

Pernicious myths about public health insurance in France

Since 1945-46, the French system of Social Security has been imposing a mandatory health insurance and thus has a captive clientele - as the insured are compelled to finance it.¹ This system has been, and is still, justified in a great measure in the opinion of the general public on grounds that it allegedly leads the French people to become equal in health and provides financing of all the cares they might need.

Yet, more than sixty years after, one can wonder whether both of these justificatory grounds do not turn out to be myths. Faced with the impossibility of financing all the health needs felt by the French population, successive governments have settled down to contain healthcare expenditures, the result being a growing bureaucratization of the health system. In fact, it is high time to contemplate the possibility of restoring competition and leaving more room to individual choice in the area of healthcare.

The myth of equality in health

In the eyes of the general public, one of the main justificatory grounds for the mandatory Social Security system is that it allegedly bestows - through universal coverage in a single public insurance plan - equal access to required medical care. By operating redistribution from wealthy persons to poor ones, and from healthy persons to those who are in poor health, it is assumed that it allows French people to become ultimately equal in health.

However, for several reasons, it turns out that it is illusory to believe that the imposition of a single public insurance plan can make the insured equal in health.

First of all, it is obvious that health is conditioned by several factors other than merely the coverage from which everyone benefits - one thinks here, for example, of lifestyle, professional occupation, genetic inheritance, and so on. Under these conditions, it is not surprising that disparities in the mortality rate endure in France, both from a geographical point of view and among different socio-professional categories. For instance, the inhabitants of Midi-Pyrénées have a life expectancy at birth which is almost 4 years higher than that of the inhabitants of Nord-Pas-de-Calais². And,



male cadres have a life expectancy at the age of 35 years which exceeds that of male workers at the same age by 7 years³ - the same phenomenon can be observed, though to a lesser degree, for female cadres and workers.

Further, one must realize that holding the same insurance cannot by itself guarantee an equal access to medical resources. In fact, significant inequalities as to this access still exist nowadays. For instance, the number of physicians per head of population varies a great deal among the different regions of France.

Thus, for every 100 000 inhabitants, there are 423 physicians in Ile-de-France, on the one hand, and only 249 in Picardie, on the other⁴.

Even hospital resources - though under the direct supervision of public authorities - are also unevenly allocated: the number of hospital units, physicians, beds and medical equipment varies significantly from region to region.

Disparities also exist in the way different groups of insured persons benefit from the health system. For example, whereas unskilled workers tend to consume more of hospital care - and thus cost more to the public insurance - than other groups at the same age and for the same sex, cadres for their part consume more drugs or ambulatory care (consultations with a general

¹ This is the case with the mandatory plan for the insured working in non-agricultural professions. The farmers' mandatory plan was put in place in 1961. See, among others, Georges Lane, "Economie appliquée de l'organisation de la sécurité sociale : De 1945 à 2005", available at: <http://blog.georgeslane.fr/category/Economie-appliquee-de-lorganisation-de-la-securite-sociale/page/5> and the Website of the French Social Security, *Historique du système français de sécurité sociale*, available at : http://www.securite-sociale.fr/comprendre/histo/historique/gdes_dates.htm.

² See the Report of the High Council on the Future of Health Insurance, entitled *L'avenir de l'assurance maladie : l'urgence d'un -->*

--> *redressement par la qualité*, Appendix 49, 2004, p. 222, available at: http://www.rees-france.com/article.php3?id_article=22.

³ The data concern the period 1991-1999. See Christian Monteil and Isabelle Robert-Bobée, from the Demographic Survey and Research Department of the Insee, "Les différences sociales de mortalité : en augmentation chez les hommes, stables chez les femmes", *Insee Première*, N° 1025, June 2005, available at: http://www.insee.fr/fr/ffc/docs_ffc/IP1025.pdf.

⁴ See the Report of the High Council on the Future of Health Insurance, *op. cit.*, Appendix 52. Data relate to the year 2001.

practitioner or a specialist, dental care, optical care, biological tests, and so on)⁵.

Lastly, even if the mandatory status enjoyed by French Social Security does allow redistribution in favor of those who cannot afford the cost of their healthcare, it also gives rise to several instances in which redistribution proceeds in the opposite direction, that is, at the expense of the poorer people.

The most obvious instance - one which is likely to become more common with the ageing population - is that of an unskilled worker or an employee with a low salary who is in good health (the risks that he falls ill are low) and who finds himself compelled to contribute an abnormally high percentage of his revenues to be insured. He finds himself obliged to subsidize the expensive care of the elderly, even if the latter can have amassed a sizeable patrimony throughout their life and, thus, find themselves in a much more comfortable situation.

The myth of unlimited resources

The second belief is that by "collectivizing" the financing of healthcare through mandatory public insurance, the French people - who do not know what they are really paying - could leave the coverage of almost the totality of their health needs to the community. They thus get the impression that collective resources have become unlimited and that, if need arises, additional taxes simply have to be levied with the help of the government.

