Chapter 27

France

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This chapter describes the French health system and in describing it helps to illuminate other systems–and, in particular, the United States. The author begins by reflecting on the values embodied in French health care–liberal-pluralism and solidarity (the American system shares these values but puts more emphasis on the first). The article explains how the French system covers the population, how health insurance works in France, and how the system developed with the passage of time.

Americans often view health systems abroad as models of what they would like to see or avoid at home. For example, the French system may be viewed as a case of "government controlled health care," "entrepreneurial office-based practice," "socialized financing," "centrally managed public hospitals," "market-oriented for-profit hospitals," or simply a "public–private mix of funding and service provision". Beyond the half-truths associated with such labels, students of health politics and policy should seek to understand the salient characteristics of health systems and how they reflect ideas and values that have shaped their institutions and political dynamics.

This chapter examines how, in France, the health system evolved into a national health insurance (NHI) model that assures universal coverage with comprehensive benefits and imposes relatively low out-of-pocket payments compared to most Organisation for Economic Co-operation and Development (OECD) nations. The health system is characterized by community-based ambulatory care (CBAC), a public–private mix of hospitals, private complementary health insurers, and national-level negotiations among physician representatives, managers of NHI and the state on payment rates for private practice. I do not cover the complex details of how the health system is financed and organized[1] because the focus here is on French health politics and policy along the road from private health insurance to the first laws on compulsory NHI in 1928, 1930, 1945, and since then. To get a sense of the health system's salient characteristics and evolution, I begin with the ideas and values that underlie its financing and organization, and endure today as French policymakers address new challenges.

Ideas and Values

Two conflicting ideas and values underlie the French health system: liberal-pluralism and solidarity.

Liberal-pluralism is grounded in principles of liberalism and what Lindblom called "disjointed incrementalism" as a strategy of change.[2] Liberalism has little to do with the 1960s American sense of social reform. Rather, it reflects nineteenth-century European ideas of *laissez faire*—letting markets operate and allowing for individualism and free choice. Pluralism embraces diverse organizations in society and dispersed centers for making decisions. In the health sector, liberalism justifies *la médecine libérale*—a set of principles, enshrined in the Medical Charter of 1927: free selection of physicians by patients, freedom of prescription and professional autonomy for doctors, confidentiality of physician–patient exchanges, and perhaps most importantly, fee-for-service (FFS) payment directly by patients to doctors. These principles have been sedulously cultivated by the medical profession to ensure a personal, symbiotic doctor–patient relationship and some physician control over their incomes. Pluralism, in the health sector, reflects the views of employers and private health insurers in the 1920s, which supported multiple insurers offering a wide range of benefits to different employers and occupational groups.

The idea of **solidarity** goes back to the French solidarist movement of the 1890s.[3] Léon Bourgeois, a former Prime Minister during the Third Republic (1870-1940) , argued that the French Revolution (1789) had placed too much emphasis on individual rights; it was time to attend to social obligations and ties to one another.[4] Following World War II, the idea of national solidarity often invoked Rousseau's concept of the "general interest," which is not the plurality of individual interests, but rather something more elevated, unifying, bordering on egalitarian. In this sense, solidarity provides a justification, distinct from liberalism and socialism, to support state-led social reform in pursuit of justice and the Republic's promise of *fraternité*. In the health sector, the idea of solidarity has evolved from justifying insurance coverage as a form of collective action within occupational groups to providing the ideological foundation for French NHI and the broader social security system of which it is a part. In this sense, national

solidarity suggests that health insurance is a right for all—sick and well, active and inactive, high and low-income—and that health insurance premiums ought therefore to be calculated on the basis of peoples' ability to pay, not actuarial risk.

