



# Rebuilding the Health Insurance System

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The French health care system is characterized by the mixity of its health insurance system. Two layers contribute to covering the same healthcare expenditures, the National Health Insurance (*Sécurité sociale*) and a number of complementary insurance companies. Such an organisation entails high management costs and encourages an increase in healthcare costs. The current regulation of the complementary insurance market also encourages risk selection, which results in inequalities in access to insurance and healthcare.

Currently, most deductibles are covered by complementary insurance. Moreover, subsidies in the form of social exemptions for complementary insurance provided by employers result in more generous coverage that encourage an increase in balance-billing, which is, in turn, detrimental to the access to healthcare for those individuals that are less well covered. Furthermore, the great variety of complementary insurance contracts makes the choice difficult for consumers, which hinders competitive mechanisms. Finally, complementary insurances currently have no means to monitor health-care providers to improve efficiency in care delivery.

Some efficiency gains can be achieved through introducing cost sharing for patients with regards to expenditure over which they have some leeway. But most efficiency gains can be expected from a better organization of care provision through the possibility for insurance companies to selectively contract with health-care providers. This possibility will depend, at the very least, on a short-term reform of the French health insurance organisation, but only a rebuilding of the system would truly foster such contracting process.

On the patient side, we suggest providing 100% coverage for hospital care, except for the *forfait journalier* (a daily lump sum payment) which would be reduced to 8 euros. For primary care, we suggest replacing all current deductibles

and other patient contributions with a unique deductible, followed by a co-payment, combined with a ceiling to cap the expenditures finally supported by individuals. Complementary insurances would not be authorized to cover the total patient cost-sharing (deductible + copayment), but the total amount of cost-sharing would be capped. Moreover, the levels of both the deductible and ceiling could be adjusted or removed (full coverage) for low income people.

A short-term reform of the insurance system would keep unchanged the scope of intervention of both the National health insurance and complementary insurance companies. It has to involve complementary insurances in contractualisation with care providers and to stimulate competition in the sector by designing a standardized contract that all complementary insurance companies should offer and by removing subsidies in favour of employer provided contracts.

Eventually, however, it is crucial to put an end to this mixed insurance system. Two possible scenarios can be considered: a decentralised public version and a version where health insurance is provided by several sickness funds in regulated competition with one another. In our proposal, both versions are based on identical funding by means of income-proportional contributions, and comply with the same principles of solidarity both between the healthy and the sick and between high and low incomes. The main issue is not the choice between private or public players but rather the quality of coverage and the introduction of mechanisms designed to boost the efficiency of healthcare expenditure. Moving away from the current organisation is a goal that might be difficult to achieve since it disrupts the current organization and long-established players that operate within it. The cost of the status quo however, appears to us high enough to invite the public decision-maker to commit to such a move.

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Although health expenditure is higher in France than in many other developed countries, the health system does not perform exceptionally well, particularly in terms of social inequalities. The French system, which is funded by universal health insurance that offers partial reimbursements supplemented by complementary insurance, is a source of both inequality and inefficiency.

The policy currently in force aims to improve the citizen coverage by extending the complementary coverage, without challenging the players involved in the health insurance system or their scope of intervention. The design of the health insurance system is not considered together with the issue of managing the supply of healthcare.

Our first observation is that the organisation of the French health insurance system makes it impossible to implement the founding principles of our system, known as the '1945 Pact' and summarised by the maxim 'from each according to his means, to each according to his needs'. Average coverage in France is generous, but does not protect individuals against the risk of very high 'out-of-pockets expenses'; in this case, access to healthcare involves a cost that is not proportionate to the individual's financial means, which contravenes the principle of 'from each according to his means'. Furthermore, whilst social health inequalities are particularly noticeable in our country<sup>1</sup>, the resources devoted to primary care are allocated according to actual expenditure observed (on the basis of a fee-for-service payment scheme), which does not reflect the idea of services being provided 'to each according to his needs'.

Our second observation is that the French system is not viable in the medium-term since it does not incorporate any real mechanism for monitoring healthcare provision. On the contrary, the way in which it is funded entails a number of mechanisms working in favour of excessive expenditure. Providing individuals the best coverage without containing healthcare expenditure leads eventually to condemn the system. There is no point attempting to improve coverage without seeking to contain expenditure.

We do not address the issue of long term care, which does not fall within the scope of the present Note. We suggest a number of short-term measures to improve the French health insurance system in terms of greater protection where healthcare coverage is concerned and greater efficiency when it comes to expenditure.

It is, however, crucial that a rebuilding of the system be considered. It currently offers a mixed coverage since both financing parties, the national health insurance and complementary insurance companies, contribute to covering the same healthcare services. It is important to put an end to

this mixed system in order to really improve efficiency. Two possible scenarios can be considered: one is a decentralised public management and the other one is a regulated competition between multiple insurance companies.

## Current performance and design of the French system

Any insurance system has a twofold objective: to limit the risks borne by the insured party and to instil a sense of responsibility in order for them to help control expenditure. Indeed, any spending overrun, regardless of whether or not it is covered by insurance, is always, in fine, funded by households. In the case of health, the accountability of the insured party is limited by the difficulties in accessing healthcare that it might give rise to. Expenditure control relies first and foremost on the accountability of care providers and ensuring that they provide appropriate care at a reasonable cost. The performance of the French health insurance system is particularly unsatisfactory with regards to the two objectives of risk coverage and expenditure control.

## Unsatisfactory performance with regards to coverage

Based on the Conseil National de la Résistance (National Council of Resistance) programme, French social security system is supposed to guarantee universal solidarity. Those responsible for designing the system did, however, provide from the outset for incomplete coverage of healthcare expenditure, allowing for optional complementary protection to be taken out. The deductible was officially intended to limit expenditure by requiring the patient to pay part of their healthcare costs. In practice, however, it has been covered by complementary insurances.

In France, healthcare coverage is divided between the social security and complementary insurances, with 76.7% of healthcare costs covered by the social security and central government and 13.7% by complementary insurances. The remaining funding, namely 9.6% of the total expenditure, is paid directly by households. This average rate of direct payment is one of the lowest in Europe, but it does include some significant inequalities, with some patients incurring very high out-of-pocket costs.

