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Considerations Concerning the Organisation of Health Systems

Report by Gilles Saint-Paul

In this report, Gilles Saint-Paul gives his thoughts on the organisation of the health system in France. As an economist working outside the health sector, he proposes a number of possible reforms for a sector of the economy with very specific characteristics. With a deliberately external view, he focuses his attention on two areas. First, the author asks what is it that can justify that health insurance and a part of health provision should be public and not private. Secondly, he explores the system of hospital financing by activity (T2A -for 'tarification à l'activité'). This is a system whereby each act performed in a hospital has an associated tariff. This has the effect of an incentive for the hospitals to adjust their costs to the level of the tariffs imposed from the outside, but naturally raises the burning question of how these tariffs get fixed. Finally, the author reaffirms the validity of measures that help all the various stakeholders in the system (patients, doctors, health insurance firms) to take on board the costs. In particular the author recommends adopting a system of fixed-sum and ceiling with the figures for these being subject to a means test.

EDITORIAL

This report considers two aspects: What is the economic justification for state involvement in the health sector? What judgement should one give to the system where each medical act has a fixed tariff, and how can the system be improved?

The first part considers the usual arguments in favour of a state-run system. But the author argues that it is essential to dispel certain elements of received wisdom, and to reset certain parameters, and not just because the economic and budgetary situation is currently having a difficult time.

The system of financing French hospitals by activity (T2A - see below) is an improvement compared with what was in place before. But it raises a certain number of issues. The report underlines the difficulty in establishing a pseudo-market in which the usual competition mechanisms for determining prices have been removed from the beginning. How should one evaluate the notions of efficiency in allocating resources and in seeking social justice? How should one reconcile redistribution and incentives? The debate about what part the patient should pay (in French 'franchise' and 'ticket modérateur') is therefore open...

Christian de Boissieu
Former Chairman of the CAE
Professor at the Paris I-Panthéon-Sorbonne University

State involvement in the health sector

To begin with, Gilles Saint-Paul asks the question concerning the justification of a public monopoly in health insurance. The author explains that the market for health-care insurance is clearly not just like any other market, in particular because it is subject to two key characteristics not found elsewhere – moral hazard and adverse selection.

Justification for state intervention in the health insurance sector

Moral hazard justifies the use of the '*ticket modérateur*' (the part of the cost not covered by the state insurance scheme), otherwise there would be no effective limit to health expenditure, it being insured at 100%. Adverse selection would lead, if not exactly to the extinction of the health insurance market, to creaming off the high risk cases and demanding correspondingly high premiums. This well-known characteristic of the insurance market applied to reimbursing the costs of health care would prevent the horizontal redistribution between the healthy and the sick, which is one of the fundamental principles of health insurance.

The health care market is also incomplete in that a certain number of afflictions or

predispositions to illness are hereditary and, being present from birth, cannot give rise to insurance *ex ante*.

In addition, the mandatory nature of health insurance is based in part on the notion that people are very short-sighted and sometimes do not see the point of insuring against serious illness if the chance of contracting such illness is very low. The state adopts a paternalistic attitude and decides to insure everyone.

Finally, the author looks at health insurance as a means of redistribution in terms of services or goods. The usual arguments favour monetary redistribution, which allows the individual the choice of how to use the sums provided, something which is impossible with specific services or goods. Nevertheless, the author recognises that a more detailed analysis of the link between income and health-care demand could modify this sort of argument.

Objections to these justifications

The author responds to each of these arguments by saying that, whilst a state-operated health insurance system is certainly one way of handling the situation, it is not necessarily the only way.

The existence of a fixed sum payable by the individual is perfectly feasible with a private health insurance scheme. In addition, it is perfectly possible simply to forbid creaming off caused by adverse election for both private and state-run insurers. In the same way, private insurers could be obliged to accept all customers, including those with hereditary pathologies or afflictions discovered at a very early age. As far as paternalism is concerned, the author suggests that mandatory subscription to a health insurance scheme, coupled with suitable publicity concerning risks, would overcome the problem of peoples' short-sightedness.

