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Towards a More Efficient Health System

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The French health care system, with a level of spending that is greater than in many other developed countries, can be considered rather good, but it displays a fairly marked degree of social inequality. The purpose of this *Note* is to suggest avenues to explore in order to improve the effectiveness of the health system in its totality. Three reforms are suggested.

First, rather than use the current logic which consists of limiting Social Security spending by reducing the rates of reimbursement, one could define a 'basket of health products' which would be available to all irrespective of their financial means. This basket would contain all medicines, drugs, doctors' consultations, and acts carried out by medical staff –both preventive and curative– in the private and public sector. The scope of covered treatments would be defined and updated in a systematic and transparent manner based on a classification of available treatments according to their respective effectiveness compared with their cost. It would be expected that treatments outside this basket would not be reimbursed, even partially, by the Social Security system.

Secondly, in order for the sums necessary for such an improvement in the system to be available, it would be appropriate to devolve an overall budgetary envelope to the Regional Health Authorities (RHAs), based on the needs of the population in each region. It would then be up to the RHAs to divide this envelope between hospitals GPs and specialists and nursing homes. They would also be responsible for the contractual arrangements and methods governing the manner in which medical professionals would be paid. Giving the RHAs responsibility for coordinating this system would ensure that medical services would be best adapted to the specific needs of the region and optimise the resources at their disposal.

Thirdly, it is urgent to ramp up the investments in health information systems. The development of electronic personal medical records requires both significant investment and a significant effort to convince both the medical world and the patient of the benefits. Firstly, it is crucial that all medical practitioners produce and share information concerning each patient, in order to coordinate treatment and to avoid unnecessary and costly examinations. This information has to be secured in order to protect patient privacy. Secondly, there should be publicly available information concerning the quality of treatment provided by hospitals, the *'maisons de santé'* (see below, page 7) and nursing homes. Finally, indicators comparing regional performance in the area of public health, social inequalities and access to healthcare, should be produced and widely disseminated.

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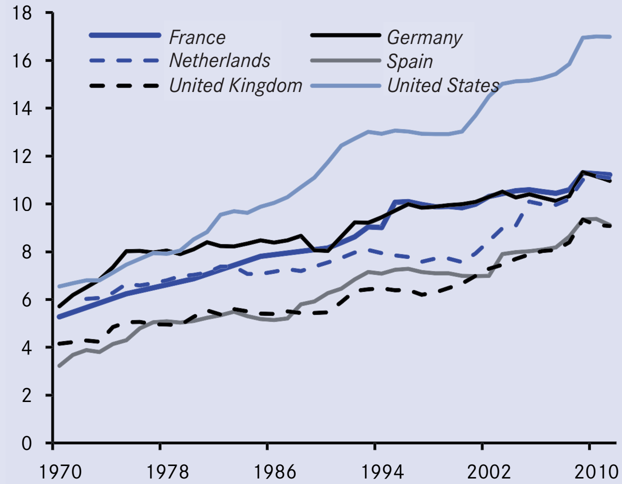
The French health system offers healthcare coverage that is both stable over time and generous. For several decades now, around three quarters of the cost of care is covered by the Social Security System or the State: in 1970 the coverage rate was 76.5% and, in 2011, 76.8%. Such stability in coverage has only been possible through ever-increasing rates of mandatory contributions. Spending on healthcare has increased more quickly than in other areas of public expenditure. The main cause of this increase is not the ageing of the population, but rather the constant innovations in the medical world. New products and new procedures are constantly appearing and their introduction and dissemination fuel increases in health expenditure[1]. As in other countries, France spends a continually increasing proportion of its GDP on healthcare (chart 1), and healthcare spending is likely to increase faster than GDP in the future to meet the population's expectation for better health and longer, healthy lives. Although such progress can be considered desirable, it creates significant social tension, particularly in the current circumstances where it is difficult to raise the level of mandatory contributions.

1. Healthcare expenditures
as a % of GDP, 1970-2011



Source: OECD (2013).

Controlling healthcare spending is a subject as old as the public health insurance system itself. Attempts to bring some sort of control to the system have been tried since the 1950s, usually combining increased contributions with reduced reimbursements. These reforms have generally been accompanied by compensatory schemes for the less well-off (since 2000, the CMU-C provides free additional coverage for people on low incomes) and people suffering from long-term afflictions (ALD for Affection de longue durée, who are covered for 100% of the treatment necessary for the particular affliction). The combination of these mechanisms has resulted in the fact that the stability in overall coverage hides great disparities among the population, with a relatively low coverage among those people who do not benefit from the ALD mechanism: in 2010, this was 59.7%[2]. The various attempts to put things right have achieved a few elements of administrative control over the provision of care, focusing on the medical profession, the applicable rates and on hospital budgets. Since 1997, Parliament has voted an annual expense target for the health system (ONDAM for Objectif annuel de dépenses de l'assurance-maladie), but such targets have very frequently been missed.

Faced with the expected increase in health spending, is it inevitable to arbitrate between increased contributions and reduced services to the public? Not necessarily. In the medium term, efficiency gains can provide increased room for manoeuvre.

In France, as in many countries, the health system is an organisational and administrative maze, coupled with a tangle of charges and rates resulting from historical conflicts between all the various players in the system –the insured population, patients, the medical world, the Social Security System, private insurance companies, provident and mutual societies, and local and central administration. Numerous administrative reports have piled up over the years examining specific sectors of the French health system. The purpose of this Note is to suggest avenues to explore in a view to improving the effectiveness of the health system in its totality. The organisation of the national health insurance system is a vast subject, but is here treated only through the notions of a basket of treatments and the coverage rates[3].

Discussions on the question of health are highly emotive as they touch on illness and death. But this in no way justifies avoiding making decisions –quite the contrary. Due to the lack of clear criteria, such arbitrations have been –and are still– made using informal criteria and without any discussion.

A powerful but inefficient system

Whereas the spending on health in France is higher than in many other developed countries, the outcomes can be considered good without being exceptional. France is top of the

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[1] Dormont B. (2009): *Les dépenses de santé. Une augmentation salutaire ?*, CEPREMAP Publication, Éditions Rue d'Ulm.

[2] In 2010, 82.4% of insurees were not concerned by the ALD mechanism see Haut Conseil pour l'avenir de l'assurance-maladie (HCAAM) (2012): *Annual Report*.