The health insurance branch of the social security is suffering a chronic deficit. A number of recovery plans have been adopted since the 1950s, combining increases in contributions with decreases in reimbursements through patients contributions and the introduction of non-reimbursement practices, deductible and flat rates. The deductibles put in

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<sup>1</sup> Cf. Askenazy P., B. Dormont, P-Y. Geoffard and V. Paris (2013): "Towards a More Efficient Health System", *Les Notes du CAE*, no 8, July.

place at the time the health insurance system was created were set rather high, at 30% for a medical consultation, 20% of hospitalisation costs<sup>2</sup>, etc. Nowadays, these figures are not capped and the costs are covered by complementary insurance. A number of co-payments have been introduced since 2004 and patients now have to pay ‘standard contributions’ of 1 euro per medical consultation or biological or imaging analysis and 18 euros for procedures for which the reimbursable rate exceeds 120 euros. Other co-payments, known as deductible were introduced in 2007, meaning that patients were then required to pay 50 cents per box of medication and per paramedical procedure and 2 euros per journey for medical transportation, with an annual cap of 50 euros. The hospital charge introduced in 1983 corresponds to a contribution on the part of the sick to the accommodation costs incurred and currently stands at 18 euros per day of hospitalisation.

The introduction of such financial contributions has been accompanied by a number of compensatory measures aimed at the least well off and the sickest. The CMU-C<sup>3</sup>, for example, has been offering free complementary cover to those on low incomes since 2000, whilst for insured parties suffering with a chronic condition listed on the long-term illnesses (LTI) list, 100% of the cost of any care related to said condition is covered. The combination of these measures results in an average level of social security coverage that varies greatly among socially insured parties. A relatively low level of coverage for the vast majority of insured parties (82.4%) who do not benefit from the LTI system : indeed, such individuals were covered at a rate of only 59.7% in 2010 (Table 1).

### 1. Average level of coverage provided by the social security for service-users in 2010, in %

	Non-LTI <sup>a</sup>	LTI <sup>a</sup>	Total
All care	59,7	88,0	75,0
Ambulatory care excluding optical	56,6	86,0	71,8
Ambulatory care including optical	51,6	84,0	67,7
Hospital	88,6	95,1	92,9
Proportion of service-user population	82,4	17,6	100,0

Note: <sup>a</sup> Long-term illness.

Source: HCAAM (2012).

Any coverage analysis must take into account the great concentration of healthcare expenditure: every year, 50% of the expenditure covered by the social security concerns only 5% of insured parties. This characteristic stems simply from the value of the treatment concerned, with costs, in

some cases, reaching extreme values that exceed the financial capacities of the wealthiest households. The obligation to insure that is imposed in France, and indeed in most developed countries, makes it possible to share such extreme risks across the population as a whole.

Individuals can, however, find themselves exposed to significant out-of-pocket costs<sup>4</sup> when the insurance offers only partial coverage with no cap on direct costs, as is the case in France (*cf.* above).

The average out-of-pocket cost in 2010 for those who had ‘consumed’ healthcare was 498 euros, including 456 euros for ambulatory healthcare and 41 euros for hospital care. However, given the concentration of healthcare expenditure, these averages are a poor representation of the risks encountered –in the case of ambulatory healthcare, 1% of insured parties have an average out-of-pocket cost of 4,026 euros, whilst for hospital care, 1% of insured parties have an average out-of-pocket cost of 945 euros. These amounts are the result of the application of the patient’s contribution system, as well as the fact that social security reimbursements are based on conventional rates, whereas Sector 2 doctors can require extra-billing and the costs of certain medical supplies, particularly in the optical field, dentures and hearing aids are far higher than the social security reimbursement rates. More than half of the out-of-pocket cost of the upper percentile, that is 2,684 euros, is the result of ‘free price setting’ (Table 2).

### 2. Annual out-of-pocket expenditure for insured parties after reimbursement by the social security<sup>a</sup>, in euros

	All	By expenditure type		By tariff type	
		Community-based care	Hospital	Enforceable rate	Free price setting
D1	18	18	0	18	0
D5	221	215	6	181	40
D10	2 090	1 812	278	985	1 105
C100 <sup>b</sup>	4 971	4 026	945	2 287	2 684
All		456	41	286	212

Notes: <sup>a</sup> Averages per decile and for the last percentile for service-users in 2010; <sup>b</sup> over the 2008-2010 period, the average cumulative value of the out-of-pocket cost for those in the last percentile of consumption stood at 10,106 euros.

Source: HCAAM (2012).

These amounts go a long way to explaining the renouncement of healthcare we are observing among those who are not covered by complementary insurance policies<sup>5</sup>. Even between those with complementary coverage, there is a

<sup>2</sup> Births, those suffering from a long-term illness and stays involving a surgical procedure are not subject to patient’s contribution.

<sup>3</sup> *Couverture médicale universelle-complémentaire* (‘Universal Medical Cover-Complement’).

<sup>4</sup> The term out-of-pocket cost here refers to amounts not covered by public health insurance with regards to expenditure covered by the reimbursement system. It includes patients contributions, lump-sum payments, deductibles, the daily hospital payment and any expenditure exceeding enforceable rates.

<sup>5</sup> 32% of those who are not covered claimed to have renounced care over the course of the year, a rate double to that observed among those with complementary insurance, *cf.* Desprès C., P. Dourgnon, R. Fantin and F. Jusot (2011): “Dépense de santé et accès financier aux services de santé” in *Les comptes de la santé 2010, Série Statistiques, DREES*, no 161, pp. 85-96, September; see also HCAAM (2012): *Rapport annuel 2012*, p. 24.

great difference in the levels of coverage provided, with 47% of policies not covering extra-billing<sup>6</sup>, on the one hand, and in some cases overly generous coverage, particularly in the framework of collective contracts, on the other hand.

Is complementary healthcare coverage accessible to all, above and beyond the CMU ceiling? Prior to the extension of corporate complementary coverage outlined in accordance with the 2013 law on securing employment, around 40% of those with complementary coverage already benefited from this thanks to a corporate collective contract. For others, access to complementary coverage is optional and involves paying a premium that is often independent of the individual's income and increases with age. The funding mechanism would therefore appear to be regressive, given, for example, that in 2006, the proportion of income spent on purchasing complementary coverage independent of the employer stood at 2.3% for the wealthiest 10% of households, but could reach up to 8% for the poorest 10% of households that were not eligible for the CMU-C<sup>7</sup>. Such an effort to secure complementary healthcare coverage alone might seem prohibitive for low-income households, causing them to decide against taking out insurance. On average, a low proportion of the population (4.2%) had no complementary insurance in 2010, although this proportion reached 8.5% among the poorest 20% of households<sup>8</sup>.

### A flawed design

France is renowned for the mixity of its insurance system, with none of its major European partners having such a structure in place<sup>9</sup>. It is also particularly costly, since it hinders the control of health expenditure and involves high management costs. Furthermore, the way in which the sector is regulated does not allow for competition that would encourage healthcare costs and complementary insurance premiums to be moderated.