In conclusion the author states that none of the arguments put forward can justify the claim that private health insurance would be ineffective. Health insurance suffers also from the system of complementary insurance, which the author would like to see replaced by a system of supplementary insurance. For each health service product, a single insurer would be involved, thereby limiting the problems associated with an absence of coordination between multiple insurers.

Critical analysis of the T2A

In the second part, the author provides a detailed analysis of the implications of the T2A system for financing health care provision. The T2A system applies to all public hospitals and to certain contracted private clinics. It consists of a grid of all the various pathologies, grouped by similarity of tests and acts carried out into GHM (*groupe homogène de malades* or diagnosis related group), with the tariff for reimbursement for each GHM. The author recognises the improvement that the T2A has achieved compared with the previous system whereby hospitals were reimbursed simply on the basis of the actual costs incurred. Nevertheless, Gilles Saint-Paul believes that certain points should be debated:

- are the tariffs correctly established?
- are the categories really homogeneous?
- does the signal given by the tariffs give rise to the desired reallocation of resources?

Tariff definition and the balance within the healthcare market

While recognising the peculiarities of the healthcare sector, Gilles Saint-Paul nevertheless recommends a microeconomic analysis of the market sector, and to study the implications of the T2A system as it affects the balance of supply and demand in the provision of healthcare.

The T2A represents a definite first step in having the importance of a price signal recognised in the market for providing healthcare. However, it is an asymmetric indicator in the sense that it has difficulty in reflecting the value that the person receiving the care perceives, and can really only act as a cost signal for the providers of the care.

On the demand side, it is difficult for the health authorities to measure the marginal value that patients perceive in the care received. They need to have recourse to ancillary studies and estimations so as to arrive at a value for a “health product”. These methods, however, tend to produce an average value, and not the marginal value, of the care provided. It is thus possible that the health authorities overestimate the value, and recommend tariffs that are too high. And in their turn, the hospitals would then be encouraged to increase the offer more than is required. In addition, such evaluations are also incapable of measuring the external benefits associated with care provision (the most significant being vaccination) that add a social value to the demand for healthcare. One solution for helping to understand the value that patients feel would be to create a form of rationing using waiting lists. The more the scarcity of a particular GHM is felt, the greater would be the increase in its tariff.

On the supply side, the purpose of the T2A would seem much clearer: the system imposes a standard reimbursement based on the average cost observed from a survey using a representative sample of healthcare establishments. The T2A encourages hospitals to improve their productivity, and to reallocate resources accordingly. But depending on the nature of the cost structure in each establishment, the consequences of an administrative tariff, equal to the average cost, can vary considerably.

If one considers that unit costs are constant and independent of the throughput, the T2A tariff will force the least productive establishments to restructure their activities, or even to close down. And if the unit cost increases with the throughput (difficulty in duplicating the same activity), the T2A tariff could have dramatic consequences because, in that situation, the hospitals would never be able to recover their costs. If increased throughput caused a reduction in unit costs (amortising fixed costs), then a classic case of a natural monopoly would result. Finally, in the situation where, for each establishment, there is an optimal size for minimising the cost of production, the T2A tariffs would have the effect of selecting the more profitable hospitals. That would raise the question of the amount of the throughput, since nothing would guarantee that those establishments with the most profitable activity using the imposed rates would be offering the optimal level of activity.

The T2A is also a powerful tool in displacing the offer of healthcare. For example, certain activities that can be handled in out-patient mode have seen their tariffs increased compared with the same care offered to in-patients. Such adjustments reflect the desire of public health authorities to favour out-patient activities to respond to a change in the demand for certain care. The author, however, wonders how in practice the public health authorities can calculate the level of increase necessary to have the desired effect on patients' behaviour, and for how long this difference in tariff needs to be applied.

To ensure overall budgetary control of health expenditure, the T2A tariffs are adjusted uniformly downwards, as soon as the ONDAM objective is achieved. ONDAM (for Objectif national des dépenses d'assurance maladie) is the provisional budget allocated to public health insurance in France. But uniformity in the lowering of tariff has absolutely no incentive effect on individual behaviour – it would be more effective to reduce the tariffs for those professionals who over subscribe, and not for the profession as a whole. In its current form, the T2A and ONDAM combination creates the problem of the stowaway on board ship. The author therefore suggests it would be better to focus legislation on individual incentives, even if that means forgoing overall control of expenses, since the latter introduces a form of overdetermination.

