Economic Note

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Valentin Petkantchin

IEM Institut Economique Molinari

The ineffectiveness of health cost containment policies in France

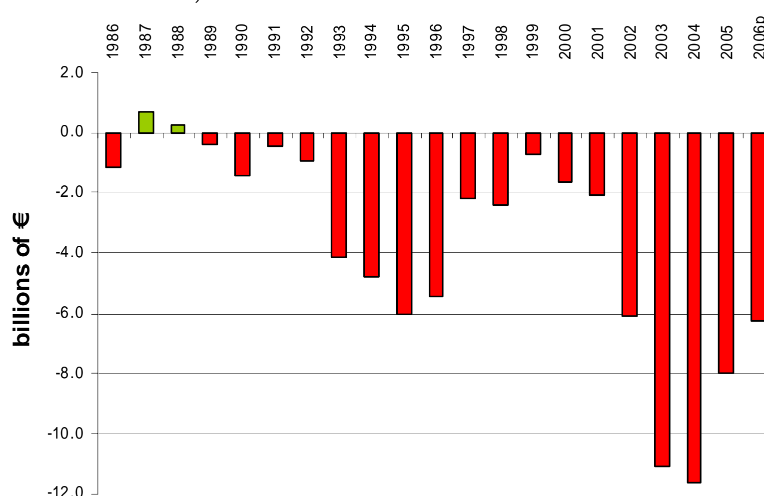
In order to contain the cost of public health insurance, public authorities in France have implemented various rationalization plans with the hope of restoring the balance of its accounts. In the face of the ineffectiveness of these plans, they have introduced - especially since 1996 - a multitude of health cost containment measures as well as measures of control over healthcare delivery to patients. Yet, these measures also turn out to be ineffective and deficits are chronic. In the setting of the Social Security monopoly, these measures are, on the other hand, likely to render the overall health system more inflexible and bureaucratic at the expense of patients.

The ineffectiveness of rationalization plans before 1996

Till 1996, the different plans sought above all to restore balanced accounts of health insurance through an increase of social contributions (removal of the ceiling on the salary base of payroll contributions in the Durafour Plan of 1975, for example) and/or a decrease of the reimbursement rates of some treatments or medical products.[1] Some plans imposed a reduction of the reimbursement rates to patients and a corresponding increase of co-payment fees (the Barre Plan in 1976), the introduction of a hospital co-payment fee (Bérégovoy Plan in 1982-83) or, still, an increase of this co-payment fee (Bianco Plan in 1991). In the same vein, the Veil Plan of 1977-1978 led to a decrease in the reimbursement rates of drugs, judged as non-essential, so-called comfort drugs. As regards vitamins, they have been delisted from reimbursement by the Séguin Plan in 1986-1987.

Even if these plans have led to the balance of the accounts of the general public health insurance scheme during some years, they have not had a lasting effect. After 1988, it has constantly been in the red (see Figure 1).

Figure 1 : The balance of the general health insurance scheme in billions of euros, 1986-2006



Note: projected figures for 2006.
Source: Eco-Santé France 2007.

The failure of cost containment measures

Faced with the fact that resources are not unlimited and that it is more and more difficult to increase social contributions in France, public authorities decided to introduce a set of additional measures in their attempts to contain health expenditures.

In this perspective, the 1996 reform marks the introduction of a new instrument, namely, the national target for health insurance spending (the ONDAM), which the Parliament approves every year. The principle which underlies this measure falls within a purely accounting logic that seeks to limit healthcare expenditures over a given period. But, in its application, the ONDAM has not gone with financial sanctions for health professionals in case of overspending and, except for 1997, the year when it was introduced, such overspending has characterized the ONDAM. Accumulated overspending till 2005 thus amounts to more than 13.5 billion euros (see Figure 2).

Furthermore, the management of the health system through measures like the ONDAM suffers from major drawbacks, and it is illusory to believe that these measures can provide an effective solution to the problems faced by the public health insurance scheme.

[1] On the different rationalization plans between 1975 and 1995, see Frédéric Rupprecht, "Evaluation de l'efficience du système de soins français", Appendix A of the Mougeot Report, entitled "Régulation du système de santé", La Documentation française, 1999, p. 160, available at : http://www.ladocumentationfrancaise.fr/rapports-publics/994000153/index.shtml.

