

Victor G. Rodwin

On the Separation of Health Planning and Provider Reimbursement: The U.S. and France

Windows can sometimes be mirrors. A look at health planning and provider reimbursement in France, for example, reflects our own problems of implementing health policy. Also, it illustrates the forces that shape health policy when national health insurance (NHI) finances private medical practice—what the French call *la médecine libérale*.¹ In addition, by analyzing the French health care system, we can evaluate some frequently proposed remedies for inadequate coverage and regulation in the United States.

The French health system is a prototype of Western European health systems. In addition, it closely resembles our own. Like the American Medical Association, French professional medical associations favor autonomy for the individual physician and oppose government regulation of their services. Historically, they have insisted on the prerogatives of *la médecine libérale*: fee-for-service payment, free choice of the physician by the patient and vice versa, and clinical freedom for the doctor. Also, as in the U.S., the French health system is financed largely by third-party payers, while the delivery of ser-

vices remains primarily under private control. In 1978, 81% of French health expenditures were collectively financed, compared to 70% in the U.S.² Movement toward some form of NHI in the United States would shrink that difference.

France has had an NHI program since 1945, under which benefits have been extended to virtually the entire population. Since then, French policymakers have confronted two persisting problems. First, health care expenditures have soared. Between 1960 and 1978, the average growth rate for French health care expenditures exceeded that of the U.S., and the trend appears likely to continue.³ The second problem stems from the institutionalization of negotiating mechanisms to set reimbursement rates. Conflicts emerged between medical trade unions and the National Health Insurance Fund for Salaried Workers (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés*—CNAMTS).

Despite differences in public administration and political style—French government traditionally has been more centralized—American and French policymakers share a common challenge. Often, they seek to link health planning to mechanisms of provider reimbursement, to increase their control over the allocation of health resources, and to contain rising costs. How did this challenge emerge in the context of French NHI? What has been done to meet it? And what are the implications of French experience for the U.S.?

To answer these questions, I begin by analyzing health planning efforts in the U.S. Then I make the case for linking health planning to provider reimbursement, and evaluate the French experience with health planning from the point of view of the foregoing concerns.

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Health Planning in the United States

Federal and state health planning efforts in the U.S. may be traced back a half-century to the monumental report of the Committee on the Costs of Medical Care, which analyzed the inadequacies of the health system in 1933.⁴ The first major effort of the federal government to promote health planning began with the Hill-Burton Hospital Construction Act in 1946. This legislation was followed by a series of amendments, regional medical programs in 1965, and the Comprehensive Health Planning and Public Health Service Amendments in 1966.⁵

Despite these efforts, the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) declared that the history of public and private sector responses to the problems of inequitable access and rising costs "have not resulted in a comprehensive rational approach to the present (problems). . . ."⁶ P.L. 93-641 is the most comprehensive piece of federal health planning legislation enacted to date. It called for ambitious reform of the health care system, with special emphasis on cost containment. The Act adopted two principal approaches to controlling rising health care costs.⁷ First, in its list of priorities, it sought to achieve long-run savings in national health expenditures by: improving the organization of health services; preventing costly and avoidable illness; and developing alternatives to expensive institutional care. Second, through its required reviews of the appropriateness of new institutional services and of existing services, it sought to achieve long-run savings by limiting "unneeded" capital and service expansion of hospitals.

These two approaches to cost control required major reorganization of the health sector. To accomplish that reorganization, P.L. 93-641 relies on three mechanisms: 1) health plans, reflecting national, state and local objectives, that outline specific steps for narrowing the gap between health needs as defined in the plan and existing resources; 2) reviews of hospital expansion programs to inform regulatory decisions on whether to authorize more hospital beds and expensive equipment;⁸ and 3) reviews of federally funded programs

to determine whether they conform to regional and local health priorities as reflected in the state health plans, the health systems plans, and the annual implementation plans.

In their documents and project review hearings, health planners repeatedly have summarized—sometimes with great eloquence—the current opinion about what constitutes an improved health system. A consensus of opinion challenges the predominant medical model of hospital-centered care and promotes the redistribution of health resources away from hospitals to environmental health services and community-based social services. In spite of the consensus of policymakers, however, the three mechanisms of P.L. 93-641 have proven inadequate to implement the state and local health plans. The reason is that the financial incentives underlying the health care system currently work at cross-purposes with the goals elaborated in the plans.

In an attempt to improve the operating efficiency of hospitals, P.L. 93-641 did authorize continuation of experiments with incentive reimbursement mechanisms.⁹ Still other measures—such as the 1972 Social Security Amendments, the Health Maintenance Act of 1973, and the Carter Administration's Hospital Cost Containment Bill—may be cited as part of a legislative strategy to alter financial incentives in health care reimbursement.¹⁰ But despite these small steps, health planning and regulatory activities in the U.S. remain separate from the institutions that finance health services.

At the national level, for example, the Health Care Financing Administration coordinates public financing of health services (Medicare and Medicaid), whereas most national health planning activities are conducted separately within the Health Resources Administration and within federal facilities and programs such as the Veterans Administration hospitals and the Indian health service. The same applies at state and local government levels. Health systems agencies (HSAs), the local expression of the national regulatory system, carry out planning activities separately from state-owned and municipal hospitals and from rate-setting agencies and third-party payers that reimburse health care providers.