Politics, Policy and the Health System

In comparison to the United States and most European nations, France is known for its strong state and centralized style of health system management.[5] But like so many paradoxes that puzzle anyone trying to understand France, the health system is, in many respects, fragmented, local, and disorganized. French citizens revolted against the excesses of the monarchy's centralization during the Revolution, yet many of these excesses survive today, along with periodic resistance to them. France is known for its revolutionary politics, yet so many of its governments, since the Revolution, have been conservative. The French are deeply attached to their Republic, yet their political discourse is known for polemic rhetoric, and they periodically march in the streets to protest their government's policies. France is notorious for its trade-union demonstrations and general strikes, yet it has some of the lowest unionization rates in Europe. Despite these paradoxes, some characteristics of the health system are unambiguous.

France's health system is not—like Cuba—a system of socialized medicine in which the entire health care workforce is employed by the state and private practice is illegal. Nor is it like Great Britain, a national health service (NHS) in which most hospitals are nationalized but private health insurance and service provision is legal and general practitioners (GPs) retain their "independent contractor" status within an "autonomous enclave" of the NHS.[6] In contrast to such systems, France's NHI model combines public, social security, and private sources of funding with CBAC provided largely by private office-based practitioners who generally insist on direct payment for which patients are reimbursed via their NHI smart card. Most hospitals are public institutions (academic medical centers, community, and other specialty hospitals), albeit with a significant role (one-third of acute beds) for private hospitals (for-profit, as well as nonprofit). To clarify terminology, public financing comes from fiscal taxes, social security financing is based on payroll taxes, and private sources of funding are from private complementary health insurance and out-of-pocket payments.

In contrast to the United States, major disagreements about health policy, in France, have rarely differentiated political parties from one another.[7] When party platforms have outlined health care reforms, e.g., when socialist candidate, François Mitterrand, was elected president in 1981, his proposals did not rank high enough to compete with other pressing reforms. Political parties in France have never advocated restructuring the overall financing and organization of the health system. In this respect, politicians are united in 'keeping politics out of health.' Political discourse around health focuses on what must be done to preserve the existing system; not to promote big-bang reform. To avoid radical reform and support the status quo in this fashion, political parties rely on the same health care interest groups to write the health programs within their respective party platforms.

French politicians typically regard their health system as a compromise—for better or worse—between Great Britain's NHS and the U.S. patchwork system. They often assert that the NHS relies on too much health care rationing and offers insufficient patient choice, and that the U.S. health system is socially irresponsible for three reasons, none of which apply to France: (1) There are too many people who are uninsured; (2) There are too many people who are under-insured; and (3) There are too many people forced to declare bankruptcy after a serious episode of illness.

Despite the prevailing consensus on maintaining the French NHI model, as the health system has evolved since the early 20th century, policymakers have debated the relative importance of the conflicting ideas and values summarized earlier, particularly with respect to the role of the state in financing, regulating, and providing health services and oversight over NHI. How these debates have been resolved through legislation, government decrees and negotiation among major stakeholders reflects the nature of French political institutions, the power of key interest groups, for example, the medical profession, hospital associations, private insurers, and the central state—parliament, the executive branch, and the highest levels of France's civil service.

Competition and Health insurance Coverage

Under its NHI program, the French population has no choice of health insurer for the statutory benefits provided to them based on their resident status. There is some choice for complementary benefit packages provided by private insurers, but these services account for only a small share (13.5%) of total health care expenditures. They cover most of the population (98%) for coinsurance, copayments, some balance billing, as well as vision, dental and hearing aids. The remaining population that cannot afford subsidized complementary coverage obtains it through a means-tested public program. National, regional, and local health insurance funds responsible for the statutory benefits under NHI are legally private organizations responsible for the provision of a public service. In practice, they are quasi-public organizations supervised by the Directorate of Social Security (DSS) within the Ministry of Health and Social Affairs (MOH) that oversees the entire French Social Security system—pensions; family allowances; health and accident insurance.