First of all, the underlying rationale of the ONDAM consists in setting sub-objectives such as expenditure targets for ambulatory care, public hospitals, private clinics, and so on. But, planning for healthcare expenditure in this way may turn out to be completely detached from reality, and cannot serve as an instrument of sound management of the healthcare system. For example, in 2005, the expenditure target for ambulatory care has been overvalued by 430 million euros while that of public hospitals and private clinics has been underestimated by 700 million euros.[2]

Next, it is important to realize that compliance with the ONDAM does not automatically entail, for all that, a balanced budget for the health insurance scheme. For example, in 2005, real expenditure was, within 40 million euros, close to the target, but the public scheme still registered a deficit of 8 billion euros, as regards the general scheme alone.

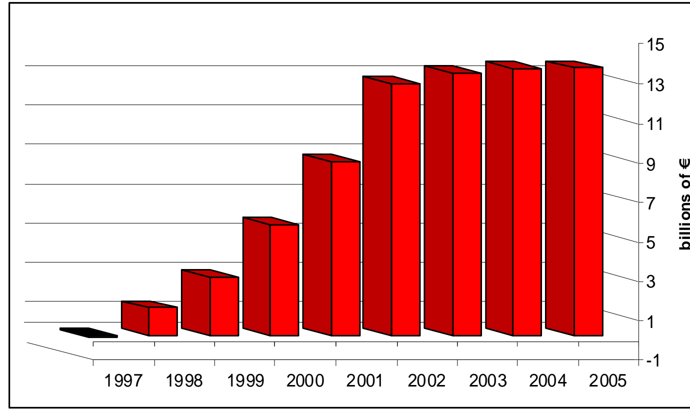
Since the introduction of the ONDAM, and abiding by inflation, accumulated deficits between 1997 and 2006 amount to more than 49 billion euros (in constant 2000 euros)[3], that is, twice more than during the previous decade. It is thus patently obvious that measures taken in order to contain health expenditures since 1996 have not solved the problem of the deficit of public accounts.

A tougher control over health cost containment?

But, faced with non-compliance with the ONDAM, is it not sufficient to sanction health professionals in case of overspending in order to guarantee that cost containment is successful?

This proposal overlooks several issues. First, if the ONDAM had been applied in France in such a way as to sanction healthcare providers in case of overspending, there is a greater likelihood that it would have been complied with, but it would also have led to a genuine rationing of healthcare. Indeed, who would be ready to provide healthcare if he finds himself sanctioned for having generated healthcare expenditures in excess of targets?

Figure 2: Accumulated overspending of the ONDAM in billions of euros, 1997-2005



Source: Eco-santé France 2007; author's calculations.

Other pernicious effects can come with these drastic measures. Healthcare providers - that is, the ones who are most under the threat of sanctions - will in all likelihood not hesitate to refer patients to other physicians or hospitals in order not to bill the required treatment. If the bill tends to decrease for some items of healthcare expenditure, it tends to inflate for other items. In Germany, for example, budget spending caps have been imposed in 1993 over physicians' drug prescriptions. The latter have referred their patients to specialists or have sent them to the hospital in order not to exceed their spending caps and, thus, incur sanctions. During the first seven months of implementation of this measure, the number of patients referred to other physicians has increased by 9% and the number of hospital admissions by 10%, compared to the previous year.[4]

Imposing financial sanctions and cracking down on healthcare providers in case of overspending do not thus constitute a remedy to the ineffectiveness of the ONDAM.

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Cost containment threatens patients' freedom to choose their physician

While ineffective in restoring the balance of the public health insurance budget, health cost containment has provided a pretext for the gradual introduction of an ever-growing number of measures that seek to exercise wholesale control over the health system and, which, moreover, harbor their own pernicious effects.

[2] See the Report of the French Court of Audit (Cour des comptes), *La Sécurité sociale*, September 2006, p. 7-8, available at : http://www.ccomptes.fr/cour-des-Comptes/publications/rapports/secu2006/rapport-secu06.pdf

[3] See Eco-santé France 2007; author's calculations. See also the various reports issued by the Audit Commission on Social Security (Commission des comptes de la Sécurité sociale), available at: http://www.sante.gouv.fr/htm/dossiers/ccss/sommaire.htm#rapports.