[3] Health insurance will be the subject of a future Note from the CAE. Hospital organisation is also not a subject treated in detail in this *Note*. In particular, we do not broach the subject of the prospective payment system that was introduced in 2004 to reform hospital payments (named *Tarification à l'activité* or *T2A*). A detailed description of the T2A can be found in Dormont B. and C. Milcent (2012): "Comment évaluer la productivité et l'efficacité des hôpitaux publics et privés? Les enjeux de la convergence tarifaire", *Économie et Statistique*, no 455-456, pp. 143-173.

European class for life expectancy at birth for women, but poorly placed in the same category for men. For men, the figures concerning early mortality and pathologies linked to behavioural risks (tobacco, alcohol) are mediocre. Although the incidence of cardio-vascular diseases and chronic respiratory afflictions is relatively low in France, cancer is rather more frequent, and industrial accidents and the rates of suicide are at the high end of the European average[4]. Overall, France is in an intermediate position when considering life expectancy in good health, both at birth and at age 65[5]. As for medical performance in the strict sense of the term, a 2012 survey compared the mortality rates over the period 1999-2007 in France, Germany, the United States and the United Kingdom, taking into consideration only those deaths that were "avoidable with appropriate medical attention". France appeared quite favourably in this survey, but this could be influenced by the low incidence of cardiac-related pathologies in France[6].

Greater health inequalities than elsewhere

Several surveys have shown France to have significant social inequalities in the health area: France has the largest difference in mortality between manual and non-manual workers, attributed to the differing rates of mortality in the two groups resulting from cirrhosis of the liver and cancer of the respiratory and digestive tracts[7]. Unequal premature mortality rates according to job level or educational attainment are also higher in France than in the majority of Western European countries[8]. Finally, for the population over 16, income level has a bigger impact on health in France than in Germany[9]. The influence of the organisation of health systems on these inequalities remains a controversial subject. It is clear though that the organisation of ambulatory care in France is not one that favours preventative actions concerning consumption of substances considered at risk. In addition, the sparse coverage of general practitioners in the urban outskirts of rural areas[10] limits the access for the local population to regular examinations for detection and early treatment of certain pathologies.

In France, health-related expenditure is covered to a level of 76.8% by the Social Security system and the State and to 13.7% by complementary health insurance companies. The rest, i.e. 9.5%, has to be paid out of the individual's pocket. This rate of individual direct payment is one of the lowest in Europe, but it hides a huge heterogeneity: a significant proportion of the population has out of pocket payments higher than a few thousand euros (see below). But above all, whoever pays the initial amount, it is always the individual household that pays in the end, be that in the form of social contributions, taxes, insurance premiums or direct payment. It is the whole gamut of spending on health that puts household budgets under stress: there is no sense in seeking to manage merely the part financed by social contributions.

A rather inefficient system

The hospitals are by far the biggest item in health spending, of which they represent just less than half, followed by doctors in private practice, representing one quarter, and then drugs and medicines which take up a further fifth. This compartmentalised view of expenditure reflects the current organisation for handling such expenditure. Yet, in practice, there are important carry-over effects from one sector to another: for example the overcrowding in hospital emergency services has clearly been identified as being in part caused by gaps in local coverage in communities by general practitioners, where nowadays it is rare to find doctors on call at night, at the week-end and during holiday periods, and where access to a doctor who charges only the Social Security rate is far from guaranteed. In the same way, inappropriate treatment for certain chronic pathologies does not help prevent elderly people becoming dependent, and can lead to expensive hospital treatment with potentially invalidating consequences[11]. The compartmentalisation of the players in the health system is prejudicial to the efficiency of the system as a whole[12]. But this is not the only source of inefficiencies.

In France, the system regulation focuses on reducing moral hazard on the demand side, whereas there is plenty to do on the supply side.

From its inception, the French health insurance system left a part of all healthcare 'products' –drugs, consultation, operations, examinations, etc.– for the patient to pay, called the

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[4] See High Council for Public Health (2012): *Annual Report*.

[5] See Eurostat (2013): http://epp.eurostat.ec.europa.eu/cache/ITY_PUBLIC/3-05032013-BP/EN/3-05032013-BP-EN.PDF

[6] Nolte E. and C.M. McKee (2012): "In Amenable Mortality –Deaths Avoidable through Health Care– Progress in the US Lags that of Three European Countries", *Health Affairs*, vol. 31, no 9, pp. 2114-2122.

[7] Couffinhal A., P. Dourgon, P-Y. Geoffard, M. Grignon, F. Jusot, J. Lavis, F. Naudin and D. Polton (2005): "Politiques de réduction des inégalités de santé, quelle place pour le système de santé? Un éclairage européen", *Questions d'Économie de la Santé*, no 92.

[8] Kunst A.E, F. Groenhof and J.P. Mackenbach (European Working Group on Socio-economic Inequalities in Health) (2000): "Inégalités sociales de mortalité prématurée : la France comparée aux autres pays européens" in *Les inégalités sociales de la santé*, Fassin, Grandjean and Kaminski (eds.), La Découverte, Coll. Recherches, pp. 53-68.

[9] Van Doorslaer E. and X. Koolman (2004): "Explaining the Differences in Income-Related Health Inequalities across European Countries", *Health Economics*, vol. 13, no 7, pp. 609-628.

[10] In 2010, the number of general practitioners in full-time-equivalents was 75 per 100,000 inhabitants in the large conurbations, against 52 in the rural districts surrounding such conurbations, see Barlet M., M. Coldefy, C. Collinet and V. Lucas-Gabrielli (2012): "L'accessibilité potentielle localisée (APL): une nouvelle mesure de l'accessibilité aux médecins généralistes libéraux", *Questions d'Économie de la Santé*, no 174.

[11] Haut Conseil pour l'avenir de l'assurance-maladie (HCAAM) (2011): *Assurance-maladie et perte d'autonomie*, June.

[12] Efficiency here is defined as the capacity of the system to 'produce' a maximum level of health with a fixed budget. It refers to 'productive' efficiency, as opposed to 'allowance' efficiency, concerning a basket of healthcare items (see below).

