Health care reforms in France: From theory to practice

Lise Rochaix
Professor at Panthéon-Sorbonne University (Paris 1) and Paris School of Economics
Chair holder: Hospinnomics
The author declares having no conflicts of interest
By way of preamble …

- Each health care reform has its ‘new’ Law in France … and its frustrations regarding implementation..

- Yet the ‘next’ reform often fulfills some of the objectives of the previous one, though calling it a different name ….

- An indication that there is ‘some’ convergence, despite hotly disputed political stances

… yet a slow process with little (if no) evaluation
Presentation outline

1. Overall performance of the French health care system
2. A bird’s eye view of the French healthcare system
3. Short presentation of main reforms
4. The way forward
5. Evaluation of public policy and its relevance in health care
Overall performance of the French health care system
France was n°1 under WHO’s league tables in 2000, mainly on ‘system responsiveness’

It was still n°1 under the 2007 European Commission’s survey of users’ satisfaction

Yet cumulated health insurance deficits reached 135 billion Euros in 2009 (11.5 billion Euros for 2009)

With:

• No significant differences in population health status compared to other EU Member States
• Persistent regional and social inequalities
• Non-neglectable co-payments with risk of increase in future
• Coordination issues between segments of care

=> The 2010 OECD study ‘Health Care Systems: Efficiency and Policy Settings’ gives a more precise picture …
Health care spending
2008

Source: OECD Health Data 2010.
Weak link between health care spending and outcomes

Source: OECD Health Data 2010.
Amenable mortality

All causes, 2007 or latest year available

Experienced Coordination Gaps in Past Two Years

* Test results/records not available at time of appointment, doctors ordered test that had already been done, providers failed to share important information with each other, specialist did not have information about medical history, and/or regular doctor not informed about specialist care.

Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.
Gaps in Hospital or Surgery Discharge in Past Two Years

*Last time hospitalized or had surgery, did NOT: 1) receive instructions about symptoms and when to seek further care; 2) know who to contact for questions about condition or treatment; 3) receive written plan for care after discharge; 4) have arrangements made for follow-up visits; and/or 5) receive very clear instructions about what medicines you should be taking.*

Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.
Decomposing the variance of health expenditure, France, 1960-1995

Source: L'Horty, Quinet et Rupprecht (1997)
A bird’s eye view of the French healthcare system

See ‘Health system in Transition (HIT) for France, vol. 12, n°6, 2010
Health insurance

• NHI
  – Mandatory, coverage for the entire population, employment based insurance

• Supplementary health insurance
  – 90% of the population with supplementary HI to cover co-payment and benefits excluded from NHI

• Exemptions
  – List of 30 ‘long term conditions’ with 100% coverage, 13% of French population, 62% of health insurance expenditure in 2008
Financing

• **1991: New levy tax** (CSG: ‘Contribution Sociale Généralisée’)
  – Larger fiscal base than social insurance contributions
  – Originally for family benefits, increasingly used for health care financing: today, more than 35% of total NHI funding.

• **The 1995 Juppé Ordinances**
  
  Vote by Parliament of target rate of increase of NHI expenditure (ONDAM -Objectif National Dépenses d’Assurance Maladie-)

• **2000: Universal medical cover** (CMU: ‘couverture maladie universelle’): two objectives:
  – Extension of benefit package to remaining fringe of uninsured residents (150,000 individuals);
  – Provision of additional cover for residents under threshold income
Ambulatory care

• Incentives on providers’ side
  – Predominantly solo-based, fee-for-service private practice with administered prices
  – Secteur II: optional extra billing, created in 1980; entry restricted since 1990; refunded partially or totally by some insurance contracts; 15% of GPs and 38% of specialists

• Incentives on patients’ side
  – Patients freedom to choose provider, with free access to specialist care until 2004 and some restrictions since then
  – Total out-of-pocket expenditure around 25%, mostly refunded by voluntary insurance coverage. Exemptions based on morbidity criteria.
Hospital care

- **Incentives on providers’ side**
  - Planning of beds and heavy equipment since 75
  - DRG type (PMSI) information system progressively introduced to replace global budget
  - ‘Unfair’ competition between public and private hospitals remains a major concern

- **Incentives on patients’ side**
  - No copayments (Ticket modérateur) for hospital care
  - A daily tariff to cover accommodation expenses set up in 83
  - on average, 8% out-of-pocket expenditure, with regular increases (around 15 euros today)
  - Financial neutrality for patient’s choice between public and private hospital care
Drugs

• 80s – 90s: Administered prices regime with discrepancies between European and national prices and high compensatory volumes achieved through advertising

• Introduction of voluntary contracting on prices and volumes at product/firm level with pricing committee (CEPS - Comité Economique des Produits de Santé), with incentives to participate in negotiations through a default clause for non-participating firms

• Incentives for generic prescribing by physicians and substitution right for pharmacists
Short presentation of main reforms

See ‘Health system in Transition (HIT) for France, vol. 12, n°6, 2010
What do French people think about healthcare reforms?