The Case for Linking Health Planning to Provider Reimbursement

The case for linking health planning to financing is based on the presumption that health plans, once they have been agreed upon by a representative and legitimate body, ought to be implemented. Katherine Bauer, who directed the most thorough studies on the theme of linkage, states the case succinctly:

Rate-setting is now being looked to as a possible means of putting teeth into the future reviews of existing institutional services, through application of reimbursement penalties on institutions whose services are found to be inappropriate.¹¹

Karen Davis urges aggressive use of reimbursement incentives to discourage costly institutional care and to encourage primary health services.¹² She advocates: reduction of physician fees for institutional services; elimination of financial incentives to prescribe costly medical procedures; relatively higher payments for primary health services, particularly in rural areas; a means of reimbursement that favors comprehensive and primary health centers; salary reimbursement of hospital-based physicians; and continued experimentation with new methods of hospital reimbursement. These concrete proposals are sound, but they deal neither with the general issues of linkage nor with the problem of designing appropriate implementation strategies.

The General Issues. To link health planning and financing, the social goals of reimbursement must correspond to those of health planning. Ideally, the reimbursement system should encourage physicians and hospitals to base the provision of services more on medical reasons than on financial incentives at the margin. This goal raises the question of what criteria to use in evaluating the effects of alternative reimbursement mechanisms.

For evaluating the effects of alternative methods of physician reimbursement, Glaser suggests the following criteria: encouraging good medicine; preventing abuse; discouraging neglect; and recruiting and allocating doctors.¹³ Although these criteria reflect important social goals, they need to be made more operational. How, for example, can a measure

of good medicine and a proper distribution of physicians be specified? What is a reasonable rate of return to physicians? Is it possible to manage physician-induced demand? In designing payment mechanisms that link health planning to physician reimbursement, planners cannot escape such issues.

For evaluating the effects of alternative hospital reimbursement mechanisms, Feldstein et al. suggest these criteria: hospital internal efficiency; efficiency in allocating resources among hospitals; control of increases in hospital expenditures; and minimization of the costs of medical treatment.¹⁴ All of these go well beyond current cost-based reimbursement practices, which base their notions of "fairness" and "reasonableness" of payment on ways of assuring an acceptable flow of revenues over expenditures. Nonetheless, such criteria do not provide guidelines for broader planning issues, such as the extent to which hospital reimbursement should be the primary source of capital funds, and determination of the regions requiring disproportionate investment and improved access to hospital and other health services. Also, the criteria are not helpful in specifying how to build incentives into the reimbursement scheme. Should reimbursement rates apply to medical procedures, hospital days or, more broadly, to illness episodes (e.g., diagnostic-related groups) or subscriber-population characteristics?

Deriving criteria to evaluate alternatives in provider reimbursement ultimately forces recognition of a central planning dilemma: how to create a reimbursement system in the health sector that encourages hospitals and physicians to pursue society's interests as well as their own. This dilemma leads us to consider implementation strategies.

Implementation Strategies. Once the social goals of reimbursement have been agreed upon and criteria devised to evaluate the effects of alternative reimbursement mechanisms, what specifically is to be done? In essence, linkage involves bridging the gap between planning and financing. With regard to physicians, this involves devising reimbursement incentives that influence the behavior of doctors in ways consistent with health planning goals. With regard to hospitals, it in-

volves the coordination of planning, rate-setting, utilization review, and third-party financing mechanisms, in order to devise consistent policies that influence hospitals to conform to national, state and local health planning goals.

- *Linking Planning to Physician Reimbursement.* In the United States, no attempt has been made yet to link health planning to physician reimbursement. Only two years ago Robert Derzon, former administrator of the Health Care Financing Administration, called for a national fee schedule as a basis for physician remuneration. Instead of reimbursing physicians under the prevailing "usual, customary and reasonable" fee structure used by Medicare as well as numerous Blue Shield Plans, Derzon's remedy involves developing a list of maximum allowable reimbursements for specific medical procedures. "Such schedules," he said, "could be set either unilaterally or by negotiations between government and physicians, but certainly not unilaterally by physicians."¹⁵

There is ample evidence that the existing reimbursement structure works at cross-purposes with health planning goals by encouraging costly institutional care, growth of specialized services, and excessive use of costly technology.¹⁶ To seriously consider a national fee schedule that links planning and financing, a number of important issues must be faced. How will the fees be negotiated? To what extent will such negotiations explicitly incorporate criteria developed by health planning institutions? For example, will linkage between health planning and physician reimbursement require physicians to set their fees so that they reflect the relative costs of producing their services? Or, will linkage be used even more forcefully to influence physician location and specialty distribution in ways recommended by health planning agencies?