‘ticket modérateur’. Fixed at a relatively high level (30% of the cost of a doctor’s consultation, for example), this is now completely covered by the complementary health insurers. The 2004 reform introduced a number of co-payments: patients now need to pay one euro to see a doctor, for a physiotherapy session, for a blood sample or an X-ray, 18 euros for a scan that costs more than the reimbursed limit of 120 euros, and 50 centimes for each box of tablets. The flat-rate charge for hospitalisation is regularly increased also. These payments reduce the expenditure by the health system, but cannot have any positive effect on the “empowerment of patients”: with the exception of consulting a general practitioner or certain specialists, which is clearly an act of demand by the patient, all the goods and services affected by these co-payments are prescribed by doctors, to whom the health service has delegated the monopoly power to decide what is medically needed. Where is the notion of “patient empowerment” in all this? Is it desirable that patients cease to respect their doctors’ prescriptions for financial reasons? If there is a doubt about the relevance of the doctor’s prescription, why should the patient be asked to sort out the items, when the powers that be cannot fix a reimbursement rate that reflects the usefulness of the drugs (see frame 1)? In the French system, these co-payments reduce the cover without increasing the efficiency of the system.

Efficiency gains are to be sought in the organisation of healthcare provision, where there is still a great deal to be done:

- fee-for-service is omnipresent in doctors’ surgeries and in private clinics and hospitals, although it is a clear incentive to increase demand and thus a source of overconsumption of this particular care item. This theoretical characteristic of payment per act has been verified in numerous empirical studies, including for France[13];
- compared to its neighbours, France does not lack doctors. But the freedom they have to set up their practice wherever they choose creates an unequal geographic representation which is a source of inefficiency in a number of ways: in over-populated regions, doctors do not always have sufficient consultations, their only source of remuneration, inciting them to induce further demand in order to increase their income; in under-populated areas, patients sometimes have difficulty getting to see a doctor;
- too many general practitioners work on their own, with an inefficient use of their time: 44% assure the secretarial role themselves, 22% do their own accounts and 14% clean the floors of their offices[14]!;
- fee-for-service does not encourage preventive medicine. It is an obstacle to the sharing of tasks between medical professionals and the formation of medical groups capable of providing a round-the-clock care service. It is a precondition to the practice of charging more than the Social Security rate, particularly by specialists;
- fee-for-service also does not encourage the coordination of care between the various healthcare providers, which could provide the patient with optimum care from the various players –local doctor, hospital, and socio-medical structure;
- in hospitals, similar problems arise from the 2004 reform. This established a prospective payment system (T2A), which actually very closely resembles fee-for-service payment, which is part of the global envelope allocated by the hospital ONDAM, and which translates into a floating point value[15]. In this situation, the overall expenditure is controlled, but there is a strong incentive to increase the number of acts, which could lead one to question the appropriateness of the care offered.

1. The inconsistencies in the policy of reimbursing drugs and medicines

The decision as to whether the cost of a particular drug is to be reimbursed or not, and at what rate, is made by the Transparency Committee of the French National Authority for Health (Commission de la transparence de la Haute autorité de santé). The decision is based on the benefit/risk ratio of the drug and the nature of the affliction or disease to be treated. It delivers a verdict on the ‘medical benefit provided’, the SMR (service médical rendu), which determines the rate of reimbursement. If the SMR is judged to be «insufficient», the drug should not appear in the list of reimbursable products or should be removed in the case of any re-evaluation. If the SMR is judged to be «low», the reimbursement rate should be fixed at 15%. In other cases the rate can be fixed at 30%, 65% or 100%.

In the majority of cases the opinion of the Transparency Committee is followed and the reimbursement rate is fixed according to these evaluations. Delays in application and numerous inconsistencies, however, cause excessive expenditure, and even some decisions that are contrary to care quality.

When the Transparency Committee re-evaluated the complete pharmacopoeia between 1999 and 2001, it recommended removing 835 items from the reimbursable list. First, the price and the rate of reimbursement for these drugs were lowered. Then, in 2005 and again in 2006, the Committee confirmed its evaluation for the majority of them. These drugs were removed from the reimbursable list in waves, the last of which took place in 2012, i.e. more than ten years after the first recommendation. Drugs used in the treatment of Alzheimer’s disease and the question of the single reference rate are two textbook cases which we discuss below.

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[13] Delattre E. and B. Dormont (2003): “Fixed Fees and Physician-Induced Demand: A Panel Data Study on French Physicians”, *Health Economics*, vol. 12, no 9, pp. 741-754.

[14] Jakoubovitch S., M-C. Bournot, É. Cercier and F. Tuffreau (2012): “Les emplois du temps des médecins généralistes”, *Études et Résultats*, no 797.

[15] Reimbursement using the T2A is based both on the activity of the establishment in question (positively) and the activity of all other hospitals (negatively).

Defining a basket of social care items

Providing the best possible level of healthcare for the whole population requires the reform of the care provision system (productive efficiency), but also reflection on the basket of healthcare 'products' that society should cover on a collective basis, and more generally on the role of healthcare expenditure in public budgets (allocative efficiency).

Choices on two levels

Taking a global view of the 'production of health', there are numerous factors that affect the health of the population, apart from immediate healthcare –education, employment conditions, housing, public hygiene, the environment, etc. In principle, all these factors should be taken into account in producing good health for everyone at optimum cost. For example, spending on education can affect the state of health by directly affecting health-related behaviour, but also through indirect effects such as increased income providing opportunities for better access to care and generally better standards of living conducive to good health[16]. However, just as healthcare is not the only determining factor for good health, improving the health of the population should not be the only objective of public authorities.

Decisions are required at several levels. The first concerns health and the other components of general well-being; in principle, it should take account of the collective will of the population, or more precisely an aggregation of all the diverse individual preferences[17]; in practice, these are decided through budgetary decisions made by the elected national representatives, who divide resources between the various missions of the State and its social institutions. Without prejudging the discussion below on the rate of coverage by the Social Security system, one can identify this stage as having started in 1997 with the vote of the annual spending on health insurance, the ONDAM, which defined the provisional sum allocated each year.

The second level where a choice is to be made directly concerns the subject of this Note: once the budget for healthcare has been set, how does one make best use of it? Which care elements should be favoured? What should be the split between prevention and cure? How should the latest advances in the medical field be embraced?