According to an opinion poll (Oct. 2009) on health care reforms:

• 90% of French respondents thought that reducing the health insurance deficit was important to ensure the sustainability of a system based on solidarity

• 62% thought that the deficit was mainly due to organisational problems, in particular, the lack of control on system use

• 55% thought that structural reforms have to be taken beyond cost containment measures;

• Among potential reforms, 69% would agree to the delisting of drugs with low medical added value ….
The steps towards structural reforms

**Paradigm shift** from the 80s (demand side regulation) to the 90s (supply side regulation) with the slow recognition that reforms are needed on both demand and supply

Attempts to contain fast growing health care spending through adoption of contracting and mixed payment schemes.
Reform process in the hospital sector

The 1995 Juppé ordinances

• 1996: creation of regional hospital agencies (ARH - Agences Régionales d’Hospitalisation -) to regulate public and private hospitals and to set budgets

• Implementation of activity based financing (T2A - Tarification de l’Activité) based on productivity scores (ISA - Indice Synthétique d’Activité) derived from DRG type information systems with progressive convergence of public and private hospitals

The 2009 HPST (Hôpital Patient Santé Territoire) Law

• Regional health agencies (ARS – Agences régionales de santé-) merging 7 regional bodies for ambulatory care, social services …

• Directorship enhanced at expense of medical power
Highlight on the regional hospital governance

Main changes
• Progressive introduction of DRG based payment scheme
• Encouragement of benchmarking and competition at regional level between public and private hospitals

Evaluation of the hospital reforms
• Carried out by IRDES (cf. Zeynep Or, Health policy Monitor, 2009)

Main results
• Contradiction between competition and centralised planning of heavy equipment + cooperation defined in regional schemes for health care delivery (SROS – Schémas régionaux d’organisation sanitaire-)
Reforms in the ambulatory care sector

Patients
- 2004: After several attempts over past 20 years, setting up of the preferred doctor scheme (‘médecin traitant) Intention: reduce patient’s direct access to specialist care by encouraging voluntary selection of doctor by patient; Financial sanctions in case of direct access (variable levels : from 3 to 30€!)
- 2009 HPST Law: Development of disease management and patient education

Professionals
- Agreements on good use of care (AcBus) defined by NHI
- 2004: introduction of lump sum payments for chronic patients through preferred doctor scheme
- NHI Individual contracting with physicians (CAPI -Contrat d’amélioration des pratiques individuelles-), on a voluntary basis, starting in 2009
- 2009 HPST Law: compulsory Continuous professional development
Highlight on preferred doctor scheme

Evaluation of the scheme
• Carried out by IRDES (cf. Paul Dourgnon and Michel Naiditch, Health policy, vol 94, n°2, 2010/02, 129-134)

Main results
• Lack of evidence to support reform decision
• Patients were in most cases already with a family doctor
• A useful step towards introduction of mixed payment schemes
• The rise in fee schedules granted to specialists as a compensation for ‘their’ loss of direct access has offset potential benefits
• Flexibility granted over time under political pressure (Direct access to gynaecologists, ophthalmologists, psychiatrists, neuro-psychiatrists and neurologists is permitted without penalty in certain circumstances and patients may change at any time) has limited the initial gatekeeping features of the reform

Result: complex payment scheme leading to difficult policy implementation
=> ‘Short term political success but little expected efficiency gains’
The ‘true’ obstacles to change

- Reluctance to make clear cut choices which makes implementation difficult
- Lack of recognition of the need to prioritize at national level, due to doctors’ legal obligation of means
- Fragmentation of professions’ representatives and strong corporatism
- Exacerbation of the value of freedom of choice compared to other objectives (equity, efficiency)
- Little use of evidence to support public policy definition
- Lack of adequate information systems on which to base contracting and incentives
04

The way forward
The shared diagnostic

While no definite answer has been given to the macro-efficiency’ question of ‘how much is enough’… and with variations in the percentage of GDP spent on health care

All EU countries converge on the need to:
- make limits on health care spending more explicit … and more binding
- make the best use of available resources (allocative and productive efficiency)
- Define priorities increasingly based on cost-effectiveness studies
OECD assessment for France

The French health care system shows:

- a generous cover (‘over the basic coverage performance’ indicator)
- A better than EU average information on quality and prices
- An ability to set priorities

Coupled with ‘limited’:

- stringency in the budget constraint
- ability to control prices billed by providers
- Levers for insurers (basic coverage)
The ‘true’ obstacles to change