Until recently, health and accident insurance were managed by three separate NHI funds: for Salaried Workers (CNAMTS); for farmers and agricultural workers (MSA); and for the Independent Professions (RSI), now under the CNAMTS. In addition, there are smaller funds for specific occupations and their

dependents, all of whom have defended their "rightfully earned" entitlements, also managed by the CNAMTS and its network of regional and local funds that reimburse patients, and/or pay health care providers directly, monitor fraud and abuse, and provide a range of other public health and informational services for their beneficiaries.

French health policymakers differed from most of their European counterparts in resisting reform efforts, in the 1990s, which introduced competition and market forces in systems with universal health care coverage.[8] American nostrums of unleashing market forces, for example, consumer-directed health care and selective contracting by competing health insurers in Germany, the Netherlands and Switzerland, or internal market competition in England's NHS, have gained little traction in France. French NHI resembles more closely parts A and B of our Medicare Program except for the fact that the entire population is covered not just for parts A (hospitals) and B (medical), but also for some long-term care services and pharmaceutical benefits less well-covered by Medicare part D or not covered at all (dental, vision and hearing aids).

Aside from offering no choice of insurer under France's statutory NHI program, there is considerable competition among health care providers and complementary private health insurers. French NHI allows patients free choice to consult GPs, specialists, private duty nurses, and physical therapists in CBAC without any American style out-of-network restrictions, surcharges and strict gatekeeper provisions in Medicare Advantage or private managed care plans. Beginning in 2005, NHI imposed a soft gate-keeping system by requiring French residents to sign up with a primary care doctor (*médecin traitant*).[9] It is still easy, however, to consult medical specialists directly conditional on a slightly higher coinsurance payment, or to arrange for direct access to a specialist with a referral from one's *médecin traitant*.[10] As for hospitals, NHI pays them directly for their care of all insured patients whether they choose public or private facilities, and wherever they choose to be hospitalized in France.

The Long Road from Private to NHI

NHI evolved incrementally in response to demands for extension of coverage and resistance to proposed legislation by interest groups strong enough to lobby members of parliament (MPs).[11] In the 1920s, resistance was led by the medical profession, farmers, small employers and private insurers, most of whom were organized as nonprofit mutual aid societies (*mutuelles*). The *mutuelles* are the voluntary organizations that provided cash benefits to replace income due to illness and premature death, and payment for medical costs due to accidents and illness. Given their deeply ingrained beliefs in individual initiative and personal responsibility, the *mutuelles* never conceived of themselves as charitable organizations; nor did they aspire to provide universal coverage.

Although private insurers, including the *mutuelles*, were strongly opposed to state intervention, as the economy became increasingly industrial and trade unions grew more powerful, new demands emerged for the state to expand health insurance coverage. Following the Great War (1914–1918), the return of Alsace and Lorraine from Germany to France created the impetus for parliament to pass its first compulsory social insurance law covering salaried workers in industry and commerce for pensions, family allowances, sickness and accident benefits. Since the population in Alsace and Lorraine had been covered by Germany's social insurance system established by Bismarck in 1883, there was general consensus among French MPs that it would be politically unacceptable to deprive Alsatians and Lorrainers of their inherited benefits. Likewise, most MPs were in favor of equalizing these benefits throughout France even if this meant responding to a complex set of conflicting demands by private insurers, employers, and physician trade unions.

France's first social insurance law took eight years to prepare before its passage in 1928. Given the number of possible "veto points" along the way for parliament to pass legislation, it is not surprising that it took a long time and that after its initial passage, a coalition of employers, private insurers and physician trade unions succeeded in rescinding the law.[11] Nevertheless, an amended version of the law, enacted again in 1930, covered all salaried workers, under an income ceiling, in industry and commerce. This law is important because it introduced the notion of compulsory health insurance and mandated benefits. Workers could still choose their insurers and physicians remained free to set their own fees, but the law established a strategic role for the state in setting payroll tax rates and covered benefits. In contrast to the original plan before 1928 to design a system of NHI for the entire French population, the effects of pluralism—multiple occupational groups lobbying MPs to defend their own particular interests—resulted in establishing one of the most fragmented systems of social insurance in Europe. Dumont aptly characterized the system as a "worksite under perpetual scaffolding" and compared it to an "unfinished cathedral" with multiple altars, steeples and cloisters, each one providing distinctive benefits for different occupational groups.[12]