These questions are at the heart of the definition of a basket of items available to all. Although the various mechanisms for providing health insurance are outside the scope of this analysis, it is worth remembering that financing healthcare can take very differing forms depending on the country. Some, like the United Kingdom and Norway, do not have health insurance –providing healthcare is a public service administered by a national health system. In others like France, care is chargeable, with the associated cost being covered, in varying proportions depending on the type of care, by the Social Security system and the complementary insurance institutions. Whatever the choice of financing, every society needs to determine the scope of "social" care items accessible to all irrespective of their financial resources. These items are what would constitute the "basket of social healthcare", the contents of which needs to be clearly defined.

The three dimensions of healthcare coverage

The coverage of healthcare expenditures is defined along three axes: the size of the population concerned; the range of healthcare items to be covered; the rate at which such items would be covered. As the budget is not open-ended, decisions need to be made along these three axes (see example in frame 2).

In France, the system of universal coverage for healthcare guarantees access to care for the totality of the population. But within any given budget, one can partially reimburse a somewhat extended range of care items (chart 2, option 1) or totally reimburse a more restricted range (chart 2, option 2). The current logic is to eschew the notion of limiting the range of items reimbursed and to progressively reduce the rate of reimbursements in order to respect the limits imposed by the ONDAM. In the absence of any systematic thinking on what items to reimburse, one is confronted with an historical patchwork of reimbursable items and rates (chart 3). Certain indisputably useful items, such as dentures or spectacles, are very poorly covered, and their rates are barely or badly regulated; certain drugs with limited or uncertain effectiveness continue to be reimbursed at the reduced rate of 15% (frame 1); reimbursement of doctors' consultations and other medical acts is based on the tariffs fixed in the contracts signed by the various institutions involved, although in certain regions much higher fees are almost universal.

The "1945 pact" is supposed to guarantee solidarity according to the principle: "from each according to his means, to each according to his needs". Today, this principle is seriously undermined. Social Security coverage for people not covered for ALD is insufficient (59.7%), which means that supplementary insurance is necessary for full access to care, and without any ceiling mechanism, the partial coverage by the Social Security system means that there is a considerable sum remaining for the individual to cover. The French High Council for the future of health insurance (HCAAM for Haut Conseil pour l'avenir de l'assurance-maladie) has calculated that the top percentile of people who received care in 2008-2010 pay more than 7,200 euros to cover[18]; the cost of a complemen-

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[16] Cutler D.M. and A. Lleras-Muney (2012): "Education and Health: Insights from International Comparisons", *NBER Working Papers*, no 17738.

[17] Fleurbaey M., S. Luchini, E. Schokkaert and C. Van de Voorde (2012): "Évaluation des politiques de santé: pour une prise en compte équitable des intérêts des populations", *Économie et Statistique*, no 455-456, pp. 11-36.

[18] HCAAM (2012) *op. cit.*

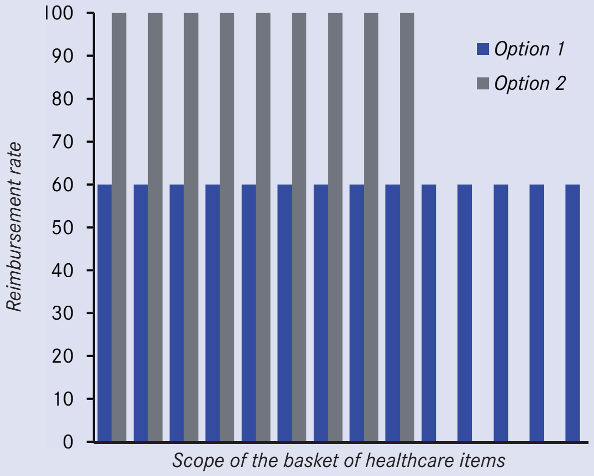
tary insurance package can be up to 8% of annual income for low-income households, which can be prohibitive and result renouncement to insurance and to the required care.

These partial reimbursements supplemented by complementary insurance are both a source of inequality and an ineffective use of expenditure. Complementary insurance simply annuls the concept of patient responsibility that the 'ticket modérateur' might achieve. In addition, the progressive erosion of Social Security cover as a means of regulating the budget is just a convenient solution which lifts any further responsibility off the shoulders of those in charge of controlling expenditure. Transferring part of the cover to the insurance companies is no less costly for the individual –it transfers public expenditure without reducing the expense for households.

Defining a "basket of social healthcare items" is an alternative to the current situation. This basket would contain all medicines, drugs, doctors' consultations, and acts carried out by medical professionals –both preventive and curative– in ambulatory care and at hospitals, which would be covered for well-defined indications. For the public authorities, moving to an organisation guaranteeing 'solidarity' coverage, based on a well-defined set of items (see frame 3), means changing the rationale in order to stop diminishing Social Security coverage concerning uncontrolled expenditure. This means no longer using a reduction in the rate of reimbursement as a means of controlling the budget, and focusing on a transparent definition of items in the basket. Instead of letting expenditure get out of control, this would improve the effectiveness of the system.

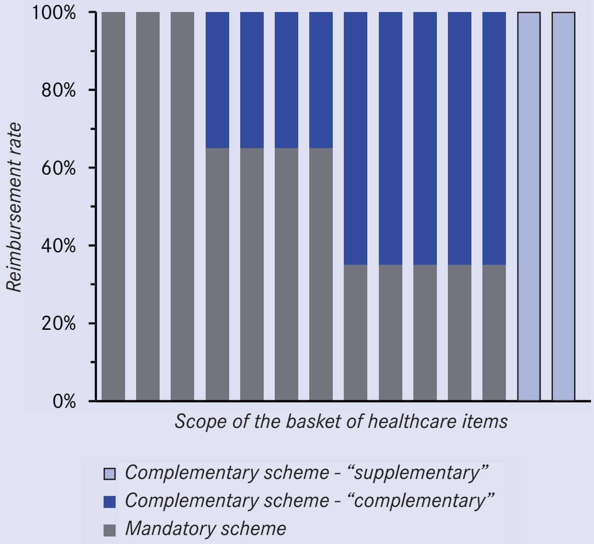
Proposal 1. Define the range of care items to which it is legitimate to ensure access to all; adjust the contents of the basket to the nation's healthcare budget; cease to use reductions in the rate of reimbursement as a means of managing expenditure.