Thanks to the redistribution carried out by the public insurer, it would thus be possible to meet all the health needs that could be felt by the French people, and so, independently of the level of their revenues. The choice thus forces itself upon us. Who would not opt for a system which guarantees that all patients receive the treatments they are in need of?

But, here again, we are dealing with a myth. The fact is that in the area of healthcare as in every other area of economic activity, resources are scarce and limited. In the face of the alleged quasi-gratuitousness of care due to this imposed "collectivization", it is the demand for healthcare which is soaring. This accounts for the fact that the public health insurance scheme has recorded deficits almost since its inception in the 1950s. Thus, the latest deficit, as recorded in 2005, amounts to 8 billion euros for the Social Security general health insurance regime alone, that is, approximately 6% of the national target for health insurance spending (ONDAM) for this same year⁶.

⁵ See the Report of the High Council on the Future of Health Insurance, *op. cit.*, p. 35 and Appendix 7.

⁶ See the Report of the French Court of Audit, *La Sécurité sociale*,

The "collectivization" of the costs of healthcare also has indirect consequences. Indeed, the mandatory contributions on which the latter rest - as is the case with genuine taxes - stifle economic activity and undermine the competitiveness of firms located in France. By raising the cost of labor, they also turn out to be a cause of unemployment.

In brief, the system of Social Security has consequences to which politicians do not remain insensitive. This might explain that politicians are constantly trying to limit and control *in fine* health expenditures and the public funds which are allocated to this end.

Arbitrary delisting and growing bureaucratization of the health system

Forced to take into account the plain economic reality about the necessary limited character of resources, public authorities have, for more than thirty years, implemented reforms in order to decide in the place of patients which of their needs deserve to be fully covered or not.

The introduction and the extension of individual patient's co-payments (the so-called *tickets modérateurs*) for ambulatory care or the purchase of drugs are examples of the cost containment measures of public health insurance.

More recently, instead of leaving patients - advised by their physician, if need arises - assess the utility of different products or medical apparatus on their own, authorities have chosen to confer this assessment to a public agency, the *National Health Authority* (HAS). In case the utility of a product or medical apparatus is judged to be insufficient (in bureaucratic jargon, if it has an insufficient medical service rendered (MSR)), the product or the apparatus is not reimbursed by public health insurance, with its ultimate beneficiaries, namely, patients, simply having no say in the matter.

Yet, as emphasized in a report published by the French Court of Audit (Cour des comptes), in the case of drugs, "(when a) product with an insufficient MSR is delisted from reimbursement, this does not imply that it is not efficient for a given pathology, but simply that the collectivity prefers to commit its resources, which are inherently limited, to other reimbursements which it deems more useful from a collective point of view."⁷ Thus, instead of satisfying all the health needs of the French population, the imposition of public insurance leads to arbitrary decisions by bureaucrats on behalf of

September 2006, p. 7 and p. 78, available at : <http://www.ccomptes.fr/cour-des-Comptes/publications/rapports/secu2006/rapport-secu06.pdf>.

⁷ See the Report by the French Court of Audit, *op. cit.*, p. 44.

the population.

But, this is not the end of the story. The existence of a *de facto* public monopoly in the area of health insurance also has consequences for the health system as a whole. Public authorities are, indeed, also in the position of exercising control over healthcare providers. In this respect, since the early 1990s, health policy in France has taken a new direction, a direction which has been re-affirmed by the reform implemented in 2004.

Till then, Social Security was first and foremost a public insurer whose major function boiled down in a great measure to providing coverage. A control over the supply of healthcare already existed through devices such as regulated fees, the regulation of the activity of physicians of the sector 2, or still again, the "health map"⁸ for hospital care, but these measures had remained quite limited. Nowadays, the tendency towards planning and overall organization of the healthcare system⁹ is becoming more pronounced. As highlighted by the High Council on the Future of Health Insurance, "health insurance can no longer content itself with being a mere payment agency for self-organized healthcare providers."¹⁰

Personal medical files, elements of a "gatekeeper" system relating to attending physicians and specialists and imposing caps on health expenditures (through ONDAM) figure among the multiplicity of measures adopted in the spirit of complete control of the health system.

Such measures can prove themselves to be useful in a really competitive context where they must pass the "market test"; in this context, the insured enjoy the possibility of changing their insurance company if they are not satisfied with the services it offers. However, in the context of a "captive clientele" like that of Social Security in France, these measures can transform themselves into a mere cost containment policy leading to a centralized planning and a growing bureaucratization of our healthcare system by public authorities.

⁸ The "health map" is a Soviet-type device used by the government seeking the planning of the needs and the allocation of hospital resources.

⁹ This is a quite common practice in the United States through the organization of integrated networks of healthcare (Health Maintenance Organizations or HMOs). In contrast to traditional insurance companies, HMOs organize and supply the totality of health care to their members. Contrary to what obtains in France however, competition exists among HMOs and on the part of traditional insurance companies. The insured can sanction the choices of HMOs and opt for a competing insurance company if the services provided by their HMOs do not meet their expectations. It is this competition which urges HMOs to use strategies in order to contain costs only when their use constitutes a genuine value-added for the patients.