- *Linking Planning to Hospital Reimbursement.* Since the early 1970s, nine state governments and at least 25 Blue Cross Plans have introduced some form of control over the determination of hospital reimbursement rates.¹⁷ Some of these experiments have included attempts at linkage, at least

between health planning and rate review. In Rhode Island, for example, a partnership was forged between planners and rate-setters to promote common objectives within a limit on hospital spending—the so-called maxicap model.¹⁸ In Maryland, as early as 1968, the Health Services Cost Review Commission was the first agency to attempt regulation of hospitals comparable to that for public utilities, while encouraging comprehensive health planning agencies to develop a state plan.¹⁹ Also, in Massachusetts, New Jersey, New York and Washington, various kinds of linkage have been achieved.²⁰

Bauer and Altman conceive of linkage as a way for rate-setters and planners to exchange information.²¹ Rate-setting agencies could provide HSAs with useful data for the cost analyses important to implementation of health plans. HSAs, in turn, could help rate-setting agencies with analyses of community need, access and quality of services.

Another approach to linkage focuses on a range of possible strategies by third-party payers—for example, writing conformance clauses into Blue Cross Plan contracts with providers and developing innovative payment mechanisms to stimulate elimination of excess capacity.²² Such actions would involve reimbursement based on optimum utilization rates, reimbursement for fixed costs associated with closure of unneeded facilities, and limits on capital spending. Other advocates of linkage go further and recommend ceilings for regional health expenditures, thereby forcing explicit trade-offs not only for capital investments but for expenditures as well.²³ Indeed, the Carter Administration's Hospital Cost Containment Bill proposed a national limit on capital spending and operating cost increases of hospitals.²⁴

In addition to information exchange, strategies by third-party payers, maxicaps and penalties for inappropriate services, linkage might encourage cost-effective modes of treatment and create disincentives for volume increases of hospital-based care and incentives for primary care, particularly in designated areas of need.

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Finally, linkage could be used as a mechanism for creating pooled depreciation funds out of which to allocate future investments and perhaps even to finance health promotion campaigns.

There has been enough experience with various forms of linkage between health planning and hospital reimbursement to raise a number of important organizational and technical questions. Among them: Who should control the rate-setting agencies? To whom should they be accountable? Should rate-setting and planning functions be combined and placed under a single agency such as a department of health, or should voluntary arrangements be established between rate-setting and planning agencies? Should prospectively set rates apply to all payers—Medicare, Medicaid, Blue Cross Plans, commercial insurance companies, and out-of-pocket payers—or should they apply only to public funds? And, most important, to what extent should hospital reimbursement mechanisms incorporate the criteria developed by health planning agencies?

Models of Linkage

An evaluation of the practical problems of linking health planning and rate-setting institutions in Maryland and Rhode Island concluded by distinguishing three models of linkage: 1) representative rate setting under one agency at the HSA level, where rates are set in negotiation among members of a broad-based council; 2) unified planning and rate setting under one agency at the state level; and 3) federal control of reimbursement rates and planning functions.²⁵

Variations of the first and second models can be evaluated based on statewide experience within the U.S., but evaluation of the third model is still premature. The recent amendments to P.L. 93-641 tend to reinforce state control over the health planning process. If, however, NHI is enacted in the U.S., the legislation is likely to increase federal control—not only over the mode of reimbursement but over planning functions as well. The French experience with health planning and reimbursement provides a unique opportunity to evaluate a federal model of linkage—one

that relies on national control of fee-for-service reimbursement to hospitals and physicians through the use of fee schedules and negotiating mechanisms between the principal interested parties.

Health Planning in France

As in the U.S., cost control and health sector reorganization are now the central concern of French policymakers.²⁶ Moreover, recent French legislation reflects similar strategies to contain health care costs and reorganize health services by broadening their planning and regulatory apparatus and altering reimbursement incentives. The Hospital Reform Act of 1958 reorganized the public hospital system by linking regional hospitals to university medical schools. The Social Security Reform of 1967 increased central government control over regional health insurance funds. The Hospital Law of 1970 called for changes in provider reimbursement mechanisms to control rising health care costs, and expanded the administrative machinery and regulatory powers of health planning.

Under the federal control model of linkage, health care financing, control of provider reimbursement rates, and health planning functions are highly centralized in France compared to their present organization in the U.S. This is particularly evident, considering that in France the tradition of central state intervention was established by Louis XIV, institutionalized by Napoleon, and has remained so strong as to become the distinguishing feature of French public administration. One might expect, therefore, that the French have successfully linked health planning to provider reimbursement. But as we shall see, even under the federal control model of linkage, this is not entirely the case.

France has three politically and administratively separate institutions that dominate health planning: the Ministry of Health, the National Planning Commission, and the National Health Insurance Fund (CNAMTS). These institutions are separate yet interdependent. All of them influence resource allocation in the health sector, but each serves different functions, responds to different interests, and is bound by different constraints.

The Ministry of Health

The Ministry of Health is a centralized bureaucracy that manages France's 893 public hospitals and carries out Parliamentary intent as interpreted by a narrow group of technically competent civil servants—technocrats. Planning tasks and methods are determined in Paris. Local and regional public health administrations execute ministerial circulars. For example, the Ministry specifies procedures for making resource inventories and passes down criteria for purposes of estimating need. The local and regional administrations send up the necessary information along with their own budget requests.

From 1954 to 1970, within the Ministry of Health, a coalition of health planners and physicians promoted rapid construction and institutional reform of French hospitals. They successfully modernized the French hospital system following a strategy of rapid growth, without paying much attention to distributional issues. At first, there were two goals: increases in hospital beds and changes in hospital organization. The first goal was promoted under the slogan "hospital humanization"—the process of converting large communal wards into private rooms and constructing new hospitals. The second goal was promoted under the slogan "hospital reform"—the policy of favoring biomedical research and reorganizing public hospitals into regional networks to improve application of the new knowledge.