[4] See J.M.G. von der Schulenburg and Oliver Schöffski, "Implications of the structural reform of Healthcare Act on the referral and hospital admission practice of primary care physicians", *Discussion Paper* N°34, November 1993, quoted in Guilem Lopez-Casasnovas and Jaume Puig-Junoy, "Review of the literature on reference pricing", *Working Paper*, April 2000, p. 19, available at: http://www.econ.upf.edu/docs/papers/downloads/362.pdf.

The various rationalization plans had left patients quite free in the choice of their physician. But, the measures contained in the 1996 reform, and reinforced by the 2004 reform, aim explicitly at further controlling and regulating patients' consumption of healthcare, especially the choice of their physician.

A first measure introduced in 1998 already invited patients to choose a "referring physician" who was to advise them in their consumption of healthcare, much as is the case with the British-style GP "gate-keeping" system.[5] Only 1% of patients opted for this device.[6]

But, since 2005, other tougher measures have been introduced. Public authorities urged all insured persons to choose a "preferred doctor" and to follow a "coordinated care pathway", that is, patients are bound to consult the preferred doctor first when a health problem arises. But, in contrast to the "referring physician" scheme, these measures make provision for financial sanctions for the insured persons. In the event of non-compliance with the new regulation, insured persons receive lower reimbursements and can find themselves compelled to pay charges that exceed the statutory fee to physicians.[7]

The savings realized with the measure that introduces attending physicians will, in all likelihood, be modest. The so-called "medical nomadism" (that is, multiple contacts - presumed as unnecessary - by patients with doctors for a single health care episode) which it seeks to limit, seems negligible. According to a report, "medical nomadism" concerned for example only 0.2% of beneficiaries and the implied extra cost amounted to 0.01% of reimbursements for ambulatory care in 2001.[8] On the other hand, the implementation of the “coordinated care pathway” scheme seems to represent an “extra administrative burden” for some physicians, being given the complex nature of conditions for coverage.[9]

In the last analysis, even if no obligation yet exists to choose a "preferred doctor" and consult him in the first place when a health problem arises, there is an unmistakable step in that direction. This encroaches on the freedom to seek medical care from a physician/specialist of one’s own choice, even if it is true that this freedom has not yet been completely suppressed as is the case elsewhere.

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In England or in Canada where this system is pushed to its logical conclusion, it is up to the general practitioner - and not to the patient who, after all, is the beneficiary of healthcare - to assess whether or not it is judicious to consult a specialist. In case of divergence of opinion, access to a specialist can be denied to the patient. Yet, being given the specific competencies of a specialist and the fact that he confronts a great number of cases falling within his specialty, his diagnosis can often be more accurate and the treatments he prescribes more effective than those of a general practitioner.

These restrictions relating to the consumption of healthcare can all the more fail to meet the needs of patients as the choice of referring patients or the prescriptions of "gate-keepers" are subject to pressure from public authorities anxious to curb health expenditures. *In fine*, even if such cost containment schemes are designed to make the public health insurance realize savings, it is essential that insured persons be able to sanction it by opting for a competing insurance plan, if and when they consider that the services provided by their public health insurance are not valuable.

Cost containment policies entail the bureaucratization of healthcare delivery

In their attempt to contain health expenditure, public authorities have also imposed more and more constraints on healthcare providers.

Leaving aside the regulation of their tariffs over which public authorities exert control since long, the manifold reforms seek more and more to control the very practice of health professionals. The freedom of exercise of private office-based physicians, as well as the conditions of practice in hospitals are here again more and more regulated. For example, treatment guidelines - guidelines for practice by pathology, introduced in 1993, which physicians must abide by in principle - as well as the more recent guidelines for

[5] For example, countries like England and Canada, among others, where access to healthcare starts with a general practitioner, the "gatekeeper". It is impossible to seek medical attention from a specialist without the referral of the "gatekeeper".

[6] See Laure Com-Ruelle, Paul Dourgnon and Valérie Paris, "Can physician gate-keeping and patient choice be reconciled in France ? Analysis of recent reform", Eurohealth, Vol. 12, No. 1, 2006, p. 17-20, available at : http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/pdf/eurohealth/vol12no1.pdf.