### Lack of coordination with regards to controlling expenditure

Insurers must seek to control healthcare expenditure for any given level of coverage in order to be competitive. Potential mechanisms for limiting costs include the following:

- with regards to the demand for care, co-payments encouraging the insured party not to over-consume, where the level of consumption of the care available can be influenced by the patient's behaviour;
- with regards to the supply, contractualisation with care pro-

viders specifying rates and forms of payment with a view to improving the quality and efficiency of the care provided.

The implementation of such mechanisms in France is hindered by the lack of coordination between the social security and complementary insurances.

With regards to the demand, whilst the patient's contribution is useful, it is difficult to understand why a complementary insurance provider and its clients would be allowed to make an arrangement to the detriment of social security, to cancel the incentive effects of the latter. A tax provision was introduced in 2006 with the aim of encouraging the introduction of so-called 'responsible' contracts, which should cover neither the standard contribution of 1 euro nor the 'deductible' or increases in patient's contribution which penalise any failure to respect the care process. These provisions are, however, somewhat modest in relation to the extent of deductibles that remain fully covered, the role of which is unclear, other than to make a share of the market available to complementary insurances.

With regards to the healthcare supply, the shortcomings of the French system are even more significant. In systems based on regulated competition between insurance companies (see Box), controlling costs requires contractualisation with care providers, with insurance providers spurred on by the quest for competitiveness. Incentives for insurance providers in France to offer an efficient service are low, since the social security has the monopoly and the current organization of complementary insurance distorts competition in this sector (*cf.* below).

In any case, the structure of the mixed system is an obstacle to any real contractualisation, which would require concerted action between the social security and the insured party's complementary insurance provider for the purposes of negotiating with the care provider or pitting care providers against one another. This process should also observe the principles of fair competition between complementary insurance providers. In other words, for each care provider, the social security would need to enter into as many negotiations as complementary insurance companies, whilst ensuring that all providers were treated equally –mission impossible! Currently, existing, limited contractualisation stems from the social security only, except for optical and dental sectors, where the low rates of reimbursement by the social security leave a great deal of room for complementary insurance<sup>10</sup>. It is worth pointing out that complementary insurance companies do not have access to personal information

<sup>6</sup> Garnero M. and V. Le Palud (2013): Les contrats les plus souscrits auprès des complémentaires santé en 2010», *Études et Résultats, DREES*, no 837, April.

<sup>7</sup> Jusot F., C. Perraudin and J. Wittwer (2012): "L'accessibilité financière à la complémentaire santé en France: les résultats de l'enquête Budget de famille 2006", *Économie et Statistique*, no 450, June.

<sup>8</sup> Dourgnon P., S. Guillaume and T. Rochereau (2012): "Enquête sur la santé et la protection sociale 2010", *Les Rapports de l'IRDES*, no 1886.

<sup>9</sup> Supplementary insurance is available in many countries but does not cover any care included in the basic package. The French system differs in that the same instance of care, such as a consultation, for example, is reimbursed up to 70% by the social security and 30% by a complementary insurance company.

<sup>10</sup> Care networks have been set up by complementary insurers to provide optical care, dentures and hearing aids, see HCAAM (2013): "La généralisation de la couverture complémentaire en santé". In the name of professional independence, doctors are strongly opposed towards any care network that might be developed by a complementary insurer. The *Conseil de l'Ordre* (National Medical Council) and doctors' unions were also greatly opposed to any performance-based payment, before the premiums proposed by the CNAMTS in return for performance measured using a series of practice quality indicators had encountered any real success among doctors. See Dormont B. (2013): "Le paiement à la performance: contraire à l'éthique ou au service de la santé publique?", *Les Tribunes de la Santé*, no 40, pp. 53-61, March.

on insured parties, which is in fact held by the *Caisse Nationale d'Assurance-Maladie des Travailleurs Salariés* ('National Health Insurance Fund for Salaried Workers', CNAMTS). Insurance companies intervene further downstream and receive only the administrative information they need to process the reimbursement, with no power to improve the efficiency of the system.

### A costly and subsidised system

The French health insurance system is costly in terms of both administrative costs and tax expenditure that are deemed necessary to ensure that its complex, semi-private structure fits the mould created by the '1945 Pact'. In order to have some idea of the orders of magnitude involved, it is worth bearing in mind that complementary insurance companies provided services amounting to 25 billion euros in 2012.

Administrative costs amount to 13.4 billion euros, including 7.2 billion for bodies operating under the social security (CNAMTS, etc.) and 6.2 billion for complementary insurance companies<sup>11</sup>. The amounts are similar for both types of operators, whereas they reimburse 75.5% and 13.7% of health care expenditures respectively. Without getting into the recurrent debate regarding marketing and communication costs in a competitive environment, it must be noted that complementary insurances have to deal with as many cases as the social security, even though the amounts involved in each case are lower. It is particularly worth highlighting the inefficiency of a system that duplicates the administrative costs of both the social security and complementary insurances.

In addition to this inefficiency, there is also considerable tax expenditure to be taken into account. Governments have long supported access to complementary insurance by means of social and fiscal aid. Such aid is granted if the contract is 'responsible' and, in the case of collective contracts, if it is compulsory. The HCAAM estimated the total amount of public subsidy for the purchasing of complementary coverage in 2011 at 5.6 billion euros, including 3.6 billion for compulsory collective contracts<sup>12</sup>. Such contracts are exempt from employers' social contributions and, until 2013, benefited from the deductibility of employees' contributions from the personal income tax<sup>13</sup>.

Such public support creates significant disparities: according to the HCAAM, the annual subsidy per contract varies from 15 euros for individual civil servant contracts to 226 euros for compulsory collective contracts and up to 260 euros for Madelin contracts (self employed), whereas many individual contracts do not benefit from any form of subsidy. Such discrimination between individual and collective contracts puts young people, the unemployed and the elderly, who have to

pay a higher premium to obtain complementary coverage, at a significant disadvantage. One of the arguments often put forward in favour of collective contracts is the pooling of risks at company or branch level. Such pooling excludes from the equation (among others) the elderly, who have more health problems, thus making a selection that inflates the cost of any additional coverage to which they might have access. In basic terms, this pooling benefits 'insiders' whilst making the situation worse for everyone else.

### An inflationary system

The subsidies received encourage companies to take out generous collective contracts. Generally-speaking, collective contracts offer far more extensive coverage than individual contracts, and this difference grew larger still between 2006 and 2010 as a result of the up-grading of collective contracts. The most important increase over this same period, however, was the coverage provided for extra-billing, in parallel with the increase in such over-expenditure<sup>14</sup>.