By the late 1960s, health planners in the Ministry of Health had succeeded in modernizing France's hospitals. But new problems emerged—disparities between public and private sectors and among geographic regions, and soaring health care costs. Throughout the 1960s, private proprietary hospitals (*cliniques*) grew at an even faster rate than public hospitals. By the early Seventies, the private sector (mostly *cliniques* but also private non-profit hospitals) grew to include one-third of the total hospital beds in France.²⁷ Though most medical technology and specialty care was, and still is, provided in the public hospitals, material conditions were far superior in the newly built *cliniques*. Prestigious public hospital buildings were dilapidated or obsolete in the Fifties and Sixties. Even in 1970, there

were still 80,000 public hospital beds in bleak communal wards.²⁸

Despite the fact that public hospitals are generally staffed with the most prestigious physicians and endowed with the most sophisticated medical technology, even the best public hospitals were losing patients to the *cliniques*.²⁹ The public hospitals sought more beds and improvements in material conditions to "humanize" the hospitals.

At the same time, health planners in the Ministry of Health called attention to the regional disparities in hospital distribution, ranging, in 1969, from 4.3 to 9.5 beds per 1,000 population.³⁰ The private sector distribution only exacerbated this inequality, for it provided 42% of hospital beds in the regions best supplied by the public sector and only 24% in the poorest regions.³¹

The legislative response to the problem of regional disparities and rising health care costs was the Hospital Law, which corresponds closely to a combination of P.L. 93-641 and state certificate-of-need legislation in the U.S. The law's goal was to improve management in the public sector and to regulate the dangerous growth, at public expense, of the private sector. To do this, the law called for reform of provider reimbursement to create financial incentives for implementation of national health policies and plans, and it established new health planning and regulatory institutions. In 1973, a national commission and two regional commissions in each of France's 21 administrative regions were established to produce health care facility plans and to authorize construction of new *cliniques* or extensions of existing ones.

In addition to creating the planning commissions, the Hospital Law divided the 21 regions into 284 health sectors. Public hospitals in each sector are required to provide a minimum range of services and to form a sort of cooperative union in which specialized personnel and medical technology can be shared. *Cliniques* are offered concessionary contracts by the cooperative union to assume responsibility for specific functions, take advantage of joint services, and thus become part of the so-called public hospital service.

At the national level, the health plan explicitly identified areas of need. Standards were

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devised in terms of hospital bed/population ratios for specific medical services. At the regional level, resource inventories were carried out for each of the 284 sectors, population projections made, and socioeconomic and epidemiologic characteristics of the population documented. The determination of norms has been crude, but the work of the regional commissions is the largest effort, to date, to apply analytical methods to the formation of health policy.³² The plans have become an essential document in the preparation of the national health plan and a critical tool in defining national health policy options. In comparing present levels of health resources to standards, health planners in the Ministry of Health have made public issues out of disparities.

The National Planning Commission (CGP)

The Ministry of Health's involvement in health planning is supplemented by the National Planning Commission (*Commissariat Général au Plan*—CGP). Unlike the Ministry of Health, the CGP is not concerned with short-term policy such as issuing regulations and creating commissions to implement Parliamentary intent. Rather, the CGP's charge is to take a long-term and broad perspective. Moreover, the CGP is run by a much smaller staff than any of the ministries. It depends on the Ministry of Health in every phase of its planning, both to assemble information and to execute ministerial circulars. The principal function of the CGP is to organize and to staff broad-based horizontal commissions, whose purpose is to stimulate consideration of broad and complex issues, and to report their findings and recommendations to Parliament.

The CGP became involved in health planning because rising national health expenditures could no longer be ignored in national economic planning. Not surprisingly, in 1965 during the preparation of the fifth national economic plan, the Commission on Social Transfers³³ underscored rapidly increasing NHI expenditures as a critical problem for the future and proposed policies to rationalize the health system.

These concerns influenced the Ministry of Health. In 1967, together with the Ministry,

the CGP organized a national task force on the future of the health sector. The task force report challenged the dominant emphasis of health planners on technological aspects of treating disease and biomedical research, and their neglect of environmental and social aspects of health and illness.³⁴ The report advocated a regionalized health system that would develop primary care, link it to secondary and tertiary care centers, and encourage substitution of ambulatory care for inpatient hospital care.

In 1971, under the direction of Robert Boulin, the Minister of Health, a three-volume report was released outlining specific programs to rationalize resource allocation within the health sector.³⁵ As did the task force, Boulin underlined the need for investing more resources in health promotion. Boulin's report recommended a variety of special programs, among them to improve highway safety and emergency medical services and to reduce perinatal mortality, alcoholism, cancer, cardiovascular disease, and mental illness. The report also proposed to reorganize the supply of health services by reforms ranging from the promotion of group practice and greater use of paramedical personnel to improvements in hospital management techniques and direct coordination of and increased control over private and public sector growth.