[7] For some specialties (gynecologists, ophthalmologists and psychiatrists), cases of emergency or in the absence of the preferred physician, the insured receive the usual reimbursement from the health insurance scheme and is thus not penalized.

[8] See the report of the Health Insurance Scheme of Independent Professionals (Canam), "Etude de la justification médicale du nomadisme", November 2001, available at : http://www.canam.fr/publications/sante/etudes_canam_gestion_du_risque_et_prevention/pdf/nomadisme.pdf.

[9] See the Report of the High Council on the Future of Health Insurance, July 2006, p. 58-59, available at: http://lesrapports.ladocumentation-francaise.fr/BRP/064000674/0000.pdf.

good medical practice can turn out to be genuine instruments to sanction physicians who do not comply with them. These measures can indeed compel them to modify their medical practice in order to realize savings on the account of the public health insurance scheme.[10]

Similarly, the computerization of the health system and the codification of medical acts present themselves as further potential means of supervision and bureaucratic control over practitioners. Being given that each patient remains an individual case that requires an independent judgment by a physician, these measures can be subject to pernicious effects that patients cannot sanction. Indeed, it is only in a competitive insurance market that an insurance company is urged to take these pernicious effects seriously into account, for fear of seeing his customers leave for a competing insurance company.

"The tariffs set by the administration, called "casemix-based financing" or T2A, are way off from sharing the coordinative virtues of competitive market prices."

These reforms also have consequences for hospitals, especially with regard to changes in their mode of financing. In contrast to the previous mode of financing based on global budgets for public hospitals and some private health institutions which are affiliated with the public hospital service, termed PSPH in bureaucratic jargon, a growing share of their financing operates, since 2004, through an administrative setting of tariffs (called "casemix-based financing" or T2A) for pathologies and hospital stays which are brought together under allegedly homogeneous groups. This is also the case for the overall financing of non PSPH private clinics.

But, the tariffs set by the administration are way off from sharing the coordinative virtues of competitive market prices. Paradoxically, this mode of financing prompts health institutions to expand their volume of activity in order to glean more funds, as stressed by a report of the French Senate.[11]

Still worse, if this regulation does not effectively allow the containment of hospital expenditures (which constitutes one of the biggest items of expenditure), they harbor, on the other hand, several pernicious effects for patients. Appraising pathologies as homogeneous or not is a matter of degree, and differences from one case to another can influence the cost of the treatment for each patient. Ill-conceived homogeneous groups and inappropriate remuneration included in the T2A could therefore prompt hospitals to discard pathologies or patients, whose cost exceeds the financing provided by public authorities.[12]

When the overall health system finds itself subject to identical regulation in this way, patients are bound to suffer from pernicious effects, the more so as they are denied the possibility of being treated differently.

Conclusion

The various measures implemented by public authorities during the past decades do not constitute an effective solution to contain the mandatory health insurance costs. But, what is more alarming, is that as the reforms were gradually introduced, additional constraints have been added, both with regards to healthcare delivery by all providers and the utilization of the health care system by patients.

The successive layers of regulation bureaucratize more and more medical practice in this way, at the expense of patients. If these policies are pushed to their logical end, patients are likely to face waiting lists and a rationing of healthcare - as is the case for patients in countries like England or Canada.

10 On the dangerous character of these measures, see Bertrand Hue, "Le piège des bonnes pratiques médicales", available at : http://www.droit-medical.net/article.php?id_article=35.
11 See the Information Report of the French Senate, entitled " La tarification à l'activité à l'hôpital : la réforme au milieu du gué ", available at: http://www.senat.fr/rap/r05-298/r05-2980.html#toc49.
12 On likely pernicious effects of the T2A, see the study by the Economic and Social Committee, "L'hôpital public en France : bilan et perspectives", June 2005, p. 164-169, available at : http://lesrapports.ladocumentationfrancaise.fr/BRP/054000659/0000.pdf.

Institut Economique Molinari

rue Luxembourg, 23 bte 1
1000 Bruxelles
Belgique
Tél. +32 2 506 40 06
Fax +32 2 506 40 09
e-mail:
cecile@institutmolinari.org
www.institutmolinari.org

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