The social security ordinances: In 1944, following the Liberation of Paris from Nazi control, the *Conseil National de la Résistance* called for a comprehensive social security system.[13] The following year, de Gaulle's provisional government appointed Pierre Laroque, as head of the new Department of Social Security. Laroque developed a plan to restore a sense of national solidarity, democratize and rationalize the 1930 NHI program.[14] Since the provisional government was reluctant about ceding power to a parliament that had voted to extend Petain's power during the occupation, democratization called for a board of directors composed of elected representatives of employees and employers to manage the NHI funds.[4] It also provided the rationale for extending coverage to all citizens. Rationalization suggested that the French medley of private health insurers be consolidated under the national fund with regional and local branches.

In 1945, the social security ordinances of October 4 and 19—two state decrees—established a social security fund for family benefits, pensions, and health insurance, and extended coverage to all industrial and commercial workers and their dependents, irrespective of their income. Private health insurers were left only with a market for private complementary health insurance beyond the statutory benefits covered under the compulsory NHI program. The provisional government established a system of social democracy to elect representatives of employers (25%) and salaried employees (75%), to the boards of directors for all national, regional and local funds in the social security system.[13] Their hope was that this governance model, inspired by Germany's Bismarckian heritage, would be more decentralized and somewhat removed from the French state whose reputation was tainted by Petain's collaboration with the Nazi regime.[15]

The social security ordinances reflected the ideas of Gaullist planners working for the French government in exile, in London, during the war. De Gaulle's social policy group under the leadership of Laroque, had been influenced by the Beveridge Report (1942) which subsequently led to the establishment of the British NHS in 1948. Laroque recognized that Beveridge's ideas on the need for a universal, unified and comprehensive welfare state would have to be adapted to France's social insurance system organized around employers, salaried workers and private health insurers.[4] As in 1930, the French proclivity for Cartesian reason had to confront the reality of power.

Numerous special interest groups such as miners, merchant seamen, subway workers, railway workers, veterans, civil servants, and other occupations, succeeded in maintaining their more favorable benefits. Moreover, those groups already covered were not inclined to pay for those who were uninsured. Paul Dutton explains that "Laroque and his successors had little choice but to build their edifice on top of these foundations. They could use new materials, build higher, and add many rooms, but the outlines of the old structure would always be visible."[4] Although Laroque had called for an ambitious, big bang style of reform, the provisional government forced a compromise between its two major parties: the Communists with the support of labor unions and the Gaullists, with strong support of business. As a result, implementation of the original plan was postponed.

The extension and implementation of NHI: Throughout the postwar reconstruction period of the Fourth Republic (1946–1958), and subsequently under President de Gaulle, during the first decade of the Fifth Republic (1958–1968), when executive power was strengthened in the new constitution, progress was achieved in extending health insurance coverage and improving benefits. Still, French attachment to liberal–pluralism exacted compromises along the way.

In 1961, a national fund (MSA) was established to extend health insurance to farmers and agricultural workers and in 1966, another fund (RSI) was established to cover unsalaried workers, artisans, and independent professionals. In 1974, a new law proclaimed, once again, that NHI should be universal and unified. But it was not until 1999 that a universal NHI law (*Couverture Médicale Universelle*-CMU) was enacted to cover remaining legal residents of France irrespective of their employment status or previous payroll tax contributions. Implementation of this law began in January 2000, when it enabled residents living below a poverty level income to qualify for free complementary insurance benefits financed by the state, and access to health services, without coinsurance payments, in health centers and outpatient hospital departments.