¹⁰ See the Report of the High Council on the Future of Health Insurance, *op. cit.*, p. 7.

The inefficiency and the dangers of bureaucratization

A well-developed and competitive system of physicians in private practice and a hospital supply which is both public and private are the traditional advantages of the French health system compared to the fully nationalized systems that prevail in countries such as the UK or Canada. It is these advantages that account for the greater flexibility of the health system and that, ultimately, guarantee care to French patients without the need of being placed on waiting lists, contrary to the situation in those countries.

But, because of the impossibility of equality in health and in response to the limited character of resources, the French system is gradually transforming itself into a system of bureaucratic rationing of healthcare. Under the pressure of cost containment, this transformation occurs at the expense of patients and the freedom of exercise of health professionals. It is not a coincidence if the *High Council on the Future of Health Insurance* already makes clear that we must "raise ourselves questions about the legitimacy of the complete freedom enjoyed by health professionals in setting up their private practice."¹¹

Under the growing pressure of cost containment of the public health insurance, French people are witnessing the gradual erosion of the advantages inherent to their health system. However, not only is bureaucratic cost containment of healthcare not likely to generate the intended effects, but it is also likely to lead to poor quality of service to patients. Even in countries which resort systematically to central planning and wholesale bureaucratization of their health system, public spending continues to soar.

In this respect, the case of Canada is illuminating¹². Abiding by inflation, public spending per capita has almost doubled in 30 years in this country. In spite of this sizeable increase, there exist significant waiting time for receiving healthcare: not only has waiting time not decreased, it has actually soared between 1993 and 2006, going up from 9.3 to 17.8 weeks in average¹³. In such a system dominated by public monopoly for medically required care, patients suffer and

¹¹ See the Report of the High Council on the Future of Health Insurance, *op. cit.*, p. 23.

¹² See Valentin Petkantchin, "Using private insurance to finance health care", Economic Note, *Montreal Economic Institute*, 2005, available at: http://www.iedm.org/main/show_publications_en.php?publications_id=117.

¹³ This refers to the median waiting time between a referral by a general practitioner and the beginning of treatment, averaged across all specialties. See Nadeem Esmail, Michael Walker and Dominika Wrona, "Waiting your turn: Hospital waiting lists in Canada", *Fraser Institute, Critical Issues Bulletin*, October 2006, p. 37, available at: <http://www.fraserinstitute.ca/shared/readmore.asp?sNav=pb&id=863>.

sometimes die while they figure on waiting lists before receiving needed treatments. The Supreme Court of Canada stresses indeed that "there is unchallenged evidence that in some serious cases, patients die as a result of waiting lists for public health care."¹⁴

To the drawback of a monopoly in the area of public health insurance, one must add the drawbacks and the inflexible character of a public healthcare system for Canadian patients.

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Restoring competition

If we do not wish to suffer from the drawbacks of this public policy of cost containment and of rationing in the future, it is time to consider a genuine opening of the area of health insurance to competition and, simultaneously, grant greater freedom of practice to health professionals.

In such a system, it will always be possible to finance the health coverage of the poorest persons through "health insurance" voucher checks, if need arises. This system would allow them to contract health coverage plans from the insurers of their choice, while at the same time taking advantage of the competition among different insurance companies.

The willingness of authorities to provide health insurance to destitute persons does not necessarily justify the institution of a single mandatory public insurance system like that of Social Security in France. It is one thing to grant public assistance to destitute persons by financing their health coverage directly, and quite another, to engage in vain attempts at controlling and conducting wholesale planning of the system in the hunt for a hypothetical balanced budget.

After all, European countries like Switzerland, the Netherlands, or Germany, have a health system which is not based upon on such a mandatory single public insurance - at least, not comprehensively in the case of Germany. The insured people can choose among competing insurance companies and insurance companies can compete among themselves, even if this competition remains regulated.

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Conclusion

What makes the mandatory system of Social Security attractive in the eyes of the general public in France is that it allegedly allows the insured to be equal in health and provides unlimited financing of all their health needs.

Unfortunately, both arguments turn out to be genuine myths, and, faced with the inherently limited character of medical resources, public authorities and Social Security have engaged in overall planning of the healthcare system. France faces the risk of joining the rank of the group of countries where the existence of rationing of healthcare and waiting lists raises serious problems as regards the access to care by those who need it.

Much on the contrary, instead of nationalizing the healthcare system, France should open the area of health insurance to competition and leave more scope to individual choice concerning health coverage for the insured, greater freedom of choice for patients and greater freedom of practice for health professionals.



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Printed in Belgium

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¹⁴ See the judgment of the Supreme Court of Canada in the *Chaoulli vs. Quebec* affair, returned in 2005, point 123, available at: <http://scc.lexum.umontreal.ca/en/2005/2005scc35/2005scc35.html>. As a consequence, this judgment has ordered to lift the ban on private health insurance in the province of Quebec, thereby logically repealing on the same occasion the monopoly enjoyed by public health insurance.