How is it possible to curb over-expenditure and the increase in healthcare costs? On the healthcare supply side, it is important that a supply priced at conventional rates always be available locally in order to give patients the choice and to make the levels of coverage offered by the social security a reality. On the demand side, it is unrealistic to think that insured parties might establish a balance of power in order to limit over-expenditure in their one-to-one consultation with the doctor, all the more so because the incomplete information they have regarding the quality of the care provided will drive them to interpret high levels of over-expenditure as a sign of quality. It is not up to the patient to make the necessary adjustments: this shows the benefits of contractualisation among care providers and the health insurance system, which, as a player, is better informed than the patient when it comes to the quality and constraints of care providers.

In the current situation, characterised by a lack of contractualisation, generosity of coverage can encourage extra-billing and increases in the tariffs applied to medical devices (glasses, dentures, etc.). Covering over-expenditure by making the demand solvent supports professional rates and heightens inequalities between individuals according to their level of coverage.

### Little incentive for insurance providers to ensure efficiency

The French health system allows little margin for evaluation, comparison and competition, meaning that it is not conducive to the provision of a high-quality service. The social

<sup>11</sup> Cf. DREES, *Comptes de la santé 2012*, p. 173.

<sup>12</sup> See Haut-Conseil pour l'Avenir de l'Assurance-Maladie (HCAAM) (2013): *La généralisation de la couverture complémentaire en santé*, Opinion HCAAM dated 18 July, available at [http://www.securite-sociale.fr/IMG/pdf/hcaam\\_avis\\_180713-2.pdf](http://www.securite-sociale.fr/IMG/pdf/hcaam_avis_180713-2.pdf)

<sup>13</sup> The 2014 Budget Law withdraws the deductibility of salary contributions.

<sup>14</sup> Garnero and Le Palud (2013) *op. cit.* and Garnero M. and V. Le Palud (2011): "Médecins exerçant en secteur 2: une progression continue des dépassements d'honoraires, la nécessité d'une réforme structurelle du système", *Point d'Information-Assurance-Maladie*, May.

security has the monopoly when it comes to basic insurance. A public service can be provided by means of a system of monopoly, provided that the latter is accompanied by competitive pitching for the concession or an evaluation involving a performance comparison, which would be the case if the structure were organised into regional agencies (see below). No such mechanism is currently in place<sup>15</sup>.

The current structure of the complementary insurance market in France does not really offer any protection against risk-based discrimination. In the absence of appropriate regulation, the competition in the health insurance system encourages risk selection. Indeed, selecting healthy, young affiliates makes it easier for companies to increase their competitiveness than seeking to contractualise with doctors for more efficient care<sup>16</sup>.

Admittedly, risk selection is discouraged by the 1989 Évin law, which outlines the principle of a lifelong guarantee for insured parties. Increases in rates must be uniform for all affiliates covered by the same contract, which excludes individual increases in accordance with the care consumption levels observed. Finally, tax provisions encourage so-called 'contrats solidaires', or joint contracts, where rates are not linked to the individual's state of health and there is no medical questionnaire to complete when the policy is taken out.

Contract segmentation does, however, enable companies to comply with these constraints whilst adjusting their rates to reflect the individual's health expenditure as closely as possible. An increasingly wide variety of products are becoming available, including modular contracts, low-cost contracts, additional voluntary contributions and optional provisions. This strategy makes it possible to identify groups of affiliates with the same levels of expenditure, thus adopting a risk selection approach and a pricing structure that reflects the individual's state of health whilst strictly observing the constraints of the joint contract.

The complementary insurance market in France is therefore characterised by a gradual deterioration in the pooling of risks between the sick and the healthy, and the evasion of competitive pressure by means of risk selection through contract segmentation. The wide variety of contracts available as a result makes the supply far more complex and difficult for the consumer to read, creating an additional obstacle to any real competition.

## Developments under way

The current policy is designed to facilitate access to complementary health insurance without challenging their scope of intervention. The joint coverage provided by the social security and complementary insurances is confirmed, with no real system in place for managing the healthcare supply and with a perpetuated inability to organize care networks that are capable of negotiating rates with health professionals (with the exception of specific sectors such as optical and dental care).

Access to complementary insurance will be extended by generalising collective contracts to all private sector employees by 2016, as outlined in the framework of the law on securing employment<sup>17</sup>, and by raising income ceilings governing access to CMU-C and ACS (complementary insurance subsidization), which could benefit 400,000 and 350,000 new CMU-C and ACS beneficiaries respectively.

The extension of collective contracts is accompanied by the withdrawal of the tax incentive, since under the 2014 budget Law, the employer's contribution has to be included in the employee's taxable income. Exemption from social contributions, however, remains effective for the employer. The difference in treatment between individual and collective contracts is therefore reduced but not altogether eliminated.

More critically, the extension of collective contracts will concern, among others, some 4 million employees who are already covered by individual contracts. In addition to the significant knock-on effect for a measure that will cost several billion euros<sup>18</sup>, this will worsen the situation for affiliates of an individual contract. Indeed, the scope of their pooling will no longer include employees who are, on average, younger and in better health than those who will remain within the realm of individual contracts.

Whilst the withdrawal of the tax incentive brings the situation of the 'insiders' more in line with that of affiliates on individual contracts, the rearrangement of affiliates of individual and collective contracts will worsen the pooling conditions for individual contracts, meaning that we can expect to see an increase in the cost of individual complementary contracts. Inequalities in the scope of the guarantees available and upward pressure on the cost of care will therefore continue.

<sup>15</sup> The Alsace-Moselle regime is a compulsory complementary insurance that is exempt from French common law, the extension of which at national level has been suggested a number of times. Funded by a 1.6% contribution on all wages, this system offers the advantage of simplicity and shows that a compulsory regime funded by contributions is less costly for insured parties on modest incomes. There is, however, no specific performance to be observed with regards to monitoring the care supply. Extra-billing, for example, is particularly developed in Alsace. See Cour des Comptes (2011): *Le régime d'assurance-maladie complémentaire obligatoire d'Alsace-Moselle*, November.

<sup>16</sup> Individual complementary insurance is therefore optional and can freely determine the guarantees offered. With this in mind, complementary insurances that would charge uniform premiums would risk losing their young affiliates, thus reducing the scope of pooling and increasing the cost of the premium accordingly. Complementary insurers then calculate premiums as closely as possible to the expected expenditure for each individual. Competition notably requires the elderly to be charged higher premiums. The premiums paid by senior policyholders can therefore be three times those paid by young policyholders.