To this day, efforts to align retirement and health insurance benefits by reducing those of special interest groups result in massive protests. The CMU law set the stage for subsequent improvements in 2016 and 2022, which eliminated previous requirements to apply for CMU every year, or every third year, depending on a person's employment status. Also, spouses are no longer covered on the basis of their dependent status; they obtain coverage individually and keep it for life. Moreover, benefits were extended to cover dental and vision care and hearing aids.

NHI and fee negotiations: Until 1960, French physicians in private practice remained free to set their own fees. With the decree of May 12, 1960, de Gaulle relied on the Fifth Republic's constitution, which allowed the prime minister to pass a decree and thereby circumvent normal parliamentary control. In this way, he established a national system of annual individual physician contracts with price ceilings on a schedule of medical fees. This system ended the traditional freedom of physicians to set their own fees and thereby violated a key principle of la *médecine libérale*. It also destroyed physician unity; for the strongest advocates of private FFS practice opted out of the NHI program and formed a new trade-union.[16] Nonetheless, by 1964, 85% of French physicians, including most members of the new union, accepted the fees paid by the NHI program.

In 1967, another government decree reorganized the NHI program by establishing the three separate national funds noted earlier—CNAMTS, MSA, and RSI. Each fund was granted a certain autonomy to manage its finances and the regional and local funds were placed under the supervision of the national funds. Governance of the national funds was no longer left to elected representatives of employers and salaried employees. It was divided among appointed representatives of trade unions and employers, with oversight by the state's DSS.[17] Following the establishment of the NHI fund for all salaried workers (CNAMTS), although one could define French NHI as a mutipayer model, de Gaulle succeeded in consolidating most health care funding within one national fund, with the other funds abiding by the same payment rates for all health care providers, thereby establishing a source of countervailing power against physician trade unions.

In 1971, CNAMTS agreed not to compete with *la médecine libérale* by establishing its own health centers for the provision of primary care. It also extended health insurance benefits to all physicians. In return, the physician trade unions signed a national collective contract with the CNAMTS, overseen by the DSS, in which they agreed to accept reimbursement rates negotiated annually on the basis of a national fee schedule.[18]

The Quest for Health Sector Rationalization

Since the early years of the Fifth Republic, as in other wealthy nations, French health care professionals have practiced in a socioeconomic context whose growth and changing patterns transformed the health sector. It has evolved from a cottage industry led by entrepreneurial physicians providing most of their services in office-based solo practice or their patients' homes, to an emerging industrial complex organized around hospitals that support specialized staff and affiliated activities such as the pharmaceutical industry, biomedical laboratories and firms producing and marketing new medical technologies.[19] During the period of reconstruction and economic growth following World War II, health policy was a response to the need for new hospitals and modernization. Later, from the 1970s, over a period of enormous medical progress, new health technologies, demographic change and exploding health care expenditures, health policy developed into the handmaiden of economic pressures to limit the rate of health sector growth.

During the growth period, to finance demand for health services, as noted above, the state extended health insurance coverage. To finance the expanding supply of hospitals, the state invested in medical education, hospital infrastructure and new medical technologies.

Health sector growth and modernization: In 1945, most public hospitals were still institutions that cared for the indigent sick and physicians working in them earned most of their income from private patients. In 1958, based on a task force report, led by Robert Debré, a distinguished physician and the father of de Gaulle's prime minister, Michel Debré, the government issued three decrees to reform the hospital system by designating regional hospital centers to be affiliated with university medical schools and changing the reimbursement of hospital-based physicians from FFS to salary payment.[20] Not surprisingly, this change provoked vigorous political opposition by physicians committed to *la médecine libérale* and hostile to the idea of being salaried like civil servants.

The hospital reform was, nevertheless, supported by many clinical professors and younger physicians. The highest ranking professors, *les grands patrons*, who resisted at first, succeeded in conserving that part of *la médecine libérale* they considered most dear—the right to hospitalize their private paying patients in "private beds" within their public hospital service units. In addition, since they were required to oversee and provide patient care, as well as engage in university teaching and research, they were offered two salaries—one from the MOH; the other from the Ministry of Education for which they accepted civil servant status. Many of the younger physicians supported the reform as an attack on the feudal hierarchy of medicine and education and on the traditional values of *la médecine libérale*, both of which often stood in the way of developing and applying the findings of biomedical research.