By the early 1970s, health planners in the Ministry of Health and the CGP no longer considered hospital construction and modernization a sufficient goal. They proposed to regionalize and coordinate health service institutions and to allocate resources so as to enhance health and reduce the incidence of illness, rather than to devote disproportionate efforts to the growth and refinement of medical techniques. In short, the aim now was rationalization, in the sense of promoting more effective and efficient resource allocation.

There has been little success in implementing either the ideas of Boulin's report or those of the national task force. The medical paradigm still predominates; medical services still are concentrated in hospitals; primary care programs and health promotion remain marginal activities; and regionalization of health services is still in the province of health planners' dreams. Although the regional health

planning commissions established under the Hospital Law have curbed duplication of hospital services by preventing construction of some *cliniques*, they have been unable to channel health resources into line with their plans. There has not yet been a single contract under which the *cliniques* join the proposed public hospital service.³⁶ Moreover, planners in the Ministry of Health, in the CGP, and particularly in the finance ministry, are alarmed by the continued growth of health care costs. In order to understand the failure to achieve implementation of health plans in France, it is necessary to examine the nature of CNAMTS and its interaction with the medical profession.

The National Health Insurance Fund (CNAMTS)

The third major institution that affects health planning in France is the CNAMTS. Although it is one of several funds within the French social security system, it finances the bulk of health services—roughly 70% of aggregate health expenditures (see Figure I). In addition, it also contributes roughly 30% of the capital for hospital construction and modernization. Its policies, therefore, represent a strong lever for the implementation of the national and regional health plans.

In French administrative law, the CNAMTS is a private organization charged with the management of a public service. But in reality it is quasi-public. Most of its revenue-generating mechanisms—payroll tax rates, wage ceilings to which these tax rates are applied, the government subsidies to cover deficits—must be approved by Parliamentary decree and by the Ministry of Labor and Social Security, which oversees the activities of the entire social security system. The eligibility and level of benefits of insurance coverage also are determined by Parliament. However, provider reimbursement rates to private hospitals and physicians are negotiated by the CNAMTS under ministerial supervision.

Established in 1967 as part of de Gaulle's administrative reform of the entire social security system, the CNAMTS was designed to exercise greater control over the previously independent regional and departmental sick

funds and to assure financial balance over the entire system's receipts and expenditures. Representatives of the state, of management (employer associations), and of employees (trade unions) were appointed to the board of directors, which was placed under stricter government supervision by the Ministry of Labor and Social Security.³⁷

Despite de Gaulle's administrative reform of 1967, the social security system represents a political style most unlike the centralized and nonparticipatory politics of the Ministry of Health. It is one of those rare French administrative structures in which a tradition of accountability, decentralization and regional autonomy is strong. Indeed, before the Gaullist reform of 1967, members of the regional and local funds were elected.³⁸ Since then, management and labor representatives have been appointed for board membership, but subscribers have received significant representation insofar as regional funds have been accountable to employees through their trade unions. Nevertheless, provider reimbursement rates negotiated by the CNAMTS over the last 20 years actually have benefited *la médecine libérale*—physicians in private practice and *cliniques*.³⁹

Although the CNAMTS provides financial support to the entire health sector, it does not have jurisdiction over the determination of hospital per diem rates in the public sector, and it negotiates with the private sector against powerful demands by the medical profession. In France, as in the U.S., hospitals are reimbursed on the basis of costs incurred. The unit of reimbursement is the patient day. For public hospitals, this rate is officially set by the government. The CNAMTS merely pays the bill. For private *cliniques*, the rate of reimbursement for each patient day is negotiated by the CNAMTS. And, for both public hospitals and *cliniques*, physicians' fees are also reimbursed. In *cliniques*, physicians are reimbursed following a negotiated fee schedule. In public hospitals, since physicians are on salaries and do not pay for the use of their equipment and facilities, the CNAMTS reimburses the hospital on a fee-for-service basis at a rate that varies according to the procedure—40%–70% of the rate negotiated in the private sector.