<sup>17</sup> Law no 2013-504 of 14 June 2013 regarding securing employment, available at <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000027546648>

<sup>18</sup> According to the impact study of the bill on securing employment, carried out prior to the withdrawal of the tax incentive, the annual cost would amount to at least EUR 1.5 billion for public finance and EUR 2 billion for the corporate sector, see HCAAM (2013): *La généralisation de la couverture complémentaire en santé*.

The social security budget law, however, plans to modify the definition of the “*contrat solidaire*” so that it no longer reimburses ‘excessive’ over-expenditure and includes sufficient minimum guarantees in order to avoid the over-segmentation of contracts.

### What is the situation in other European countries?

Beyond their diversity (*cf.* Box), the health insurance systems in place in other European countries are generally based on regulated competition between insurance funds, with the notable exception of the United Kingdom, which has a state system whereby care is provided by means of a public service and funded by taxation.

These foreign examples show that solidarity between the sick and the healthy, and a funding based on the means of the individual (1945 Pact) are possible both with a state system (United Kingdom) and with health insurance provided by competing insurance companies. In the latter case, funding can reflect varying degrees of solidarity, whether it is based on contributions, as is the case in Germany, or on premiums, as is the case in Switzerland. In order for the multiplicity of insurance providers to result in more efficient expenditure, it is important that insurers be able to regulate the healthcare supply and that competition be effective. One unanimously selected means of achieving this is the standardisation of the contract, which makes it possible to establish a degree of price competition for a standard product. Compensation mechanisms are ultimately designed to avoid risk selection. The implementation of such systems is as yet too recent to make any kind of assessment, and debate in the countries concerned focuses on the improvements to be made with regards to compensation since risk selection appears to still be present. Furthermore, there has been some delay in contractualising with care providers, despite the fact that this is essential for the purposes of increasing efficiency.

As for the demand side, it is regulated by means of co-payments (deductibles, patients’ contributions, etc.) in many countries, although such regulation is still accompanied by protective caps. Insurance policies in these countries are not permitted to cover co-payments. The introduction of co-payments has failed to win unanimous support, however; indeed the introduction of a deductible was rejected in Denmark due to the risk of the under-treatment of those on low incomes, and the British system offers free access to care.

None of these systems have adopted a multi-level structure; only one type of operator is responsible for funding care, be it a public operator, in the case of the United Kingdom, or an insurance company chosen from among several, in the case of other countries.

In France, complementary insurances cover the patient’s contribution, and direct costs are not capped. Within the

complementary insurance market itself, contracts are not standard; risk-based pricing, particularly where age is concerned, is common practice, and there is no risk compensation to combat risk selection.

### Mechanisms for appropriate coverage whilst containing costs

The aim of the health insurance system is to provide the sick with the appropriate coverage without it costing citizens too much, whether in the form of contributions, premiums, taxes or direct payments. The first stage in cost containing involves defining the ‘solidarity healthcare package’ for which the decision is made to implement a funding system that guarantees solidarity between the sick and the healthy and between those on high and low incomes<sup>19</sup>. The second stage involves implementing a series of mechanisms designed to improve the cost containing, i.e. efficiency in care delivery for health care included in the solidarity package, whilst guaranteeing protective coverage.

### On patient side, finding the right balance between cost-sharing and coverage

Any insurance policy provides the policyholder with monetary compensation in the event of a damage. But the form this compensation takes is very significant. When the payment in case of damage takes the form of fixed payment that is independent of the costs incurred by the insured party, the coverage will not induce higher expenditure. With regards to car insurance, for example, compensation for a broken windscreen in the form of a fixed payment of 400 euros has a very different property from a compensation that would be proportional to the cost of repairing the damage. When the insurance company reimburses 95% of the cost of replacing the windscreen, it does not control the cost of repair charged by the garage, nor does it encourage the insured party to use the most efficient supplier.

Of course, the analogy with car repairs has its limitations, but it also helps illustrate the problems we are facing with health insurance design. The insurance company does not observe the diagnosis, but only the treatment prescribed and ‘consumed’; the patient makes the decision to see the doctor when he/she experiences a health problem, but it is the doctor that makes the diagnosis and determines the care required.

As the state of health and the level of healthcare required are not observed by the financing party, any health insurance mechanism must choose between comprehensive coverage (100% of the cost of care), which supports access to care but can result in excess expenditure<sup>20</sup>, and reduced coverage, which aims to moderate the patient’s expenditure by cost-sharing:

- the first issue relates to the leeway the patients have as concerns healthcare expenditure. If they have no

<sup>19</sup> Voir *Note du CAE*, no 8, *op. cit.*

<sup>20</sup> Geoffard P-Y. (2006): *La lancinante réforme de l’assurance-maladie*, CEPREMAP, Éditions Rue d’Ulm.

## The funding of care in other European countries

The funding of care in all European countries is based on principles of solidarity, with provisions varying greatly to guarantee the application thereof.

In the **United Kingdom**, care is funded by taxation and provided by means of a public service known as the National Health Service (NHS). Access to care is universal and free of charge for users; only optical and dental care and drugs require the patient to pay a modest sum. Whilst international comparisons on the matter may be difficult, surveys have shown that user satisfaction levels are high, particularly where ambulatory care is concerned<sup>a</sup>. Delays for accessing hospital care can, however, be significant<sup>b</sup>. The care system is decentralised, with regional structures responsible for assessing healthcare needs. The ambulatory medical service is structured around group practices that are funded largely in accordance with the quality and efficiency of the care provided, based on a list of indicators that take into account the characteristics of the local population and measures undertaken to reduce healthcare inequalities. In summary, there is a great deal of regulation in the United Kingdom, but this involves the healthcare supply exclusively and is not based on demand. The way in which professionals operate is open, but the ground rules and objectives are set by the supervisory authority and are expressed through performance-related pay.

Quality-related performance in the fields of ambulatory medicine, public health and healthcare inequalities put the United Kingdom on the same level as other countries, with a much lower level of expenditure; in 2011, for example, healthcare expenditure accounted for only 9.3% of the United Kingdom's GDP as opposed to 11.6% in France and 11%, 11.3% and 11.9% for Switzerland, Germany and the Netherlands, the three countries examined in this box, respectively. In addition to the low cost of the British system, there are two lessons we can learn from it – on the one hand, the health insurance system is not the only structure with the ability to provide access to care; on the other hand, a healthcare system can be managed exclusively based on the healthcare supply.

**Switzerland** decided in 1911 to enable insured parties to choose between different health insurance companies. The 1996 health insurance law introduced a number of elements to regulate competition between insurers, with the notable prohibition of any risk-based pricing.