Like the Flexner Report and Regional Medical Programs in the United States, the Hospital Reform accelerated health sector modernization. It consolidated and channeled the diffusion of high-tech medicine and reduced the gap between biomedical knowledge and its application. During the first 15 years of the Fifth Republic, planners in the MOH and National Planning Commission (NPC) initiated a hospital construction program similar to our Hill-Burton Program in the United States. As in the United States, there was widespread agreement that investments in health care were needed. Hospital infrastructure was upgraded, communal wards in public hospitals were converted into private rooms, and health planners initiated policies to coordinate the growth of public and private hospitals.[21]

In contrast to the British NHS, one of the French health system's long-standing and distinguishing characteristics has been its public–private mix of hospitals for which NHI pays most of the costs. Private hospitals, particularly the for-profit ones, have been the strongest refuge for *la médecine libérale* because physicians there are paid FFS and patients choose their physician. During most of the 20th century, these hospitals differed from public hospitals and private nonprofit hospitals, most of which have developed close associations with public sector partners. The for-profit hospitals typically cared for patients with less complex medical diagnoses and provided almost half of all surgical and obstetrical care. Today, since most for-profit hospitals are part of larger hospital systems and many engage in highly specialized care for cancer and heart disease, these differences have narrowed. Nonetheless, almost all academic medical centers are in the public sector. Since the public and private nonprofit sector hospitals also serve as sites for medical education and research, the high-tech and super-specialty medical treatments remain mostly in the public, and a small number of private nonprofit medical centers, while the private for-profit sector now performs more than half of all surgery.

Until the early 1970s, French high-level civil servants trained in prestigious national schools—Ecole Polytechnique and the National School of Administration (ENA)—succeeded in modernizing the French economy, constructing and upgrading hospital infrastructure and compensating, through the social security system, many of the victims who lost their jobs due to the contraction of agriculture and reorganization of industry. This phase of health sector growth coincided with a period of triumphant success in medicine and the biological sciences. Politicians, citizens, and health professionals agreed, as a general rule, that more was better—more medicines, more hospitals, more health professionals, more innovation. Such agreement among major interest groups resulted in little political debate about priorities in the health sector. Over the decade between 1959–1969, expenditure on social security (health insurance, family allowances, and retirement pensions) more than tripled and in the early 1970s, the social security budget grew to exceed the state's budget leading policymakers to invoke a "social security crisis."[22] During this phase which takes us up to the present, there has been more conflict about how to protect the prerogatives of *la médecine libérale* while also adapting the health sector to economic constraints.

Rising health care costs: By 1973, the convergence of rising health care costs, Europe's energy crisis and economic recession, forced policymakers to pursue new goals focused on how

to contain the growth of health care costs and manage health services in a world of growing biomedical research, pharmaceutical innovation, and diffusion of new medical technologies. The cost problem was typically explained by the Ministry of Finance (MOF) and the NPC in the following way.[23] Rising NHI expenditures lead to a "structural deficit," that is, revenues don't keep up with payments. This results in fiscal and parafiscal pressures (from income and payroll taxes), which affect disposable income of employees and production costs of industry. Employers pass on these costs to consumers—either through real wage losses or price increases for their goods—and this conflicts with the nation's economic goals of developing an industrial sector that can compete in international markets. Such conflicting goals, in turn, provoke concern about how to improve access to quality health care, contain costs, and finance NHI coverage to sustain France's commitment to national solidarity.

