of 5.25% has replaced most of the previous employees' contributions to the social health insurance funds. This tax is also levied on unemployment benefits and sickness benefits at a rate of 3.95%, and on pensions at a rate of 4.35%, making an increase of 0.40% in the latter case, as prescribed by the Act on Health Insurance of 13 August 2004.

The General Social Tax is now one of the main sources of national health insurance funding, accounting for approximately 34% of the total in 2003. A special fund, was also created in order to manage the new 'social debt repayment tax'. This tax was set at 0.5% of the total income and is levied on the whole population, with the exception of a few exempted groups. The Jospin Government kept this tax, although the Socialist Party was against its creation in 1996, and in the end, the said Government actually accelerated the process of substituting social contributions for the General Social Tax.

Health insurance is gradually becoming an instrument for redistribution, since it is being financed via income tax [7,8]. From the equity

point of view, the CSG is taking two opposite directions. First, as it is applied to revenues of most kinds including pensions, property rental and interest from shares, and not only to salaries, it provides greater equity than payroll taxes. On the other hand, however, the CSG is applied to only about half of each individual's taxable revenue. This means that the wealthiest tax-payers are exonerated from large amounts of income tax. This 'deductibility' is an example of what Merton has called 'the Matthew effect' [9]. Here we have a case of regressive distribution practices, or what the French economist Perroux used to call redistribution the wrong way round ('*à contre sens*'), giving more to the rich and less to the poor. This result is congruent with Wagstaff and Doorslaer's first findings (WDEA), which yielded a low negative Kakwani index. However, it is difficult to conclude *a priori* whether the funding of the French health system is showing a progressive or regressive trend, for at least two reasons. First, due to the change in the methods used to make WDEA assessments, especially in terms of the equivalence scale for income and health care payments, the index was positive and this makes sense, since the French NHI system includes both high and low earners [10–12]. The second reason is that the basis of CSG calculation has often changed. The latest change has focused on the percentage of the earned income on which the CSG is based, which went up in January 2005 from 95 to 97%. The impact of the shift from social contributions to earmarked taxes as means of funding the NHI has not yet been assessed in terms of vertical equity.

Introducing Universal Health Coverage

Since 1 January 2000, Universal Health Coverage (CMU) has been covering the neediest members of society. The first part of the CMU provides all those residing lawfully in France with basic coverage, irrespective of their employment status or their insurance contribution record [2]. The second and most important part, in quantitative terms, provides free complementary coverage, on a third party payer basis, for those whose income is currently less than EUR 576 per month per person or EUR 864 for two people living together. A more generous tax policy is also being gradually introduced to encourage the growth of complementary insurance. In 2003, complete CMU coverage was made available to about 2% of the population, who benefited from a 'basic package of goods and services' defined *a priori* by law. This package includes ambulatory and hospital services as well as health services such as dentistry and optics, for which most patients are generally reimbursed at a lower rate, on the basis of a set price [13]. Apart from those benefiting from this package, the general rules, such as the co-payment rules, are applied to those insured under the CMU system, which is financed by the basic statutory and complementary schemes. The mutual associations and commercial insurers are allowed tax credits of about EUR 227 a year per person enrolled, to meet the cost of complementary coverage.

The current CMU is not quite in line with the objectives initially announced. It does not resemble Clinton's 1992 plan, which was also named 'Universal Coverage'. In fact, almost every French citizen already had the right to national health insurance coverage, which has always been 'mandatory'. One might say that the egalitarian goal was achieved even before the CMU was introduced. To give the word 'universal' greater reality, the socialist government therefore decided to introduce a third-party payment scheme. This affected not only the policy goals, but also the economic principles underlying the reform. The CMU shifted from an egalitarian approach ('universal' coverage) to a Rawlsian idea of public welfare (i.e. a completely free basic package for the poorest). This approach leads to policy goals where the worst-off members of society are made to benefit the most from a given policy.