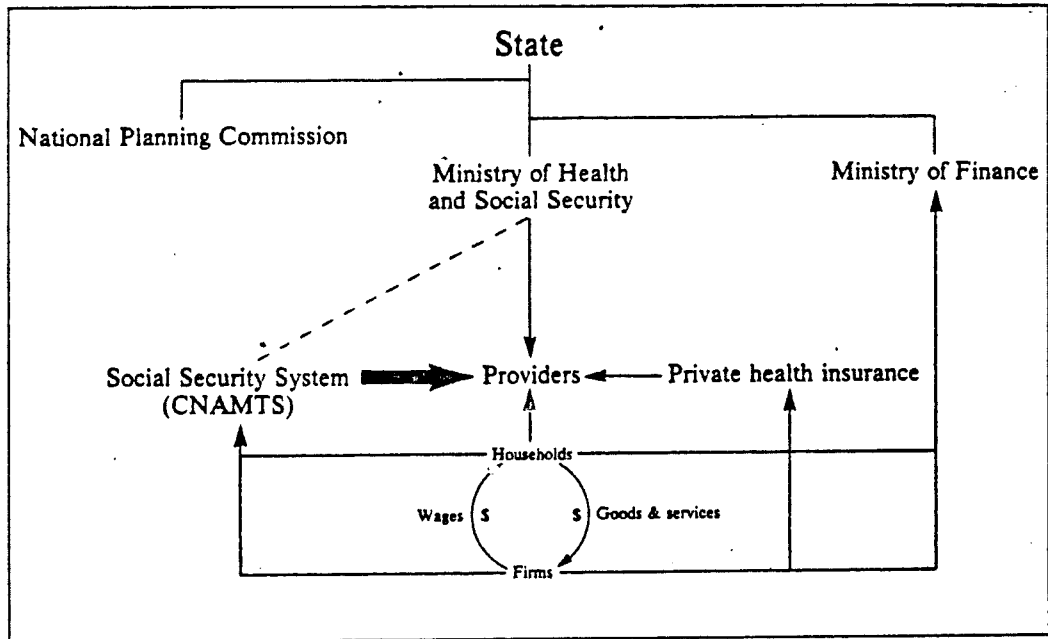


Figure 1. Health care financing in France

Note: The dashed line represents statutory authority. The arrows refer to financial flows.

Until 1968, the CNAMTS negotiated daily hospital fees for *cliniques*, on the basis of per diem rates of the closest public hospital. Since average costs of public hospitals tend to be higher than equivalent costs of *cliniques*, this system of provider reimbursement enabled the medical entrepreneur to cream the market. *Cliniques* consistently have handled easy cases—especially maternity care and routine surgery—leaving the public sector with the serious medical cases requiring prolonged hospitalization and capital-intensive care. In contrast, by law, a public hospital must be open 24 hours a day, must keep its occupancy rate under 95%, and must be equipped to handle all emergencies. Moreover, public hospitals include regional teaching hospitals engaged in biomedical research and medical training. Thus, in the 1960s, while public hospital costs rose faster than those in the private, proprietary sector, *cliniques* were reaping profits from the CNAMTS, and their bed capacity grew at a faster rate than in the public sector.⁴⁰

In the public and private sectors alike, reim-

bursement incentives have encouraged long lengths of stay to maximize total per diem fees reimbursed by the CNAMTS. There are no financial incentives for hospitals to develop large outpatient departments, since they are reimbursed on the basis of costs incurred for their inpatient services. Nor are there incentives for hospitals to encourage ambulatory surgery, home care programs, and other less costly modes of health care delivery.

These terms of provider reimbursement are not the result of explicit policies democratically set and forcefully pursued by the CNAMTS. The board of directors of the CNAMTS has never pursued explicit policies such as hospital construction and modernization, or health sector rationalization, let alone health promotion. Rather, the CNAMTS has responded to pressures emanating from the strongest recipients of its funds—the medical profession. The medical profession largely determines what services are produced in the health sector and consequently what expenditures will be made by the CNAMTS.

In April 1977, the French government ad-

vised changes in the hospital reimbursement rates, proposed a copayment fee (equivalent to about \$4 a day) for each day spent in the hospital, froze patient day rates, and reduced reimbursement rates for nonessential drugs from 70% to 40%. Simone Veil, the Minister of Health, stressed that it was less necessary to find new sources of finance for health care than to "control," i.e., slash, expenditures.⁴¹

Economies in the hospital could be achieved by limitation of the number of beds and more appropriate utilization of existing ones, but only active planning can assure control over expenditures while assuring better quality care.

By "active planning," the Minister of Health evidently means the need to link health planning activities to provider reimbursement. This concern is not new. Article 23 of the Hospital Law of 1970 called for reform of provider reimbursement rates in order to give hospital managers more flexibility and to "harmonize" reimbursement rates between private and public sectors. In 1972, in an attempt to implement the Hospital Law, the Ministry of Health issued regulations requiring stronger representation of the CNAMTS on public hospital management boards. Also, the General Inspectorate of Social Affairs recommended that linkages between the CNAMTS and the public hospital be strengthened further, so as to increase the role of the CNAMTS in setting the daily rate of reimbursement for a public hospital.

In 1976, a group of students from France's elite National School of Public Administration (ENA) published an analysis of the relation between the CNAMTS and the public hospital. In their analysis they suggested that "the contradictions between the exigencies of good management and the rules of hospital remuneration should be eliminated."⁴² They explained that "the relations between health insurance and the public hospital are more influenced by factors resulting from their historic evolution than by a rational distribution of skills and responsibilities." Finally, they questioned the legitimacy of an administrative system in which two health planning institutions—the Ministry of Health and the CNAMTS—can follow divergent policies.⁴³

Conclusions: The Battle Over Linkage

Despite NHI and national health planning activities in France, the policies of the Ministry of Health, the CGP, and CNAMTS are not yet effectively linked; in fact, they often work at cross-purposes. Provider reimbursement incentives encourage the multiplication of medical procedures and the maximization of patient days, whereas health planners are concerned with controlling rising costs by shifting the burden of care from inpatient to outpatient services and fostering health promotion rather than high technology curative services.

The sixth national economic plan proposed better technical training to teach new administrative technologies and greater remuneration to attract abler minds to the hospital management profession.⁴⁴ However, salary increases in the public sector require a change of rank in the French civil service hierarchy—a change that has been suggested not only for hospital administrators but also for nurses and other paramedical personnel. Such attempts to reform well-entrenched structures provoke immediate opposition from the finance ministry, which is not known for its receptiveness to across-the-board salary raises for civil service personnel!