Monitoring insurance premiums in this way results in two notable difficulties. Insurers are encouraged not to accept individuals at a higher than average risk, since they will require expenditure that exceeds their premium. Conversely, a healthy individual may not wish to take out such insurance, refusing to 'pay for others'. In order to resolve these issues of selection and anti-selection, the law imposes the sharing of health risks right across the population by making it compulsory for all residents to take out insurance and for all insurance providers to fulfil all requests for policies. Furthermore, a risk compensation mechanism has been put in place to discourage companies from seeking out the 'right risks' by enabling those insurers that cover a higher-risk population

to receive funding from those insurers whose affiliates represent less of a risk. The risk compensation mechanism is based on an individual health expenditure forecast based on the age and gender of the insured party, as well as the risk of serious illness presented by a hospital stay. An insurance provider cannot improve its situation by seeking to select risks but must commit to striving to increase the efficiency of care.

The form of the policies and the package of care covered are determined by Swiss federal law. Establishing a standard contract triggers a form of competition that is limited to price competition. Furthermore, all insured parties are liable for an annual deductible that varies from 300 CHF (around 250 euros) to 2,500 CHF and, beyond this, for a co-payment amounting to 10% of the cost of care. The out-of-pocket cost is, however, capped, with 100% cover for care exceeding 700 CHF over the space of the year, in addition to the deductible.

In Switzerland, as is also the case in the Netherlands, insurance providers are prohibited from offering policies that would cover the deductible and patients contributions. Despite not being very widespread in the beginning, the concept of contractualisation with care providers is becoming more developed, but controlling expenditure is primarily the responsibility of insured parties by means of deductibles.

In **Germany**, the choice of insurance companies was introduced in the 1990s for 95% of insured parties. Liability to insure, prohibition of selection, premiums independent of age or state of health, standardisation of policies and risk compensation – all of the principles of regulated competition apply, funded by contributions calculated according to the income of the individual, a principle of which the Germans are very fond. Since 2009, contributions have been paid into a central fund which then redistributes the resources available to the various insurers in accordance with the number of insured parties and the characteristics thereof. Insurers may request additional premiums, but these currently represent a minimal proportion of the funding, namely 0.4%, and the new government plans to ensure that they are determined based on income. Cost-sharing on the part of insured parties were introduced in 2003, including the hospital charge, user charges of 10% on drugs, etc. These contributions are restricted by an annual ceiling determined based on income.

In the **Netherlands**, the 2006 reform introduced regulated competition and authorised the setting up of healthcare networks. Insured parties are subject to an annual deductible that can vary from 165 to 650 euros, with a cap on all contributions to expenditure. The way in which the system is funded is a hybrid of the German and Swiss systems, based partially on premiums and partially on an equalisation fund fed by social contributions. The reform resulted in the restructuring of the sector, which is now rather concentrated, with four companies covering 80% of the market. Oddly, healthcare expenditure in the Netherlands has sky-rocketed since 2007, leading some observers to consider this an indication of the inability of such a system to control costs. This slippage is due partially to an increase in the scope of care reimbursed and partially to a significant increase in the salaries of both GPs and specialists over the period in question. These increases did not fall under the jurisdiction of insurance funds but were decided at central level.

<sup>a</sup> European Commission (2009): *Special Eurobarometer: Patient Safety and Quality of Healthcare*.

<sup>b</sup> After a reduction until 2008, these delays have started to increase again. See Limb M. (2013): « Hospital Waiting Lists in England Reach Five Year High », *British Medical Journal*, no 347, August.



influence, reducing the level of coverage will have no effect on expenditure and serves only to decrease the reimbursements<sup>21</sup>;

- the second issue relates to the level of cost-sharing, in the event patients do have some influence over their expenditure. What is the right balance? There is a trade-off between offering a good coverage and providing incentives to limit expenditure by means of a cost-sharing.

Economists measure the patient's influence over healthcare expenditure based on the price elasticity of demand, i.e. the reactivity of expenditure to a 1% variation in price (or coverage). The most convincing estimations stem from a controlled experiment carried out in the United States between 1974 and 1981. Over that period, different levels of coverage were randomly assigned to groups of individuals. The estimations resulting from this experiment still feature in various publications and discussions even today. The latest evaluations performed have shown that it is not possible to confirm that the rate of coverage has any influence over hospital care consumption. Ambulatory healthcare expenditure is, however, sensitive to coverage, with the value of elasticity yet to be established<sup>22</sup>.

No-one would decide to have a kidney transplant simply because it would not be a very costly procedure. The zero elasticity of the demand for hospital care confirms this intuition. As a result, hospital care expenditure cannot be controlled by means of patient cost-sharing but have to be fully covered by health insurance. With this in mind, the current 20% patient's contribution and the lump-sum payments associated with a hospital stay are both inefficient and fail to reflect the objective of solidarity.

This is why we suggest 100% coverage for hospital care, in accordance with the principles of the solidarity care package and at conventional rates. The HCAAM calculated that for 2010, the withdrawal of patient contributions, lump-sum contributions and daily lump-sum payment would result in a loss in revenue of EUR 2.6 billion<sup>23</sup>. The daily lump-sum payment, which stands at EUR 18 euros, aims at covering accom-

modation costs. It would seem logical to cover this risk. We would suggest limiting the payment to food and drink costs, which the patient would have to pay, in any case, if he were not hospitalised. Based on the budget coefficients of food and drink for low income and retired people, a minimal value of EUR 8 has been established. Based on the number of days' hospitalisation observed in 2010, this corresponds to a revenue of EUR 458 million<sup>24</sup>. The revenue loss resulting from this measure could be covered by abolishing all subsidies for collective insurance contracts.

Ambulatory care expenditure is analysed in a different way. Putting aside those suffering with chronic conditions, more than 80% of insured parties incur low levels of recurrent expenditure. Since price elasticity for this type of care is significant, introducing cost-sharing does help limit overconsumption. In order to reduce the risk of excessive out-of-pocket costs, however, the annual contribution must be capped.

In addition to the expected impact of patient cost-sharing, it is important to understand that, with regards to recurrent expenditure that is common to all insured parties, it does not make much difference whether the patient cost-sharing takes the form of a contribution or of a deductible. Let us, for example, take the case of an insured individual who is sure to visit the doctor once a year –for a EUR 23 consultation. With a deductible, he will have to pay this amount from his own pocket. Alternatively, if he is fully covered without a deductible, the insurance company will cover this expense but charge him EUR 23 euros on his insurance premium or contribution. In any case, the insured party will have paid EUR 23<sup>25</sup>.