Resource allocation, incentives and appropriateness of care

Budget allocation

Three-quarters of the resources allocated each year to running the health system come from statutory health insurance funds, and the remainder from individuals either in the form of direct payments to the providers or indirectly via the contributions paid to the mutual associations or private insurers for complementary health insurance coverage [14]. In discussing budget allocation, it is proposed to look at the decision-making and resource distribution processes managed by the mandatory

Table 1. Evolution of the ONDAM: targets voted versus reality (%)

	1997	1998	1999	2000	2001	2002	2003	2004	2005
ONDAM voted	1.7	2.4	1	2.9	2.6	4	5.3	4	3.2
ONDAM observed	1.5	4	2.6	5.6	5.6	7.2	6.4	5.2	–

schemes, which can be described as 'strategic resource allocation processes' [15].

Up to the 1997 Act, health insurance expenditure was supervised by the 'social partners' in charge of sickness fund management, namely the employers' and employees' unions. The weakness of the protagonists' management and enforcement skills obviously led to compromises: increasing the expenditure and budgets provided a means of avoiding choice-linked conflict, for example. To tackle the deteriorating financial situation of the NHI, the Juppé Plan introduced budgetary reforms. Since then, Parliament has been voting an annual national health insurance spending objective (ONDAM), which sets target financial limits on health insurance expenditure by the NHI. As shown in Table 1, this target has never been reached, or only in 1997, the first year.

The Government splits the overall target into sub-targets between health care sectors, namely public hospitals, ambulatory care, private clinics and social care (institutions and services for elderly and disabled people), and between the regions as far as public hospital expenditure is concerned. Let us now look at how the resources are allocated to public hospitals.

In order to gradually reduce the regional disparities in health status and health care, while focusing on local public health priorities and the organisation of the health care system, the Government is distributing hospital budgets according to a new regional resource allocation process. First a target sum is worked out and secondly, a convergence method is used to reach this target. Allocations are based on a needs indicator including medicine, surgery and obstetrics (MSO) and long term care, and on a calculated efficiency indicator. When assessing needs, three sub-indicators are used. The health needs indicator is determined by comparing the regional standardised mortality ratio (SMR) with the national average. The hospital needs indicator is based on 'equality of resources to meet the needs', and is calculated taking the regional demographic structure into account. The third sub-indicator focuses on the expenditure corresponding to the MSO patient flows in the various regions. The economic efficiency (i.e. regional productivity) indicator is measured by comparing the regional average activity index with the national average.

The second stage in the process of allocating resources to the regions is to make the actual observed budgets converge with the targets. In practice, the convergence method introduced by the Government was intended first to bring the three least well funded regions (Nord-Pas-de-Calais, Poitou-Charente, and Picardy) up to the level of the fourth last on the list (Alsace), secondly, to ensure that moderately under-funded regions (such as Burgundy and the Central region) will move towards the target level, and thirdly, to provide the best-funded regions (such as Ile-de-France, Provence, and Midi-Pyrénées) with only the funds necessary to sustain their performances [14]. There is only slight evidence that the system of regional readjustment introduced in 1997 has worked. In 1999, an accelerated system was introduced to help the three poorest regions to catch up. By the end of 2001, the gap between the actual regional budgets and the target budgets was still substantial. However, there is some evidence that this system has by now partly compensated for the low endowment levels of the latter.

At the individual hospital level, given the regional rate of increase, a slight adjustment is made in order to take into account the actual costs and case-mix. However, this mechanism deals with only around 2% of the total budget.

Payment of providers

Payment of doctors, dentists and pharmacists

Sixty-two percent of physicians work in solo practices, and the remainder are in small group practices. The physicians contract with national

health insurance funds and are paid on a fee-for-service basis according to a nationally negotiated fee schedule. Tariffs are set via a formal process of negotiation between the government, sickness funds and professional representatives. A move from 'contracts' to constraints clearly occurred during the 1993 and 1997 negotiations between the NHI and the physicians. This led to an agreement to restrict health care spending and its volume, not only by pre-defining limits but also by introducing 'medical references' relating to the non-use of specific medical procedures, examinations, clinical tests and drug prescriptions ('Référence Médicales opposables').