Proposals to reform reimbursement rates of the CNAMTS to *cliniques* have met with equally formidable resistance. When health planners in the Ministry of Health and in the CGP propose to rationalize the health sector by implementing the Hospital Law and linking health plans to adjustments of CNAMTS provider reimbursement rates, the medical profession and hospital associations emerge as a powerful barrier to change.

What are the implications of French experience for the United States? Two trends stand out:

- 1 *The emergence of health planning to rationalize resource allocation.* Planners and managers have increasingly intervened to regulate the demand, supply and distribution of health resources. They have: placed controls on hospital expansion and capital expenditures; designed incentives to promote the substitution of ambulatory care for hospital care; placed strict reimbursement and quality controls on hospitals; shifted

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methods of provider reimbursement from fee-for-service to capitation or prepaid systems; and encouraged physicians to work on a salaried basis in large institutional settings.⁴⁵

- 2 *The resistance to institutional change.* Rationalization of major resource-allocation decisions through health planning has provoked conflict throughout the health sector because of the effects of proposed reforms on different interest groups. This has exacerbated strains between what Alford calls "corporate rationalizers," who seek to extend their control over the directions of health sector change by reorganizing the delivery system, and "professional monop-

olists," that is, medical professionals and certain hospital associations, who are fighting to maintain their control and resisting bureaucratic intrusion into their affairs.

The first trend suggests that health planning can and will in the future be linked to provider reimbursement. But the second trend suggests that the so-called professional monopolists will not tolerate it. The conflict is real and the stakes are high for all concerned: the state, the medical profession, and the ancillary interest groups. Indeed, no other aspect of health policy—in France or in the United States—is likely to receive such close attention in the 1980s.

References and Notes

- 1 For more detail on the institutional set-up and ideological roots of the French health care system, see Rodwin, V. "The Marriage of National Health Insurance and *La Médecine Libérale* in France: A Costly Union," *Milbank Memorial Fund Quarterly*, 59:1, Winter 1981, pp. 16-43.
- 2 Sandier, S. *Comparaison des dépenses de santé en France et aux U.S.A. 1950-1978 (rapport préliminaire)*, Study commissioned by DHEW, NCHSR, Paris: CREDOC (Centre de recherche pour l'étude et l'observation des conditions de vie), 1979. Collective financing refers to all financing coming from third-party payers: social security, private health insurance or government. In France, the National Health Insurance Fund of Salaried Workers (CNAMTS) covers most of the costs, whereas in the United States they are covered by private health insurance and government revenues.
- 3 Ibid.
- 4 Committee on the Costs of Medical Care, *Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care*, Chicago: The University of Chicago Press, 1932.
- 5 The Hill-Burton Hospital Construction Act was amended in 1949 (P.L. 81-380), 1954 (P.L. 83-483), 1964 (P.L. 88-433), and 1970 (P.L. 91-296). The 1964 amendment added long-term care facilities and expanded the program to include the modernization or replacement of facilities. The 1970 amendment expanded the program to include neighborhood health centers and outpatient facilities in poverty areas and rural communities. Regional medical programs were created by Public Law 89-239, and comprehensive health planning by Public Law 89-749.
- 6 Public Law 93-641, 93rd Congress, Jan. 4, 1975, Section 2.
- 7 Ibid., Sections 1502, 1523 and 1532.
- 8 The reviews of hospital expansion programs are known as the certificate-of-need process originally authorized under P.L. 89-749 and renewed under P.L. 93-641. The reviews of capital expenditures are known as the 1122 Provisions, since they are authorized in Section 1122 of P.L. 93-641.
- 9 P.L. 93-641, op. cit., Section 1526.
- 10 Social Security Amendments (P.L. 92-603, Section 222); The Health Maintenance Act (P.L. 93-222); Hospital Cost Containment Bill of 1977 (H.R. 6575).
- 11 Bauer, K. *Cost Containment Under P.L. 93-641: Strengthening the Partnership Between Health Planning and Regulation, Final Report*. Cambridge: Harvard University Center for Community Health and Medical Care, January 1978, p. 29.
- 12 Davis, K. "Health and the Great Society: Successes of the Past Decade and the Road Ahead," in D. Warner, ed., *Toward A New Human Rights: The Social Policies of the Kennedy and Johnson Administrations*, Austin: University of Texas, 1977.
- 13 Glaser, W. *Paying the Doctor: Systems of Remuneration and Their Effects*, Baltimore, MD: Johns Hopkins Press, 1970.
- 14 Feldstein, P. "An Analysis of Reimbursement Plans," in *Reimbursement Incentives for Hospital and Medical Care*, Washington, DC: Social Security Administration. Research Report 26, 1968.
- 15 "Impact," DHHS Region VIII Health Planning Newsletter. PACT Health Planning Center, Denver, CO, Vol. 2, No. 10, 1978.
- 16 Schroeder, S. and Showstack, J. "Financial Incentives to Perform Medical Procedures and Laboratory Tests: Illustrative Models of Office Practice," *Medical Care*, 16:289-298, April 1978; Blumberg, M. "Rational Provider Prices: An Incentive for Improved Health Delivery," in C. K. Chacko, ed., *Health Handbook—1978*, Amsterdam: North Holland Publishing Company, 1978.
- 17 Bauer, K. "Hospital Rate Setting—This Way to Sal-