The form the cost-sharing may be debated: it could, for example, be a co-payment that greatly decreases as it approaches the ceiling. The ceiling could cover a period of several years, and relate to a wide scope that would include long-term care expenses (an issue that will not be dealt with in the present Note). Preventive care (vaccinations) and maternity-related care should be exempt from any such co-payment. In any case, the patient's contribution should be limited to ambulatory care.

<sup>21</sup> In theory, a reduced coverage could affect the level of expenditure even if the patient has no direct influence, if doctors take into account the problems that could result from excessive out-of-pocket costs; this could stem from a sense of empathy on the part of the doctor towards their patient or, in the case of recurrent care, the fact that the patient might want to change their doctor should the decisions made by the latter systematically result in overly costly care. In practice, the results of controlled experiments carried out in the United States do not undermine the impact of the recurrence of care; it is only for hospital care (infrequent care) that expenditure is not sensitive to the level of coverage.

<sup>22</sup> Aron-Dine A., L. Einav and A. Finkelstein (2013): "The RAND Health Insurance Experiment, Three Decades Later", *Journal of Economic Perspectives*, vol. 27, no 1, pp. 197-222. Since the contracts in this experiment imposed a ceiling on out-of-pocket costs, drawing from it a single measure of the price elasticity of the demand for care is a delicate matter; the authors find reductions in expenditure of between 9% and 18%, whereas the rate of co-payment varies up to 25%, figures that they are careful not to express in terms of elasticity.

<sup>23</sup> These amounts are currently largely covered by complementary insurance and therefore by the premiums paid by insured parties.

<sup>24</sup> This flat rate per day has nothing to do with an incentive to limit the duration of patient's stays. Hospital care expenditure does not depend on the patient's coverage. Furthermore, changes to the hospital pricing system, notably the withdrawal of the daily rate in the early 1980s, followed by the introduction in 2004 of lump-sum payment per stay, regardless of duration, triggered and later accelerated the decrease in the duration of patients' stays, a drop that was beneficial not only in terms of curbing costs but also in terms of quality of care since it limits exposure to nosocomial diseases.

<sup>25</sup> Where participation (premiums, contributions, etc.) to insurance is income-based, a full coverage ensures solidarity between rich and poor, whereas a deductible that is not based on income does not; it is, however, possible to make the deductible dependent upon the income of the insured party.

**Proposal 1.** To cover 100% of the cost of hospital care, with the exception of a daily lump-sum payment) of 8 euros. With regards to ambulatory care, to replace all current deductibles and patients contributions with an annual deductible and a co-payment that could be determined on the basis of the patient's income. The deductible and co-payment should not be covered by complementary insurances but should be capped.

Given the poor performance of the French system in terms of social health inequalities, one may object to any financial contribution on the part of patients based on the argument that such payments represent an obstacle to those on low incomes entering the care system. Indeed, low-income people already delay their initial contact with doctors, despite having a level of health that tends to be inferior to that of the rest of the population. It was, in fact, this very argument that led to the rejection of co-payments in Denmark. It does not necessarily mean, however, that we have to reject the principle of a financial contribution on the part of the patient, since deductible can be proportional to income<sup>26</sup>, or indeed reduced for those on low incomes.

#### **On supply side: the payer or the insurer must be able to contractualise with care providers**

The proposal to abolish patient's contribution for hospital care must be accompanied by mechanisms designed to limit induced demand in hospital care: the system has to be monitored on the supply side. For ambulatory care too, providers must be held accountable with regards to the level of the care consumed and extra-billing.

Possible solutions should refer to payment schemes and selective registration of doctors and care providers<sup>27</sup>. Decentralised regional health agencies (*Agences Régionales de Santé*, ARS) and insurance providers themselves have to be in a position to contractualise with care providers. Contracts should specify payment schemes, price levels, the location of doctors, working hours, adoption of the recommendations for good practice issued by the *Haute Autorité de Santé* (French National Health Authority) and support for public health objectives.

**Proposal 2.** Payers (regional health agencies or insurance companies) should be able to contractualise with care providers.

With regards to hospital care, yardstick competition should be managed centrally for the purposes of setting rates, beyond ARS or insurance level. It is important that the regulator stops manipulating rates to monitor hospital care supply. This creates rents that stimulate induced demand. Likewise, introducing a floating point in rates to cope with budget constraints creates detrimental incentives to expand the number of medical procedures. One policy instrument can only serve one purpose, meaning that rates have to be set in a way that improves the efficiency of hospital care delivery. The way in which the hospital care supply is managed has to be determined in conjunction with ARSs, with regards to the care process, and special subsidies should offset any additional costs imposed on establishments for the purposes of completing public service missions.

### **Reform of the health insurance system**

A marginal reform of the health insurance structure in place in France would respect the current scope of intervention of the social security and complementary insurances whilst also addressing some shortcomings in the system, but only a complete rebuilding is likely to promote a high-quality system that is accessible to all and ensures budget balance. The two types of reform are not incompatible insofar as the former can be undertaken whilst the latter would be under work.

#### **Short-term reform**

The heterogeneity of complementary insurance policies currently enables insurance providers to develop risk selection strategies and makes the supply rather opaque. The solution would be to design a standard contract for complementary insurance that would cover care expenses at conventional rate, and to ask complementary insurers to display their price for this offer.

Furthermore, subsidies granted to collective contracts have no economic justification. They introduce a degree of inequality between citizens in terms of accessing complementary insurance and encourage overly generous coverage which in turn fuels extra-billing. Following the withdrawal of the tax exemption in 2014, the government should also abolish the exemption with regards to the employer's social contribution, a saving in public expenditure that could only improve the functioning of the sector<sup>28</sup>. Companies should also be free to choose their own complementary insurance in order to give employees the possibility of accessing high-quality complementary health insurance at a lower cost; clauses that envisaged any designation or recommendation by the branch have fortunately been withdrawn.

<sup>26</sup> Geoffard P-Y. and G. de Lagasnerie (2012): "Réformer le système de remboursement des soins de ville: une analyse par micro-simulation", *Économie et Statistique*, no 455-456.

<sup>27</sup> Cf. *Note du CAE*, no 8, *op. cit.*

<sup>28</sup> The social contribution rate currently in force is a reduced rate of 8% and does not apply to small businesses.

Finally, in order for competitive pressure to result in increases in efficiency, complementary insurance companies should be given the means to contractualise and therefore to break away from the current situation whereby they receive an invoice about which they lack information.

**Proposal 3.** To create the conditions to real competition within the complementary insurance sector by drawing up a standard contract that all insurance providers will have to offer and by eliminating distortions related to social exemptions. To involve complementary insurances in contractualisation practices by giving them access to the necessary information.