The real income of French GPs and specialists increased annually from 1990 to 2001 by 0.5, and 0.7%, respectively. Some economists analysing the health care system in terms of the social dynamics have observed that the fees for services are particularly inflationary in the context of the oversupply of physicians [16] and that they are also liable to increase the income range among physicians [17]. There currently exist considerable differences in annual income among specialities, and these have increased over the last twenty years. In the year 2002, the average annual income earned by ambulatory physicians (i.e. those practising 'médecine liberale': see below) ranged from 55 000 EUR among GPs to 100 000 EUR among cardiologists and anything up to 200 000 EUR among radiologists.

In this sector, despite its tradition of 'liberalism', there used to be no price competition. However, in 1980, bowing to pressure from the physicians, the Government created a 'Secteur II' for those who wanted to opt out of the NHI scheme. Members of this sector are practically free to fix their own fees, which can exceed those negotiated at the national level by as much as 50% on average. Patients themselves and complementary insurance schemes pay for the difference. Those who have opted for this system, accounting for about 38% of all specialists and 15% of all GPs in 2001, have to pay higher social insurance contributions but their professional benefits are higher than those of 'Secteur I' physicians (although the differences vary among specialities). Given the great importance of physicians in the decision-making process, cartel practices of some form or another are liable to develop, since the pattern of distribution shows the existence of particularly large numbers of 'Secteur II' physicians in some areas and some specialities. Case-studies have shown that supplier-induced demand can be measured using data on 'Secteur II' physicians' practices and their density. These studies show that the strength of the induction capacity varies among specialists, depending on their position in the health care channels [18]. It is also worth mentioning that under-the-counter modes of payment are rather common in both hospital and ambulatory settings, especially in the case of surgical operations.

Dentists are also paid on a fee for service basis. As the actual cost and prices are higher than the NHI tariff, patients themselves have to pay for most of the dentistry care they receive.

French pharmacists mainly practice on a private, individual basis in private retail pharmacies. However, about 10% of them work in public and private hospitals. Individual, independent pharmacists' income comes from the sale of medicines, medical devices and other products, such as cosmetics and fitness-related items. Around 80% of the medicines purchased by patients are largely reimbursed by the NHI. The recent trend towards better resource allocation in the area of pharmaceuticals has led to an attempt to promote the use of cheaper generic drugs. Since 2001, pharmacists have been encouraged to substitute generic drugs for the branded forms when delivering physicians' prescriptions, while maintaining their profit margins. The number of retail pharmacies authorised to set up shop is fixed on the basis of population size criteria. However, in 2003, there were about 23 281 retail pharmacies owned or managed by pharmacists (i.e. one for every 2400 inhabitants in France, as compared to the average of one for every 3500 inhabitants in the rest of Europe). These high numbers are mainly due to the fact that since physicians' prescriptions are not actually limited, the pharmaceutical market is more profitable in France than in many other developed countries.

Hospital payments

The introduction of prospective budgets for public and for non-profit hospitals was intended to improve cost control, but did not actually decrease the costs. These objectives were defined on the macroeconomic level in terms of resource allocation. On the microeconomic level, hospitals could continue to be cost-inefficient. Yet one of the theoretical prerequisites for policy objectives and micro-financial mechanisms to fit together is the

existence of links between resource allocation and case-based hospital payment.

Nevertheless, some reforms have been attempted to improve the hospital information and funding processes. The 'Programme de Médicalisation du Système d'Information' (PMSI) provides hospital discharge records which are the French equivalent of DRGs, called 'Groupes Homogènes de Malades' (GHM). Since the hospital reform measures passed in 1991 were enforced, the PMSI has been introduced at all public hospitals. An 'implicit price' resulting from the calculation of an activity index – 'Indice Synthétique d'Activité' (ISA) – has made for better relations between hospitals and payers, thus strengthening the hospital funding process based since 1998 on the local ISA. The budget now depends on both specific hospital costs and an adjustment based on a regional case mix index giving the mean cost per case [19].