• Lack of economic information systems on which to base contracting and incentives
• Fragmentation of professions’ representatives and strong corporatism
• Exacerbation of the value of freedom of choice compared to other objectives (equity, efficiency)
• Absence of use of public policy and economic evaluation through lack of competences at decision-making level
• Lack of recognition of the need to prioritize, still true today!
The trade-offs between objectives pursued by each country’s social contract

- **France**
  - **Equity (access)**
  - **Freedom (users and providers)**

- **United Kingdom**

- **United States**
  - **Cost minimisation for a given quality**
Enhancing the democratic process

- Increasing responsibility for the French Parliament through the vote of the indicative health insurance target budget (ONDAM - *Objectif National Quantifié des Dépenses d’Assurance Maladie*)
  - No longer an open ended retrospective payment system but a prospective definition of the financial target
- Accountability : The gouvernement is now accountable to the Parliament for the respect of ONDAM
- Increasing importance of patients and citizens through national and regional health committees (*Conférences de santé*)
Taking financial constraints seriously!

The global economic crisis will make EU financial constraints on public deficits increasingly stringent which will require:

• Ensuring that ONDAM is no longer overspent (currently under scrutiny)
• Sharing equitably the increased financial burden associated with technological progress and long term care with both supplementary insurance (while avoiding opting out) and users (while avoiding income effects)
• Reducing moral hazard on both supply and demand side through enhanced responsibility
• Introducing true prioritization mechanisms at the time of introduction of new health care technologies based on full health technology assessments
Evaluating health and health care policies

- Encourage evidence generation, guidelines production, evaluation of health care technologies
- Use full evidence when assessing health care strategies, including economics
- Systematise evaluation of public policy to learn from own mistakes
Evaluation of public policy and its relevance in health care
Purpose: Shedding light on ‘hard’ choices

Under scarcity, interventions must be prioritized

=> Evaluation can help by:

• Measuring the impact of health policies
• Understanding the mechanisms at work and their roles
• Help choose the optimal mix of policies

Three main objectives

• Public deficits control
• Improve quality of public services (value for money approach)
• Improve accountability (democratic control of public spending)

=> Towards ‘Evidence-Based Policy’
The key problem?

Inferring causality

Impact measurement implies attributing a percentage of the change to one among many possible explanations

=> From correlation to causality

• Identifying all possible mechanisms
• Building a convincing counterfactual (control group)

Public Policy Evaluation implies:

• Defining a reference framework (a set of criteria on intervention success)
• Formulate policy relevant research questions, in line with the reference framework
• Using both quantitative and qualitative tools from social science (economics, sociology, philosophy, etc.)

=> a global approach, beyond budget impact analysis
Moving to ‘Evidence-Based Policy’?

The 60s

The US General Accounting Office (GAO), followed by the UK and Scandinavian countries

The central role of EU from the 90s

Making benefit cost analysis a requirement for EU funded projects

The recent ‘South’ dynamic

External demand for evaluation (World Bank, IMF, WHO) and fight against poverty: experimental methods development with the Abdul Latif Jameel Poverty Action Lab (J-PAL)

Ester Duflo:

“You can put social innovation to the same rigorous, scientific tests (...) and in this way, you can take the guesswork out of policy-making by knowing what works, what doesn’t work and why”.
In France too?

In theory: the 18/11/1998 decree

« Public policy evaluation aims at assessing the efficacy of an intervention by comparing its results to its assigned objectives, given the available means ».

In practice …

• Objectives are sometimes blurred, if not contradictory
• Measuring impacts is difficult, due to the non univocal relationship between inputs and outputs (multiple mechanisms)
• Obstacles due to policy makers’ reluctance to be judged
The necessary condition?

Access to individual data to measure SMART indicators

⇒ Accounting for heterogeneity
⇒ SMART indicators (Specific, Measurable, Achievable, Relevant, Timed)

• Survey data (limited representativeness)
• Administrative data (size effect)
  – Private (ex: patients’ networks ‘Patients like me’)
  – Public (ex: French national health insurance data –SNDS, fiscal data)

⇒ The future: data linkage
The recent steps in France

• The recent legal steps towards data access in France
  – Statistical data (July 2008 Law)
  – Fiscal data (July 2013 Law)
  – Health data (January 2016 Law)
  – Numerical data (October 2016 Law)

• An increased use of socio-economic calculus
  – Haute Autorité de Santé (CEESP)
  – Health Ministry (DREES)
  – …
Conclusion

In order to anchor public decision on scientific productions (Evidence-Based Policy) in France, more must be done on:

- Easier access to linked data sources
- Production of relevant, robust and SMART indicators
- Results’ analysis using econometrics
- Reform micro-simulations

Convincing decision-makers that evaluation can be useful remains the biggest challenge: France Stratégie has set up an expert’s committee for this purpose.
Thank you for your attention

www.hospinnomics.eu