2. Scope *versus* rate of reimbursement for the basket of healthcare items



Source: Authors.

3. Current split: mandatory scheme/complementary scheme



Source: Authors.

Clarify the priorities

Defining the basket of social healthcare items means tackling head-on the thorny question of priorities. One method for prioritising would be to establish, as far as possible, a classification of all items according to the improvement in health obtained in relation to their cost. Several measures of the impact can be imagined. They would need to take account of the reduction in mortality, the improvement in the quality of life and the reduction in the number of disabilities. A cost/effectiveness ratio would be calculated for each treatment in order to define the priorities. The basket of items would then comprise those items with the best indicators of effectiveness per euro expended.

The advantages and limitations of such a cost-effectiveness approach have been widely studied and evaluated[19]. The QALY cost-utility method (frame 4) is extremely controversial as a result of the methods used. It is fundamentally sound, but the controversy has been carefully exploited by the healthcare product industry such that it created in certain countries, including France, a long-lasting rejection of any approach based on criteria surrounding general and clear choices in healthcare. Yet, transparent criteria are essential when defining the contents of a healthcare basket. Such medico-economic evaluation has been significantly delayed in France: it

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[19] Fleurbaey and *al.*, *op. cit*.

2. An example of the choice between the size of the population to be treated and the contents of a basket of care items

At the end of the 1980s, a reform of Medicaid in the State of Oregon was proposed to widen the coverage of this public health insurance to all those living below the poverty threshold, whereas previously the criteria in place meant that only 57% of such people were eligible. With no change in the budget, widening coverage to a larger population meant reducing the number of care items that would be reimbursed. To achieve this, detailed work was undertaken to identify the most effective care items in order to draw up a list of those that should receive priority. After extremely stormy debates, the reform was successfully implemented: An extra 100,000 people were covered by Medicaid and the initiator of the reform was elected State Governor.

During the debates, the choices were presented in a fairly brutal manner: if coverage were stopped for transplants of the heart, the liver, the pancreas and bone marrow, which might concern some thirty-four people over two years with uncertainty as to their success, the Medicaid programme could cover the care needs for a further 1,500 people over the same period[a]. This form of prioritisation does not mean that the community should not pay for certain transplants because of a fairly low clinical efficacy; it simply says that it is preferable first to guarantee access to care for a larger proportion of the population. If one is confronted with a fixed budget, by defining priorities for the available care items one can improve the health of the widest population possible.

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[a] Welch H. and E. Larson (1988): "Dealing with Limited Resources", *The New England Journal of Medicine*, vol. 3, no. 3, pp. 171-173.

required a decree by the French National Authority for Health (HAS for Haute Autorité de Santé) in October 2012 to enable its use for registering new drugs.

When comparing the effectiveness of a treatment with its cost, one must be aware that the cost is not fixed in concrete –it is the result of negotiations with the producer for the price of a drug, or the efficiency gains in treatment provision. Achieving productive efficiency enables one to increase the size of the basket of social healthcare items.

Finally, these evaluations need to be constantly updated to enable new treatments to be added to the basket. If these new entrants are supposed to replace existing items at a lower cost for the same effectiveness, then the latter would be removed from the basket after a medically appropriate transition period.

As of now, it is important to rationalise the decisions concerning the rates of coverage and costs. Leaving aside any question of cost/effectiveness ratio, drugs whose efficacy is no longer recognised should cease to be reimbursed. This is far from being the case in France. To take an example, veinotonic drugs, for which the medical benefit provided was judged insufficient in 2005, were nevertheless reimbursed at the rate of 15% for a further two years before being totally removed from the list. Besides the ineffectual expense that the 15% reimbursement represents, the majority of the complementary insurers continued to reimburse the remaining 85%. There was thus no saving for households, whose premiums increase with no account taken of the efficacy of the treatment. The most recent example concerning anti-Alzheimer drugs is even more edifying. The ratio between their efficacy and their side effects was considered as insufficient by the Transparency Committee, and thus the reimbursement was reduced to 15%. However, since most Alzheimer sufferers are covered by the ALD mechanism, such treatment remains de facto covered at 100% by the Social Security system!

3. Cover provided by a basket of social healthcare items

According to our definition, the contents of the basket of social healthcare items must be available to everyone, whatever their financial means. To achieve this, three alternative organisational structures are possible: a national health service; universal health insurance covering the basket of care items; a system combining Social Security and mandatory complementary insurance. The third option, the closest to the current French system, would require profound changes, because accessibility for all will require the creation of mandatory insurance schemes to cover the part of the cost of the basket items not covered by the public health insurance portion. The split between the part covered by the State and that covered by the private insurers would remain to be determined, but the latter would be able to operate in competition with each other. Between them, they would assume the cost of the full basket of care items to which every citizen would have access. The overall coverage rate would be close to 100%. But the items not in the basket would not be covered at all by the mandatory insurance scheme. They can be covered by a supplementary insurance subscribe. The principle is simple: if a care item is useful, it should be reimbursed at 100%; if it is not, it should not be reimbursed. We should point out here that such a system does not rule out the use of thresholds or co-payments, non-reimbursable by private insurers, the use of which being decided by their relationship with the idea of patient responsibility or access to healthcare[a].

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[a] Geoffard P-Y. (2006): *La lancinante question de l'assurance-maladie*, Opuscule du CEPREMAP, Éditions Rue d'Ulm.

In addition, it is reasonable to expect that the same molecule be covered by the same rate of reimbursement. When a 'generic' version of a molecule is available, the Social Security actually pays more for the branded version than it does for the generic form even though it is the same molecule, unless it has been included in a group called 'tarif forfaitaire de responsabilité' (TFR – responsible payment tariff). Today, the TFR groups represent only 16% of the generic market, whereas it should cover 100%.

Proposal 2. Develop medico-economic evaluations and use the results to give a transparent definition of the basket of social healthcare items. Abolish forthwith the 15% reimbursement rate, and install a single reference reimbursement rate for each molecule.