This process might imaginably give rise to fictional competition between the providers: it seemingly mirrors Shliefer's principle of yardstick competition [20], as each hospital's prices depend on those of the others, and hospitals thus become 'price takers', 'compelled to work as if they were in competition and minimise their production costs' [7]. However, the present case of 'yardstick competition' does not in fact completely fit the theory. For instance, hospital autonomy is not great enough to trigger competition, at least in the public sector. Managers' internal decisions are governed by strict rules (as to the numbers of staff per hospital bed, for example). Organising a sort of 'auction' between hospitals, thus creating a completely competitive situation, would be both unrealistic and inefficient. On the contrary, the current hospital budgeting system is still based on historical data, and does not take sufficient account of the efforts made by each hospital to improve its performances. However, PMSI data will be increasingly used to allocate resources.

Since the 1990s, contracting has been one of the main strategies used to improve the resource allocation process. The contracts are based on a five-year 'hospital project' that has to fit into the regional plan (SROS). The theoretical aims of these contracts are to avoid transaction costs and to fill the information gap between the health insurance system and state agencies on the one hand and individual hospitals, on the other hand. However, this potentially useful contracting procedure between Regional Hospital Agencies (ARHs) and hospitals, which serves to clarify objectives, is just one aspect of efficient hospital governing [21]. The ARHs have to restructure the hospital supply to match local needs, but the suppliers are given no strong incentives. Hospital funds are allotted mainly on the basis of previous activities. In addition, public hospitals know that despite their endemic deficits, they cannot go bankrupt.

Moreover, the contract between each hospital and the ARH is now part of an information game where opportunistic behaviour sometimes occurs. Only 20% of all French hospitals had signed contracts of this kind by the end of 2000.

This finding is surprisingly consistent with agency theory: as long as the incentives (i.e. the promise of a larger budget) are too weak for hospitals to feel like openly declaring accurate information about their actual costs, quality, and changes of activity to the ARHs, there is nothing rational about signing contracts. The Director of an ARH is not a political agent. He can nevertheless be said to be one of the 'public choice theory victims', since he may prefer social peace to implementing efficient but heavy-handed policies. Some tacit collusion is also liable to occur between the Director of an ARH and the hospitals, to the detriment of the principal agent (i.e. the central Government) [22,23]. The number of contracts signed in 2003 is said to have increased, but no national data are available so far on this point. This increase may be attributable to the constraints imposed by the ARHs on each hospital, since contracting has now become mandatory for private for-profit hospitals.

As far as for-profit hospitals are concerned (these account for around one-third of the hospitals, one-third of the admissions and a quarter of the beds), the financing system is mainly based on per diem prices. In 1992, these establishments were included in the National Quantified Objectives (OQN), which focus on the total share of private hospital expenses for which the national health insurance system pays. Since 1996, this objective has been integrated into the national health insurance spending objectives (ONDAM) mechanism and regionalised. All fee-paying interventions carried out at these 'clinics', as they are called, are subject to the tariffs set by contract with the Regional Hospital Administrations. If the overall annual target is overshot, tariff readjustments can be introduced in the framework of agreements between private hospital owners'

organisations and the State. The main impact of this process has been to favour ambulatory care and elective surgery in the for-profit sector.

Experiments on a system known as 'tarification à l'activité', are now under way with a view to merging public and private hospital financing systems. This new financing system involves both lump sums (for activities such as emergency wards and research) and a French Prospective Payment System (PPS). As this rather complex mechanism is gradually introduced into the allocation process, it will be possible to assess the effects on hospital strategies. The goal of this assessment will be to tune the fee schedule to targeted objectives, mainly to improve equity [24]. However, looking at the US experience, it is predictable that given the huge differences between the cost structures of private and public hospitals, the main effect of this effort towards harmonisation will be that specialisation will benefit from the economies of scale achieved.