The question of the homogeneity of the GHMs

Defining the GHMs raises the thorny question of how precise is the mapping of the various pathologies. Not only do they have their own defining characteristics (respiratory, digestive, etc.) but, with each pathology, there is also the question of how severely afflicted is the patient. Depending on the severity, a flat-rate reimbursement could lead to adverse selection. However, international comparisons suggest that France has developed a particularly detailed version (more than 2,000 GHMs, compared with Germany's 1,200).

In addition, though, there is the inherent heterogeneous nature of the care and treatment offered from one healthcare establishment to another. It is quite possible that a single rate T2A does not lead to homogeneity in the quality of care provided, but rather to different lengths of time on waiting lists – high quality establishments effectively rationing their care and appointments more easily obtained elsewhere. It is fair to say that the link between the T2A tariffs and an acceptable quality of care is not obvious, and the idea needs to be treated with caution.

The question of reallocating resources

The T2A is designed to give a price signal to care providers. Ideally, this signal should encourage them to adapt their offer as a function of their costs relative to the tariffs in place. But it is far from certain that establishments react systematically in this way. The effect of some recent incentives involving the possibility of bonuses for following this policy have not yet had the time to be measurable. In passing, one should note that the logic of aligning production costs would indicate that certain establishments should cease certain activities, but the strength of the opposition to this idea is sufficiently strong to delay or even prevent such closures.

Economic policy and health care provision

The French system of health insurance tries to manage two objectives which push in opposite directions – ensure equal access to health care for all citizens, and put a brake on ever increasing costs. It would seem that increasing the level of the *ticket modérateur*, thereby installing a dose of individual responsibility, even progressive, should have a positive budgetary effect, without necessarily involving a significant anti-distributive influence.

The author is in favour of a fixed-sum/ceiling mechanism, annualised perhaps, where the sums involved would be linked to the individuals' incomes. By adopting this idea, the government would be choosing to have health insurance working as a vertical redistribution system.

Gilles Saint-Paul proposes an ambitious reform, consisting of establishing individual health accounts. Such accounts would be credited initially with a certain defined sum. Each time any health care 'product' was used, the account would be debited. No-one would be obliged to pay any negative balance but, on the other hand, someone with a positive balance, above a certain threshold, could ask for that to be reimbursed in cash. With such a health account system, someone who makes the effort in terms of prevention, detection and early treatment could see him/herself with a positive balance over time. This could be a significant financial incentive to adopt such beneficial practices. On the other hand, a system with an annual ceiling with the excess being paid for by the state would be much less of an incentive for those who go beyond such a ceiling, and such people would be much less likely to moderate their consumption or adopt good practice once this ceiling had been reached.

Gilles Saint-Paul believes that such incentives could also be directed towards healthcare professionals. The T2A is clearly a first step and it provides the price signal, but it fails to provide the connection between the tariffs and the incentives for redirecting care. Overcoming this obstacle requires implementing processes for incenting public hospitals, or developing private institutions, be they non-profit-making or otherwise. It would seem desirable also to extend the idea of the T2A to those medical practitioners who operate outside the hospital system in private practice. It is fair to point out, however, that any reorganisation carried out as a result of applying the T2A tariffs would be less effective and also more painful for small scale surgeries than for large hospitals. But the current trend for doctors to form private urban groupings of some size would suggest that extending the 2A concept to these structures would be a help.

Comments

According to **Franck von Lennep**, Gilles Saint-Paul's arguments are mainly based on his view that the price signal offered by the T2A system is not sufficiently used by the principal stakeholders in the French healthcare system. But von Lennep is not convinced that an increased recourse to the mechanism would always be desirable.

As far as individual behaviour is concerned, von Lennep questions the pertinence of the moral hazard *ex ante*. And as for the moral hazard *ex post*, if this exists – and it is clear that reimbursing the totality of health expenditure is an obvious incitement to over consumption – the quantity concerned would seem to be marginal. In addition, by increasing the proportion paid by the patient, all expenditure is reduced, not just that which is considered as ineffective, which suggests treating this idea with some caution. An excessive reduction in expenditure on health – especially that devoted to prevention – could prove to be counter-productive.