- vation?" *Milbank Memorial Fund Quarterly*, Winter 1977, pp. 117-158.
- 18 Altman, D. *Connections Between Hospital Rate Setting and Planning in Maryland and Rhode Island*. Harvard Center for Community Health and Medical Care, June 1976.
 - 19 Cohen, H. "Experiences of a State Cost Control Commission," in M. Zubkoff, I. Raskin, and R. Hanft, eds., *Hospital Cost Containment: Selected Notes for Future Policy*. New York: Prodist, 1978.
 - 20 Sweetland, M.; Altman, D.; and Motter, W. *Institutional Responses to Evolving Health Planning and Regulatory Programs: Case Studies From Two New England States*. Harvard Center for Community Health and Medical Care, January 1978; Evans, R. *Linkages Between Planning, Regulation and Rate Setting in New Jersey: The Case of A Perinatal Care Center Designation*. Harvard Center for Community Health and Medical Care, January 1978; and Brown, J. *Facility Expansion and Facility Closure: Two Case Studies in Health Planning and Regulation from Rochester, New York*. Harvard University Center for Community Health and Medical Care, January 1978.
 - 21 Bauer, K. and Altman, D. *Linking Planning and Rate Setting Controls to Contain Hospital Costs*. New York: Division of Resource Development of the Public Health Service, DHEW Region 11, October 1975.
 - 22 Hollander, N. "Linking Health Planning and Reimbursement: Blue Cross Organization Experiences." Paper delivered at the American Public Health Association annual meeting, Washington, DC, Oct. 31, 1977.
 - 23 Blum, H. *Expanding Health Care Horizons: From a General Systems Concept of Health to a National Health Policy*. Oakland, CA: Third Party Associates, 1976. See chapter written with J. Showstack.
 - 24 H. R. 6575, op. cit.
 - 25 Altman, D., op. cit.
 - 26 For more elaboration on this theme, see Rodwin, V. "Health Planning in International Perspective," in H. Blum, *Planning for Health*. Second Edition, New York: Human Sciences Press, 1981.
 - 27 Guionnet, A. "Données statistiques sur l'hospitalisation," in *Hospitalisation publique et privée*, Nos. 37 and 38, 1974.
 - 28 Castaing, M. "Hôpital, ce malade chronique," *Le Monde*, Feb. 21, 1975.
 - 29 In Paris, the most prestigious hospitals are managed by a public agency—*l'Assistance Publique*. In 1973, the image of *l'Assistance Publique* sank so low that the central administration ran spots on television, in movie theaters, and in the daily press to sensitize public opinion. On April 8, a publicity campaign was launched, bringing 70,000-80,000 Parisians to 28 of AP's 37 hospitals.
 - 30 Pour une réforme hospitalière: Rapport présenté par M. Roger Grégoire, in *Pour une politique de la santé*. Reports presented to Robert Boulin. Paris: Documentation Française, 1970, p. 207.
 - 31 "Situation des hôpitaux publics," Memorandum of the Fédération Hospitalière Française to the Ministry of Health and Social Security, in *Revue Hospitalière de France*, 1973, p. 665.
 - 32 Rodwin, V. *Health Sector Planning for the Paris Region: A View From Outside*. Consulting report for the Service régional de l'équipement de la région parisienne, Paris, November 1975.
 - 33 *Rapport général de la commission des prestations sociales*. Fifth National Economic Plan. Paris: Documentation Française, 1966.
 - 34 *Réflexions sur l'avenir du système de santé*. Report of the Groupe de travail sur la prospective de la santé: Documentation Française, 1969.
 - 35 *Pour une politique de la santé*. Reports presented to Robert Boulin. Paris: Documentation Française, 1970.
 - 36 "Un décret permet aux cliniques privées 'à but non lucratif' de participer au Service hospitalier public," *Le Monde*, May 27, 1976.
 - 37 Dupéroux, J. J. *Sécurité sociale*. Paris: Dalloz, 1971.
 - 38 Galant, H. *Histoire politique de la Sécurité sociale française*. Paris: Armand Colin, 1955.
 - 39 Brunet-Jailly, J. "Quelques évidences sur l'évolution du système de santé," *Revue économique*, No. 3, 1976. Also, for an analysis of provider reimbursement incentives in France, see Rodwin, V. "The Marriage of National Health Insurance and *La Médecine Libérale* in France: A Costly Union," op. cit.
 - 40 de Kervasdoué, J. "La politique de l'Etat en matière d'hospitalisation privée, 1962-1968: Analyse des conséquences de mesures contradictoires," *Annals économiques de Clermont-Ferrand*, No. 16, 1980, pp. 25-56.
 - 41 *Le Monde*, Oct. 30, 1977.
 - 42 "L'Assurance maladie et l'hôpital public," in *Revue française des affaires sociales*, special issue, July/September 1976, p. 206.
 - 43 Ibid.
 - 44 *Rapports de la Commission Santé*, Sixth National Economic Plan, Paris: Documentation Française, 1971.
 - 45 Alford, R. *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press, 1975.

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