Adapt the resources to the needs of the population

Healthcare supply should be aligned to the population's needs

The implementation of health-related choices as described above needs to reflect the needs of the population in terms of healthcare. These needs, however, differ by region, depending on the socio-economic characteristics of the various populations. Even so, the menu of healthcare items on offer does not coincide with these needs. To improve the productive efficiency of the health system, it is important to encourage a better geographic distribution of doctors, but also to ensure that doctors work more closely with the other medical professionals, through a better delegation of tasks. The development of structures for out-of-hours consultations with local non-hospital doctors (so-called 'maisons de santé') would offer a better geographic coverage, round-the-clock availability, and continuity in the course of treatment. The 24 hour availability within these structures of both on-call doctors and socio-medical staff should help ease the congestion of hospital emergency departments, currently the only places known to the population for round-the-clock service.

The items that determine the cost of treatment are numerous and varied. Beyond taking into account the patients' needs, the decisions taken by those providing treatment are influenced by their impact on their own situation, in particular their income. The regulator needs to put in place payment mechanisms that incite the medical profession to act in the general interest (frame 5). In the case of doctors, for example, there should be a system of remuneration that favours prevention and the provision of treatment appropriate to the needs of the patient.

The question of the geographic distribution of doctors and their coordination with other health professionals is intima-

4. The cost-utility approach using QALY

The cost-utility approach uses the concept of QALY (Quality Adjusted Life Years) on which to base decisions concerning different treatments capable of improving peoples' health. Health improvements are quantified in terms of the increase in the number of years of life-expectancy, weighted by the quality of that life increase: each year is weighted by a coefficient between 0 and 1 representing the quality of life starting with perfect health, with a coefficient of 1, through all the stages of ill-health down to death, with a coefficient of 0.

A treatment A, which costs 20,000 euros per patient and capable of gaining on average 1 QALY, will have a ratio of 20,000 euros per QALY; treatment B, which costs 10,000 euros for an average benefit of 0.1 QALY, would have a ratio of 100,000. In this example, one can see that, with a total budget of 1 million euros, one could choose to treat fifty patients with treatment A giving, for the population as a whole, an increase of fifty life-years in perfect health; alternatively, one could choose to treat 100 patients using treatment B, but this would only achieve an increase of ten life-years in perfect health. Treatment A would therefore be preferred to treatment B as its cost-utility ratio is more favourable.

This prioritisation criterion can be used in two different ways:

- one could define an acceptable threshold for the cost per QALY and include in the basket all those care items whose cost-utility ratio was below this threshold. In our example, a threshold of 50,000 euros per QALY would allow treatment A to be included but would exclude treatment B;
- alternatively, one could decide based on the available budget. If the pathologies treated respectively by treatments A and B concern respectively twenty and fifty patients per year, the sum required to treat this total population would be 20 × 20,000 euros + 50 × 10,000 euros = 900,000 euros. If one has a budget of 1,000,000 euros, both these treatments would be included in the basket; but if one only has a budget of 500,000 euros, then only treatment A can be offered to all those who could benefit from it, and treatment B could only be offered to ten out of the fifty patients who could benefit. Treatment B would therefore only be offered in exceptional circumstances.

De facto, defining a threshold by QALY or a total budget are two alternative ways of obtaining the most efficient improvement possible in the health of a population. In both cases, one needs to decide which treatments will be given priority. In order for this threshold of acceptability in terms of life-years gained to be considered as acceptable and valid its definition needs to be as transparent as possible, involving a maximum number of sections of society. Finally, it should not be applied mechanically, but rather it should be used as a reference which would enable one to establish a level of acceptable cost, and a level which clearly is unreasonable.

tely linked with the methods of remuneration. Today, delegating medical tasks clashes with the structural effects of the fee-for-service in private practice, which encourages individual practice. However, modern information systems offer considerable possibilities for improving the organisation of healthcare delivery. Today one is able to know in fine detail the healthcare needs of a given population. One can also measure the activity of a particular healthcare structure, even for private practice. There is nothing to prevent the remuneration for a particular structure being based on these indicators.

It is true that the CNAMTS, the institution that controls the French Social Security reimbursement system for both patients and doctors, has recently introduced several payments that complement fee-for-service: a *per capita* supplement of 40 euros for each patient benefiting from the ALD mechanism; a tariff increase to encourage doctors to work in areas where numbers are insufficient, in group practices and healthcare clusters; and finally a performance oriented payment. Since January 2012, general practitioners may receive payment for meeting certain objectives relating to the organisation of their surgeries (electronic transmission of reimbursement claims, use of computer aided prescriptions, an annual compilation of a patient's medical history), and the quality of their medical activity (handling of chronic illnesses, preventive activities, prescribing generic drugs). These mechanisms certainly move towards a better efficiency of medical acts.

Despite this, payment per act still predominates and, with it, the desire to practise individually. Cooperation between healthcare professionals, which has begun to develop in certain larger structures, is not occurring among individual doctors, largely as a result of the absence of a suitable method of remuneration for the professionals concerned. Improvement of the patient's treatment path between his doctor, the hospitals and the socio-medical services is being hindered, largely by the silo effect generated by the various players concerned and by the relatively weak financial power of the RHAs. Finally, the financial inducements for doctors to set up in areas with insufficient numbers, in place for some years now, have not shown themselves to be effective. A recent survey carried out for France has shown that the measure is probably not an appropriate tool, given the preferences expressed by doctors[20]. However, it is at the level of prevention and the means of entry into the health system that social inequalities are in part played out. Guaranteeing good access to primary care would seem to be an essential strategy in reducing these inequalities.

Give the Regional Health Authorities the means to manage the system of healthcare supply

Since the 2009 law on "Hospitals, Patients, Health and the Regions" (HPST for 'Hôpital, patients, santé et territoires'), the Regional Health Authorities have been recognised as the appropriate players to organise access to care and patients' treatment paths (frame 6). However, they do not have the means to carry out this task. The care under their responsibility is financed through separate budgetary envelopes, each guided by a different logic, be it the hospitals through the ONDAM, the socio-medical teams or ambulatory care: the financing of the latter has no relation to needs, but is based on actual patient consumption that is reimbursed by the Social Security system. In all, the RHAs are able to exercise a choice of action concerning an infinitesimal part –less than 2%– of the expenditure which falls in principle under their responsibility[21].