One of the main features of the whole system is the huge range of hospital costs arising at each GHM/DRG. As Henriet has noted, 'this inequality is prejudicial both in terms of equity and efficiency' [25]. The resource allocation process encourages the better-off hospitals (those where the costs are lower) to make false declarations about their case mix, for instance, while the less well-off hospitals (those where the costs are higher) have to reduce their activities. Therefore, implicit prices do not reflect the true situation and can lead to opportunistic behaviour. Recent studies carried out by the French Ministry of Health have shown that the costs differ widely between hospitals, mainly due to regional differences. This finding confirms that current differences result from the historical budgets allocated before the PMSI was established. The results of a study performed in 2002 actually show that the differences decreased slightly between 1997 and 2001, since the poorest regions had become better endowed. In any case, the definition of the PMSI base has changed every two years, and new items therefore need to be taken into account in the calculations. These data could also be used to assess acute care efficiency [26]. In a recent study, it was concluded on the basis of these data that public hospital productivity is increasing on the whole in France, since activity (estimated in terms of the total number of ISA points) is increasing, while the real prices (taking the changes in the case mix variations into account) are decreasing [27].

Appropriateness of care

One prerequisite for appropriate care is a sufficient supply of physicians. The main quantitative method adopted in France for this purpose is the *numerus clausus* defining the number of students admitted to the second year of medical studies. When the *numerus clausus* was first created in 1971, this number was approximately 8600, but in order to prevent an over-supply of physicians, it was reduced to 3500 in 1993. Demographic projections have shown that to maintain the relative number of physicians per capita at the 2001 level, it would be necessary to increase the numbers admitted sharply from 5100, in 2003, to more than 7000 per year by 2010. This policy has to deal with two contradictory objectives: maintaining the traditional monopoly enjoyed by the French medical profession [28], and improving health care provision in some geographical areas and some specialities. Incentives have therefore been introduced to encourage young physicians to settle in departments such as central France and rural areas where there is a shortage of doctors.

Members of other professions, such as dentists and nurses, are regulated in a similar way. In 2003, the *numerus clausus* for dentists was 903. The number of state nurses' diplomas is determined by each nursing school, whether or not it is attached to a hospital, and depends on national assessments. The underlying rationale here is that decreasing the numbers of health professionals will prevent the supply-induced demand mechanism, which causes inefficiency and wasted resources, from coming into operation. The current shortage of nurses, particularly in the private sector, is due mainly to the work conditions rather than to the salary level as it was some years ago. In France, the idea of doctors allocating previously medical tasks to nurses is being studied, but is far from being ready to put into practice.

As far as quality is concerned, French health professionals are highly skilled and qualified. However, lifelong training is a much weaker point, and a long conflict between physicians' organisations, the NHI, and the State has resulted in a situation where consistent on-the-job training is almost impossible to set up. Here again, although the issue apparently focuses on who should pay, the most important point has been maintaining a high level of physician autonomy in the decision-making process. As a result, most new medical information is disseminated by pharmaceutical

companies via scientific meetings and visits by sales representatives.

To improve this rather inefficient system, there has been a move towards evidence based medicine. For instance, the 'Agence Nationale d'Accréditation et d'Evaluation en Santé' (ANAES) releases guidelines that are increasingly followed by physicians. These guidelines are now accepted by the majority of French physicians because they are written by peers and involve no direct incentives or penalties.

The French Government also deals with the appropriateness of care whenever it refuses to reimburse medicines which yield purportedly insufficient health benefits. Decisions of this kind are in fact mainly taken for financial rather than public health reasons. What needs to be changed is the French pharmacists' habit of selling more pills than strictly necessary; but this practice is mainly due to the strength of the pharmaceutical industrial lobby.

Likewise, the growing concern about nosocomial infections and medical errors is a sign that quality and appropriateness of care need to be tackled by the health care system. Nosocomial infections cause about 9000 deaths every year and are now continuously assessed as part of the hospital accreditation process. In the ambulatory field, one indicator of this growing concern about medical errors was the fact that private insurance companies recently decided to increase their rates for physicians wanting to protect themselves from the consequences of malpractice claims from patients. However, the Government does not want France to become as addicted to malpractice trials as the USA. It has therefore been decided in the short term to help physicians to pay their insurance rates and in the long term, to change the law to protect physicians from the risk of unjustified legal procedures.