The problem of how to contain rising health care costs is far more complicated than managing health sector growth because it raises a host of new issues. To begin with, health policymakers confronted regional inequalities in population health and access to health care. In addition, new studies made them aware of the uneven medical care quality among hospitals and regions. Also, new questions emerged about the need to coordinate hospital care with CBAC. Finally, the period from the 1970s to the 1990s, coincided with the introduction of new provider payment methods: fee-for-service for physicians in CBAC and private hospitals; and *per diem* reimbursement followed by global budgets and activity-based payments based on diagnosis-related groups (DRGs) for hospitals. The evolution of provider payment methods raised questions about the effects of CNAMTS' payment policies on the structure and evolution of the health sector and the extent to which it should take on a more active role in designing financial incentives more in line with the announced policies of the MOH.[24]

There was little consensus about these issues. Hospitals and physician trade unions defended their share of health care expenditures and argued for more resources; the state, itself, was divided among the MOF, the MOH, the DSS; and the CNAMTS was divided among representatives of employers and trade unions. The only agreement that successfully kept the health system afloat was the consensus around preserving the broad elements of the status quo. As former President Giscard d'Estaing once put it: "France will remain a country which through the pluralism of its health system, will succeed in reconciling *la médecine libérale* and the socialization of its cost (NHI)."

Giscard d'Estaing's comment is typical of political party positions on health care reform. As Jean de Kervasdoué observed, political party positions are developed by subcommittees with strong representation of the same key interest groups that seek to maintain the status quo. Consequently, these platforms have never focused on the fundamental issues of health care reform: power, unbounded clinical freedom to prescribe, institutional change; in short, how to adapt the financing, payment methods, and organization of health services to the exigencies of technological, social, and economic transformation.[25] Over the past 50 years, policymakers sought to contain the growth of health care costs, while confronting all of the issues raised above and taking on new crises (e.g., AIDS, the contaminated blood scandal and bovine spongiform encephalography), as they emerged.

Stop-gap responses to contain rising costs: In simple terms, policymakers faced two principal options for addressing the structural deficit of NHI funds: increase revenues and control expenditures. Increasing revenues is conceptually easy but politically challenging. This can be accomplished by increasing payroll taxes, raising wage ceilings to which they are assessed, or extending the taxable base beyond payroll to fiscal taxes. Controlling expenditures is far more complicated because it involves many more choices about trimming back benefits, increasing out-of-pocket payments, or regulating prices (those set by the MOH for hospitals; or those negotiated with physicians and other health professionals working on an FFS basis). Depending on how prices are regulated, and by how much they are reduced or allowed to increase, physicians and hospitals have demonstrated a remarkable ability to adjust the volume of their services to achieve their own revenue targets. In response, policymakers have developed new tools to measure, and eventually control, service volume. Another longer-term approach to contain long-run health care expenditures led the state to implement capital controls designed to limit hospital expansion and modernization, regulate the diffusion of new medical technologies and limit the number of students admitted to medical schools.

French policymakers combined a mix of all these methods in their quest to contain the rise of health care expenditures and rationalize the health care sector. Despite the 1967 decree that granted the CNAMTS a certain autonomy to balance its revenues and expenditures, and the use of these stop-gap methods, health care expenditures grew at rates exceeding the growth of GDP. Price controls, volume controls, and capital controls were politically possible because they did not threaten the existing financing and organization of the health system. Nor did they alter the overall management of the system.[23] Physicians remained free to determine the mix and quantity of resources they prescribed though they shared no financial responsibility—neither in private practice nor in public or private hospitals; the CNAMTS paid for health care without exercising management controls on what was provided; and the MOH exercised regulatory authority over all public hospitals even though it paid a small fraction of their expenditures (most funds came from the CNAMTS). The lack of effective linkage between the institution in charge of payment (CNAMTS), the regulator (MOH), and providers was sometimes compared to a *ménage à trois* thereby complicating the quest for health sector rationalization.[24]