5. Treatment providers and their remuneration

The patient, the treatment provider and the organisation that pays have very different levels of information. Since the responsible public authority has little knowledge of the patient's health, it cannot judge whether the treatment provided is justified or not. In such circumstances, the method of remuneration needs to be simple: this could be determined by the time spent working (salary), the number of patients registered (capitation), or the number of consultations (payment per act). The more fixed rate mechanisms could lead to unsatisfactory quality or even patient selection, whereas the payment per act could lead to unnecessary acts. But thanks to modern information technology this asymmetry in the information available to the key players can be reduced. This gives the possibility of better remunerating the treatment that is offered in the interest of the patient, using indicators of treatment quality and of public health.

Each RHA should be allocated a financial envelope that corresponds to the estimated needs of the population that it serves. This would allow an improvement in the efficiency of the system, by breaking with the current situation whereby the reimbursements made by the Social Security are a tacit acceptance of the overconsumption associated with the demand from regions with an excess of doctors, and the under-consumption caused by the difficulties of access to care in regions with a lack of doctors. This would cause a shift from a budget based on consumption to one based on needs. This change in logic implies that the RHAs need to have effective control over the financing of all the key players –the hospitals, the private doctors and the socio-medical teams. Finally, the RHAs would need to have the means to coordinate the supply side of healthcare, notably by taking charge of contracts and remuneration procedures for doctors and other healthcare professionals in general.

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[20] Delattre E. and A-L. Samson (2012): "Stratégies de localisation des médecins généralistes français: mécanismes économiques ou hédonistes?", *Économie et Statistique*, no 455-456, pp. 115-142.

[21] Cour des Comptes (2012): *Rapport sur la Sécurité sociale*.

These conditions are necessary to stimulate real change in the organisation of care and a move towards greater efficiency. The detailed information available to regions concerning the characteristics of their populations in terms of morbidity, on medical deserts or local 'maisons de santé' projects, give them a certain legitimacy for fixing the requirements for doctors setting up their practices and the associated conditions. Having the right to conclude contracts and decide the method of remuneration should encourage a certain type of organisation (in a particular zone, in a 'maison de santé' sufficiently large to have round-the-clock availability, with specialised nurses to handle those who only need routine care, with a social worker to organise home visits for dependent people living at home, etc.)

In order to better adapt healthcare supply to the needs of the population, there are two possible routes. In the more administrative version, the RHAs would act as employers, offering employment opportunities to healthcare professionals, along with the associated working conditions and methods of remuneration. In the other less interventionist method, the RHAs would delegate the public health mission to health structures (notably the 'maisons de santé') which would be financed by a per capita allowance based on the number and characteristics of the people employed and taking account of the quality of care provided. It would be up to each structure to organise itself in the best way to fulfil its mission. There is no objection in principle to the RHAs choosing either of these versions or even allowing both to co-exist within the region[22].

To date the representatives of the medical profession have vehemently opposed any regulation concerning their choice of place to work, calling it selective contracting, although this type of regulation already exists in France for pharmacies and private nursing organisations. It also exists for the medical profession in Germany and in Denmark, where there are fixed quotas dependent on the number of inhabitants per doctor.

Regarding the forms of remuneration –salary, fee-for-service, capitation, fixed lump sums with performance related bonuses– doctors express a wide variety of views. Some are implacably opposed to any thought of abandoning payment per act, others would prefer to be salaried, whilst others, although firmly attached to the principles of freedom to exercise their profession, are not opposed to changes in the manner in which they are remunerated. A decentralised organisation at regional level would allow a diversity of methods to be used according to the preferences expressed by the players concerned[23].

To improve the system of following patient progress through the healthcare system, it is crucial that the RHAs control the budgetary envelopes for all types of care. To be 'interested' in alleviating the pressure on hospital emergency services by having a better on-call system in the 'maisons de santé', a common fund is essential. For example, if better tracking of patients' treatment could create savings by reducing the number of accidents involving elderly people falling, these savings could be diverted to provide better conditions for dependent elderly people or to improve other care elements.

As the regions are of a considerable size, each region could create smaller decision centres concerning the supply of healthcare covering populations of a smaller size, whilst still maintaining control over financial and organisational decisions for private doctors, the hospitals and the socio-medical teams. In the Primary Care Trusts in England in the early 2000s, 303 decision centres were responsible for organising all types of healthcare for around 160,000 people. In France, under the terms of the HPST law, the RHAs could reshape their main geographic population areas into health territories.

In addition, with a view to improving patient treatment tracking, the RHAs would be able to grant extra funds to finance the hospitals for carrying out activities of general interest for the health of the population (teaching and research, the emergency outreach service, poison control centres, mobile units for palliative care or for the elderly, etc.).

Finally, regionalisation of healthcare services should not restrict patients' interregional mobility. In the same way that there exists a compensation method between health systems throughout Europe, there would be a system for indemnifying one region for care provided to another region's residents.

Proposal 3. The RHAs should be responsible for the totality of the budget allocations for financing and coordinating all healthcare provided by local doctors, the hospitals and the socio-medical teams. They must be able to control the supply of healthcare, including the contractual arrangements and forms of remuneration for the totality of the medical profession.

Develop information systems

Digital technology is today mature, robust and capable of providing powerful, secure tools for use by healthcare professionals – for example, the electronic personal medical record which enables each healthcare professional to know the patient's medical history at their very first consultation; or informa-

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[22] In countries where there is regulated competition between several entities for health insurance, the insurers contract with the care providers to have treatment and care provided more efficiently.

[23] In the discussions on limiting the propensity for doctors to charge more than the Social Security rate, the profession uses the argument that property prices and rents in large cities such as Paris, Lyon and Marseille fully justify the higher fees. It is clear that a regional authority would be better able to appreciate the validity of this argument than any form of centralised discussion. Following the agreement with doctors signed in 2012, the CNAMTS has been seeking, not without a certain difficulty, to find a more subtle definition of what constitutes an excessive rate as a function of geographic criteria.