Access and outcomes

General issues

One of the main features of the French system is the fact that it gives free access to health care, making no distinction between primary and secondary care. Patients who need health care have been free so far to choose which physician they consult and have also been allowed to refer themselves to specialists. They could choose between public and private hospitals and between outpatient and hospital treatment. Most general practitioners have not yet started to play the role of gatekeepers, although a few of them have been making some attempts on these lines since 1996.

The recent reform on Health Insurance is about to change the landscape. By July 2005, all those benefiting in France from health insurance coverage must choose their main physician ('*médecin traitant*'). As a result, it will cost them more to consult a specialist directly, without being referred by their '*médecin traitant*'. However, the new rules are still flexible (the main physician can be either a GP or a specialist, for example, there are no geographical constraints and the cost incentives are fairly weak).

In France, physicians and patients certainly attach great value to their freedom of practice and choice. Partly as a consequence of this tradition of freedom, complementary health insurance is widely purchased (by around 86% of all French households in 2003) to cover co-payments. Rather than containing expenditure, recent cost sharing initiatives have therefore promoted voluntary health insurance coverage. A recent study undertaken at IRDES has shown that complementary coverage has significantly affected the use made of physicians' services, as individuals with complementary coverage actually consult physicians considerably more frequently than those without [29].

User charges

Between 1980 and 2003, the public share in health care spending decreased from 79.4 to 75.5%. A restructuring plan launched in 1993 reduced the rates of health expenditure refunded to individuals by the NHI. Concomitantly, the role of complementary health insurance has increased to 12.3%, and the contribution of user charges to total health expenditure, which amounted to 10.9% in 2003, is much higher than in other European countries. In addition, since January 2005, insured persons are being charged a one-Euro co-payment fee for each outpatient medical intervention or consultation and each medical laboratory test they undergo. This one-Euro user charge is not covered by the complementary insurance schemes.

Two contradictory trends can be observed at present. The first centres on the increasing numbers of insured people who benefit from

universal health coverage or who are covered because they have a specific long, chronic disease. The implementation in 2004 of a special insurance fund for the elderly is the latest example of this long-term trend, the aim of which is to keep the level of social solidarity as high as possible while decreasing the out-of-pocket user charges. For example, the number of patients benefiting from 100% coverage increased recently because the list of relevant diseases was extended. The contradictory trend is that some less visible decisions are being taken to shift the health care burden from the State to the patient. For instance, in order to reduce the cost to the NHI of the increasingly large '100%' population, the total reimbursements will be restricted to health care items explicitly prescribed to treat the main pathology, and expenditure on injuries resulting from sports and other obviously risky activities will be reduced.

Waiting lists

The French health care system supports a large relative number of practising physicians per capita, amounting to 335 per 100 000 members of the population in 2002. This figure increased steadily over the last two decades from 193 per 100 000 in 1980, and this is one of the main reasons why waiting lists are not really a problem in France. The greatest increase has occurred among specialists, who were more numerous than GPs in the mid-1990s. However, the general growth of the number of both specialists and GPs has been slowing down since the early 1990s. One particular characteristic of the French system is that an increasing number of specialists hold two positions, one in the public hospitals and one in the private sector, the latter of which yields a higher income in many specialities. This has led to a shortage of physicians in some specialities such as anaesthetics and psychiatry at public hospitals.

Likewise, based on the figures available on hospital nurses, the supply, in terms of the labour force, is showing a long-term increase, since there was an annual rate of about 3% between 1980 and 2001. In other countries, the lack of supply is the main reason why the problem of waiting lists has been on the agenda for over 30 years. This problem does not arise in France, where the inputs into the health care system are not only numerous, but have also been increasing steadily for more than half a century.

It sometimes happens of course that in some rural and mountainous areas and in some medical specialities, medical resources are relatively scarce. However, even in these cases, waiting list-related problems are not a real issue: this relative shortage simply makes access to medical care more difficult than elsewhere, since patients living in these areas have to travel to the cities to consult a physician.