Concerning the healthcare providers, von Lennep salutes the subtlety of Gilles Saint-Paul's analysis of the implications of the T2A system. This idea could also be taken further. Efficiency gains are possible both in the hospital environment and in the local doctors' surgeries (in the area of drug prescriptions for example). The tariff lever is real – as exists in Germany, the T2A tariffs should be on a sli-

ding scale at the level of care provision by establishment, and not at the national level as is the case with ONDAM. Nevertheless, over and above these price-based incentives, it's the whole healthcare system that needs redesigning. Defining a basket of care items, recommendations on best practice and a far better coordination between the local doctors and the hospital teams are all essential steps, and deserve to be given serious consideration.

Brigitte Dormont agrees with Gilles Saint-Paul both on the pertinence of an economic analysis and on the need for clarity in defining the health service's objectives, as well as measuring its performance. However, she believes that some of the conclusions from this economics-based treatment are pushed to a level that renders them difficult to implement. However, Dormont does recognise that the report highlights certain essential truths – the need to have a clear separation between the role of the standard health insurance and that of the complementary insurance, the inability of the T2A system to respond to three simultaneous objectives, and the thorny problem of incorporating the concept of care quality into the T2A tariff definitions.

But she is disappointed that the report did not include a statement on the current situation with regard to running the health system and show how it had improved, or otherwise, compared with the previous report from the CAE under the guidance of Michel Mougeot.

As for the hospital function, Brigitte Dormont claims that the T2A tariff grids are so precise that they resemble a system of payment by act, something which would itself be likely to create the demand. In addition it is necessary to take account of the two types of moral hazard (that concerning supply as well as that concerning demand) and compare their respective effects on demand for care.

Brigitte Dormont then turns her attention to the question of health insurance, the subject of the majority of her comments.

The key question is not whether the system is public or private, but rather its status (mandatory or optional) and the number of organisations offering the insurance (a single insurer or several in competition with each other). The paternalistic argument put forward by Gilles Saint-Paul is certainly relevant but, over and above the individual's incomplete appreciation of risk, there is a second reason that justifies health insurance being mandatory: *a posteriori*, critical and emergency care is necessarily the responsibility of the community. It is inconceivable that those who suffer from severe and critical conditions should be left without any care, just because they chose not to be insured.

As Gilles Saint-Paul points out, the tandem of obligatory basic insurance/complementary insurance is a peculiarity of the French system; elsewhere, optional insurance is additional and reimburses expenses incurred other than those that are covered by the mandatory system. The French system may well be a source of inefficiency, but the analysis needs to go deeper. First, for those who do not have access to a company scheme, the subscriptions are on a sliding scale. They can be very high for the more modest households, effectively creating a barrier to entry. Secondly, the complementary insurers get round the ban on basing subscription rates on the person's state of health by offering a variety of different contracts. They segment the market in such a way that the the individual is oriented towards the contract the company prefers he takes. This has the effect of of reducing the level of mutualisation along with high subscriptions for certain people. Thirdly, the fact that the majority of complementary insurers compensate for any reduction in the rate of reimbursement by the state system (for certain drugs, for example) can be counterproductive. Fourthly, what remains for the individual to pay can be very high for a small minority of people, those who do not have complementary insurance and those not covered by the system for long-term pathologies.

Brigitte Dormont is convinced that the current health insurance system needs to develop and adapt. This could involve regulating the complementary insurers, prohibiting selection with compensation for the risks involved. One can also imagine a single insurer or a regulated competitive environment for several. Another solution would be to have a capped amount, with everyone paying a fixed sum which would serve to finance those who needed to go beyond the cap as a result of requiring long-term repetitive treatment.

The obligatory part of the insurance should be based on a minimum basket of care, according to Brigitte Dormont. Obviously, defining such a basket, plus understanding how it should evolve in line with technological advances, would necessitate some tough budgetary choices about where to make savings. Finally, the current French system is increasingly using certain medico-economic indicators, in particular the QALY measurement, as a means of evaluating an individual's state of health.

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