However urgent such provisions may be, nonetheless, they cannot offer a definitive solution owing to the great complexity involved in any coordination between the social security and complementary insurances in agreements with care providers looking after clients of multiple complementary insurances.

### Rebuilding the system

The mixed social security-complementary insurances system inflates management costs and is detrimental to the efficient management of the healthcare supply. It goes hand in hand with the inadequate regulation of complementary insurances, which does not prevent risk selection, or significant inequalities in terms of access to additional coverage, and which does not protect insured parties from significant out-of-pocket costs.

**Proposal 4.** To bring to an end the mixed health insurance system by setting up an unified funding for care, based on a decentralised public mode or on a regulated competition between insurance companies.

There are two possible versions of a unified system:

- option A: public management with decentralised monitoring of the healthcare supply;
- option B: regulated competition between insurance providers.

With both systems, a common base would be determined to comply with the principles of the 1945 Pact and encourage efficient healthcare expenditure; this would involve equal access for all to the care included in the solidarity package, funding based on contributions proportional to income, the withdrawal of patients contributions where hospital care is concerned, the

potential introduction of patients contributions for ambulatory care that would be capped and regulated according to the income of the individual (Proposal 1), contractualisation with care providers and the development of a centralised information system with regards to healthcare performance.

With the public option, ARSs would be responsible for monitoring the healthcare supply, as suggested in Note du CAE no 8, since they would have to contractualise with care providers by developing a variety of strategic choices between regions or within a given region with regards to convention and payment schemes. A centralised information system should produce and disseminate indicators for assessing ARS performance in the fields of public health, quality of care and access to care in order to evaluate their strategic choices. Indicators would be standard right across the country for the purposes of comparing ARSs.

The option of regulated competition between insurance providers, meanwhile, involves drawing up a standard contract corresponding to the solidarity care package and prohibiting risk selection combined with a risk compensation mechanism and the absence of risk-based pricing. Insurance companies would be responsible for contractualisation with care providers. A centralised information system should produce and disseminate indicators for assessing insurance providers performance in the fields of public health, quality of care and access to care for the purposes of comparing them and enabling citizens to make an informed choice.

Both systems are very close with regards to the principles of solidarity, access to care that does not involve any financial barriers and protection against the risk of excessive expenditure. They would be funded in the same way, by means of income-based contributions<sup>29</sup>, a source of funding that would more closely resemble the principles of the '1945 Pact' than the current system, where access to complementary insurance often requires payment of an income-independent premium. In both cases, the central government should play a crucial role in determining the solidarity care package (*cf. Note du CAE*, no 8), producing information systems and improving the quality of care. It would also be responsible for allocating the resources provided by contributions to ARSs (option A) or insurance providers (option B) according to the needs of the populations under their care. It would oversee the regional compensation associated with the freedom of movement between regions with the public option, or introduce risk compensation in the case of regulated competition. Finally, it would ensure the smooth running of the system and would be particularly vigilant with regards to the possibility of rationing with the public option and the location of doctors and the potential development of risk selection in the case of regulated competition.

The French National Health Authority (*Haute Autorité de Santé*, an independent authority) would also have a crucial role to play in producing healthcare quality indicators and

<sup>29</sup> Even with option B, the insured party does not pay any premium directly to the insurance provider of their choice.

recommendations for good practice, as well as producing medico-economic evaluations to help prioritise care for the careful formation of the solidarity care package.

One of the difficulties with the public option relates to the incentives that will need to be put in place in order to make it beneficial to ARSs to promote the efficiency of the health-care supply. ARS management teams would need to be made aware, by means of monetary or professional incentives, of the importance of controlling both the cost and the quality of care. Directors and member of management teams should also be free of any pressure. Independent authorities have been created in other sectors (including monetary policy, the regulation of network industries, prudential and financial supervision and, of course, justice) for the purposes of protecting the public sphere from lobbying and election deadlines. With regards to the way in which care is structured, the *Haute Autorité de Santé* should be given real regulatory power that is effective at regional level.

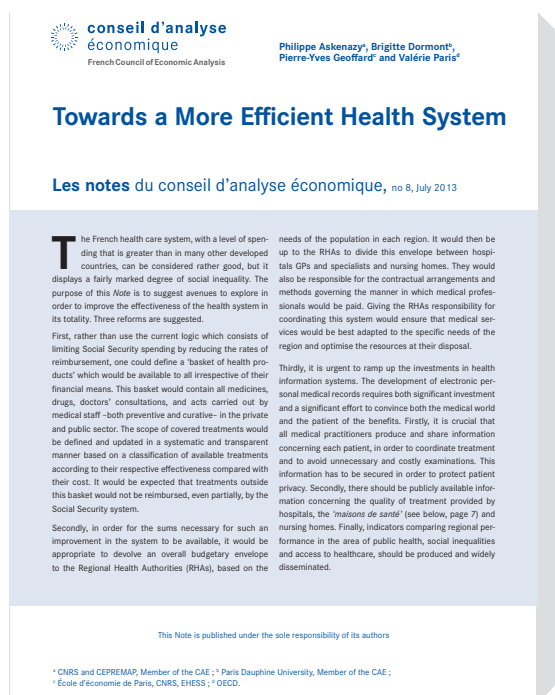
The difficulty with the regulated competition option lies in the performance of the risk compensation system in truly discouraging risk selection. Experience in other countries has shown that competition between insurers represents a very strong incentive to select risks. There is ongoing discussion in these countries on how to improve the formula used to predict the healthcare costs associated with the characteristics of individuals.

Finally, what about the ARSs or insurers ability to contractualise with care providers? With the public option, the monopoly of ARSs will normally give them considerable negotiating power. Exercising this power, however, requires the ability to impose a credible threat of removing any hospital or doctor charging excessively high rates (or providing care of an insufficient quality) from the reimbursement list, thus stripping the care provider of the vast majority of its activity. Activating this 'nuclear weapon' is not self-evident, particularly when faced with potential political pressure in which the regulation authority will need to act as a shield. This problem is perhaps less acute with the regulated competition option, whereby the same care providers would interact with several insurers, provided that the latter do not offer insurance providers exclusivity agreements. Otherwise, the latter would lose authority in monitoring the care supply if they had to compete to attract doctors to their networks. In any case, transparency and advertising with regards to the rates and the quality of care providers are essential to regulating the system.

Moving away from the mixed system is a goal that might be difficult to achieve since it disrupts the current organisation and long-established public and private players that operate within it. The cost of the status quo would, however, appear to us high enough to invite the public decision-maker to commit to such a move. ●

## For more information

The *Note du CAE* no 8 puts forward a number of proposals for improving the efficiency of the health care system rather than periodically lowering the rate of reimbursement



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