Outcomes

During the last decade, improving health gains has been a core aim in many statements relating to health policy in France. The 2004–2008 Public health bill will focus on reducing the burden of disease and premature death on both individuals and communities. In order to reach these objectives, larger amounts of money will be allotted to medical research and the public health sector will benefit from larger resources. In addition, national campaigns to fight alcoholism and tobacco-related diseases have been launched. However, nothing has been scheduled up to now as far as assessing the impact of this new law. Greater stress has also been placed on morbidity and its effects on quality of life, especially in the case of cancer, via a national plan, and cardiovascular disease.

One of the objectives of the 1996 reforms was to improve the links between public health policies, health priorities and resource distribution. However, health services are just one of the interrelated factors involved in health outcomes and health inequalities in the country. In France, the social and spatial inequalities are relatively more pronounced in terms of prevention than access to health care. There is also evidence that these inequalities are more conspicuous than in other European countries [14]. Furthermore, some indicators have worsened, especially in the fields of perinatal health and HIV infection [14], and life expectancy at birth was found to be more than ten years shorter in some parts of northern France than in the south [30]. There is also evidence of discrepancies between social groups, such as those observed in a comparative study between skilled workers and executives and members of intellectual professions during the 1992–1996 period, when the gap in terms of life expectancy at age 35 was 6.5 years [31]. The mortality risk is three times higher for the unemployed than for working people [32], and many authors have concluded that inequality is on the increase [33].

An IRDES survey on health and social protection (SSP) has been carried out every 2 years since 1998, and gives two overall invalidity and vital risk scores. A score higher than 1 indicates a low health status, given comparable age and sex. The disparities in morbidity between socio-economic groups observed with this measure are still very large: for instance, unskilled workers were found to have an invalidity risk score of 1.13, while that of executives and members of intellectual professions worked out at 0.86. Similar differences were noted between the vital risk scores, which amounted to 1.1 versus 0.93, respectively. From Figure 2, based on 1998 SSP data, disparities in morbidity can be seen to exist, due to differences in income among working people. Other factors, such as educational level, access to information and the social environment, also have an impact on access to care. Collet has observed that people living under precarious conditions are reluctant to seek health care, even if the services are free of charge [34].

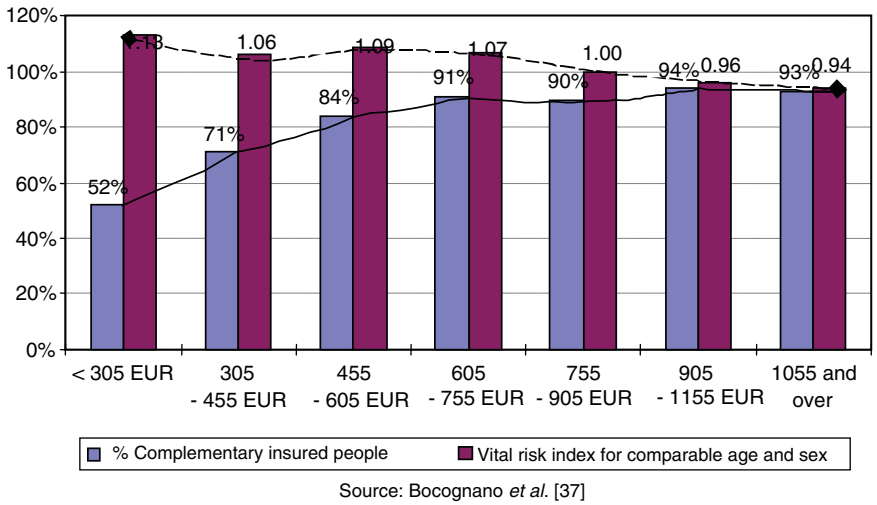
The 'Haut Comité de la Santé Publique' (HCSP) experts have noted that despite the context of overall health improvement, the topic of health inequality has been less well documented in France than in other countries. The reason for this situation is that greater importance has been attached in this country to the performances of the health care system. Huge resources have been mobilised for this purpose, and this has given rise to the illusion that we have an egalitarian system catering for equally distributed needs. However, since the mid-1990s, some interesting reports and studies have provided useful data and analysis on this particular topic [14].