6. The Regional Health Authorities

The Regional Health Authorities (RHAs) were set up as part of a general overhaul of public policies. The twenty-six RHAs were created by the law of 21st July, 2009, called “Hospital, Patients, Health, and the Regions” (HPST for ‘Hôpital, patients, santé et territoires’). Their mission is to improve access to healthcare and to counter the silo effect between the hospitals and private doctors, with a view to improving the patient’s treatment path. According to a recent report from the French Cour des comptes[a], the creation of the RHAs should be seen as a major structural reform in driving the health system by strengthening its regional ties, and by removing the administrative complexity. But the RHAs are a long way from having the means to carry out their mission: institutionally, they are under such close control from the centre that it belies their status as a public body. The governing health department continues to directly treat dossiers concerning certain health establishments and to allocate budgets that have been retained at national level, further undermining the RHAs’ authority. Attempts at joint initiatives with the local health insurance offices struggle to get off the ground, because the RHAs do not have access to the CNAMTS’s information systems. Finally, the RHAs’ financial muscle is totally out of line with their mission: their choice in this area concerns less than 2% of the expenditure that they are supposed to control, from budgets that have been allocated in separate envelopes, thus accentuating the silo effect, in total contradiction with the transversal nature of healthcare supply.

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[a] Cour des comptes (2012): *Rapport sur l’application des lois de financement de la Sécurité sociale*, September.

tion about the quality of the care treatment dispensed to help patients choose and to create the basis for an understanding of the performance of the regions in the area of public health.

Such development is necessarily costly and will not produce instant savings. But it is an investment for a significant improvement in the quality of healthcare and in the efficiency of the system. Patients have every interest in avoiding redundant, substantial, even painful, tests and examinations. Reducing the inequality in access to healthcare is also at stake. Just as in the education system, the quality of a public service can differ from one establishment to another. For a patient, knowing where, and where not, to be treated, especially in cases of severe afflictions, is priceless information, but is something only known informally by relatively few. Put another way, the lack of information can often constitute, more than the financial barrier, a factor that increases inequalities, something that could be reduced by public dissemination of information concerning the quality of treatment.

Such organisation of information systems needs to be established at a national level[24]. For electronic personal medical records, the information has to be kept private and protected. The reverse is the case concerning performance indicators for healthcare providers and decision centres (RHAs or smaller units), where the information needs to be public and widely disseminated.

Generalise the electronic personal medical record

Since the launch of this project initiated by the 2004 law on health insurance, the electronic personal medical record (DMP for dossier médical personnel)[25] has resembled a permanent building site. When it was relaunched in 2010 it had been opened to about 300,000 people, with numerous gaps in the information held, whereas it should have already been in use for tracking patient care for all. The reasons for such an accumulation of delays have not been clearly defined, but they include technical difficulties, significant reticence from the medical profession, and public suspicion. It is urgent to make the necessary investments in order to convince all the players in the health system to seize this tool in the service of quality and efficiency in the provision of care.

Disseminate information concerning the quality of healthcare

Information needs to be produced and made publicly available concerning the quality of treatment administered in hospitals, ‘maisons de santé’ and homes for dependent elderly people (EHPAD for Établissements d’hébergement des personnes âgées dépendantes).

It is true that public information concerning hospitals is already available via the plate-forme d’informations sur les établissements de santé[26] information platform. This site publishes, for each establishment, indicators concerning the fight against hospital-acquired infection and the quality of the welcome accorded to patients (handling of pain, communication, working as a team in the cancer unit, etc.). It does not, however, provide any information concerning the medical per-

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[24] This is already the case.

[25] The DMP is an electronic record containing the patient’s medical history and current treatment, created with the patient’s prior approval, designed in order to share information between healthcare professionals: patient history, results of laboratory tests, X-rays and other imaging results, current treatment, etc. The aim of this information sharing, which is fully secured, is to avoid redundant examinations, tests and prescriptions and to coordinate better the treatment required.

[26] The acronym for which is Platines, see www.platines.sante.gouv.fr

formance by activity, which is why the French rush to buy hospital ranking published in the popular magazines. The indicators used in these classifications have not been authenticated by the institutions concerned, but they have the distinct advantage of showing how each hospital compares with others in very precise areas (childbirth, cataract surgery, hip replacements, etc.). The undeniable success of these lists shows the extent of public demand for information on the quality of treatment.

The prospective payment system (T2A) provides hospital incentives to be efficient in order to create a margin between the rate fixed by the regulatory body and the actual cost. The incentives put in place risk encouraging hospitals to limit quality in the search for cost savings, unless there is competition for quality. Economic theory predicts that competition at fixed price (which is the case with T2A) will tend to increase quality if demand is a function of quality, in other words if patients choose their hospital on the basis of the quality of care it delivers. It is in this light that, apart from the dimension of equity, the interest in disseminating information about the quality of treatment delivered by each hospital needs to be understood.

For this quality competition to function correctly, it is not enough just to publish the information –those who provide a better quality need to see their efforts rewarded with increased revenues resulting from the increase in demand. The payment system design needs to take account of this effect, and not drain off the revenues brought about by this increase in activity by an automatic reduction, as the floating point system does at the moment with the T2A. Applying rates for a stay in hospital at a regional level would provide a more appropriate tariff structure, as it would not depend on the value of the point for all the other hospitals as it does at the moment, but would apply a sliding scale beyond a certain level of activity defined by the RHA for the specific hospital in question.

Publish information concerning regional performance in the areas of treatment quality and access to care

Performance indicators need to be produced and published concerning the decision-making bodies, such as the RHAs[27], in order to make judgements about the effects of the choices made in the area of care provision. It would be the same nationwide, allowing comparisons of one RHA with another (or smaller entities, within an RHA, with each other). The indicators would reflect the different categories of expenditure as well as public health oriented achievements. Such results would include information that would enable the detection of any rationing of treatment, in particular a measurement on the trends in waiting lists, indicators that are markedly absent from the current monitoring of the French care system.

Proposal 4. Develop information systems aimed at the medical profession, patients and the authorities concerned, in order to minimise unnecessary examinations, engender competition for quality in the various establishments, promote equality of access to healthcare and give the appropriate authorities the tools necessary to drive the system effectively.

Conclusions

The French public health system has been the subject of numerous reports and attempted reforms. Today one can use existing institutions (Regional Health Authorities) and modern information system techniques to change the logic that drives the public health system as a whole, with very significant gains to be made in terms of efficiency and in equality of access to healthcare. To this end it will be necessary to make reasoned choices both as to what basket of healthcare items should be reimbursable, and as to the acceptable freedom of doctors to choose their place and manner of exercising their profession, and the manner in which they should be remunerated. ●

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[27] As well as for smaller decision centres which would be situated downstream of the RHAs.

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