The future

On the whole, the French health care system is still a highly administered but effective system, which has been improved in terms of productivity, quality and equity over the last decade. However, all attempts to radically eliminate excess costs and wasted resources have failed as if the French system was too path dependent on stakeholders' situation rent.

Classical theorists assessing this system and its related reforms in strictly rational terms would no doubt conclude that this system lacks incentives. However, the content of the reforms and the history of their implementation show that it is not so much the lack of incentives *per se* from which the reforms are suffering in France as the lack of involvement of those who work within the system in the continuous definition of incentives and control mechanisms. Incentives are not something which is granted in this system: they are rather embedded in the social structure [35]. Therefore, for a reform to be effective, it is more important to achieve a consensus about its implementation than about its goals.

In the near future, one key dynamic factor is the certification process which is being applied



Source: Bocognano *et al.* [37]

Figure 2. Health status and Voluntary Health Insurance (VHI) coverage per Unit of Consumption (UC)

throughout the whole French health care system, starting with hospital accreditation. From the technical point of view, accreditation simply provides an opportunity to assess, control, and rationalise ongoing work organisation and practices. From the bureaucratic point of view, it might be seen as a means of filling the information gap between providers and purchasers. The fact that ANAES, a national Agency closely linked the Ministry of Health, is responsible for the accreditation process indicates that it might play a role of this kind in the future; and the fact that the accreditation report is available on the Ministry of Health web site is also a sign that ANAES will soon be strongly involved in the rationalisation process.

However, from the economic point of view, the game seems to be more open. The accreditation process is developing and extending the concern for quality among all providers. The board of administration of the French NHI recently asked to have a kind of quality assurance procedure introduced for ambulatory care and networks of health care providers. In addition, private insurers have already implemented managed care tools of this kind. Along with the regionalisation of the French health care system, quality assessment and management is about to give a new dynamic impulse to reform initiatives that has been mainly focusing on cost containment up to now.

Reflecting this move, ANAES has become the 'High Health Authority' ('*Haute Autorité de Santé*'). As prescribed by the 2004 Act, it will deal with the whole spectrum of medical practices and draw up guidelines and assessment processes on a large scale.

All in all, recent developments in French health policy therefore suggest that a new reshaping of the whole health care system may be in sight. This reshaping is occurring in response to the need for a 'new governing' approach because many stakeholders are involved in the system of economic regulation. Starting with some new means of coordination, such as health care networks and quality assurance, a gradual move is also being made towards a more integrated picture of health economy no longer focusing on acquiring the latest technology and increasing the numbers of highly skilled staff. This picture is based on the idea that some improvements, whether in the field of prevention or those of cure and care, can be brought about by appealing to people's sense of social and individual responsibility, on similar lines to what is already being done to tackle working conditions, cancer, road accidents, disabilities, and many aspects of elderly people's living conditions. All these social issues are now at the top of the French health, social, and economic policy agenda.

Strangely enough, this move has been reinforced by the recent positivist belief that a rational economic approach will clarify the choices to be made. It is also worth noting that greater attention is now being paid to the relationships between inputs and performances in the decision-making process. This means that new emphasis is being placed on the efficiency of health providers at all levels, and is about to be implemented for public health priority setting purposes. This general trend, which will involve all public sectors, is in line with the new Organic Law on Finance Laws ('Loi Organique Relative aux Lois de Finances' LOLF). Actually, although the French health care system has the economic expertise necessary to define appropriate policies at the theoretical level, it may lack the qualifications and know-how required to implement them. The forthcoming challenges are therefore likely to be institutional and ethical rather than financial ones.

The efficiency of the future French system might be said to depend on its ability to improve its consistency, using the regional structures as a lever. Although the move towards contractualisation is still rather slow, it can at least be said to provide a means of harmoniously combining market forces and planning tools. If this is achieved, and if regional health insurance and local state agencies come to be managed by citizens acting as regional representatives, the monopsonic public health insurance system will really be able to act on behalf of the consumers [36].

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