The Juppé Plan and its Aftermath

By the early 1990s, economic shifts related to the European common market, globalization, the preparation for a new European currency—the Euro—all contributed to the design of a more structural approach to health care reform. Prime Minister Alain Juppé's Plan addressed the entire social security system, including NHI. Among his many lasting reforms was the passage, in 1995, of a constitutional amendment mandating parliamentary

approval of all social security expenditures. This was followed by three government decrees, in 1996, which mandated parliament to set a health care expenditure target, increased fiscal taxes to finance these expenditures, and reinforced state control over public and private hospitals. Other elements of the Juppé Plan aimed to align, meaning reduce, retirement benefits of railway workers and other so-called "special regimes" of the social security system. These measures provoked the most massive demonstrations before the yellow vest protests in 2018, and the response to President Macron's law to raise the retirement age from 62 to 64 years, in March of 2023. Prime Minister Juppé was forced to resign, but his government's decrees affecting the health sector—like those of 1945, 1958, and 1967—were legal procedures to bypass parliamentary votes; and they have endured.

The Juppé decrees increased a fiscal tax *(cotisation social généralisée*-CSG) introduced in 1990 to supplement payroll taxes for NHI. Unlike the payroll tax salaried wage earners, the CSG was applied to all taxpaying residents and all sources of income, including capital. It has continued to increase as a share of total health care financing. Likewise, Juppé's legacy of directing parliament to set an annual national target for health care expenditures legitimized the state's increasing role in overseeing the management of NHI. It initiated a period of progressive state intervention to rationalize the health sector by integrating the health system across hospitals and the administratively separate domains of CBAC, public health and social services. One of the first steps in tightening state control of hospitals was the establishment of a hospital accreditation agency. Another important step was the establishment of regional hospital agencies (RHA) whose explicit responsibility was to coordinate public and private hospital services.

In 2004, as a logical extension of the Juppé Plan, the state established the Union of NHI funds (UNCAM) that placed CNAMTS, together with MSA and RSI under the leadership of UNCAM's Director, appointed for a five-year term by the state. This brought UNCAM under direct supervision by DSS in the MOH, which strengthened the role of the state in UNCAM's negotiations with physicians and other health professions over the setting of fees and new measures to regulate private medical practice. It also facilitated the state's role in completing the extension of universal coverage (CMU) for all legal residents in France irrespective of their occupational and employment status.

The Hospital, Patients, Health and Territory Act (HPST): In 2009, HPST strengthened administrative control over the management of physicians in public hospitals and sought to integrate public and private hospitals and encourage their coordination with CBAC, public health and social services. To achieve these objectives, HPST renamed the RHAs as Regional *Health* Agencies, and merged them with regional health insurance funds, regional public health programs, all under the hierarchical control of the MOH. One might have expected this reform to provide a modest nod to the importance of decentralizing state authority and allowing regions to develop their health systems in response to the specificities of their population's health status and health care organization. In practice, the law reinforced central control over the RHAs, which in turn tightened MOH control over public and private hospitals. The HPST also provided budgets that empowered the new RHAs to fund experiments to promote managed care by encouraging networks of health care providers in CBAC to target specific diseases and underserved areas.[26] In addition, the 2009 HPST law introduced a soft gate-keeper system providing financial incentives for patients to obtain referrals from their GPs (*médecins traitants*) before consulting specialists directly.[9,10]

Following the passage of HPST, a National Strategy, announced by the MOH in 2010, recognized the need to improve patient pathways (*parcours de soins*) by redesigning the geographic organization of services. In 2016, under President François Hollande, another law to "Modernize Our Health System" was passed. It reaffirmed the importance of a public hospital service coordinated with the activities of private hospitals, established a national agency in charge of hospital data reporting and analysis, established territorial hospital groups to reinforce coordination, and encouraged the creation of community-based professionals (CPTS) to plan for local health service areas. As this chapter is written, the Minister of Health has proposed legislation to require all health professionals in private practice to join one of the thousand CPTS groups covering France. Physician trade unions have agreed, in principle, as long as the decision is voluntary.

One interpretation of Juppé's health reform and its aftermath is that they reflect a distinctly French strategy to bring managed care not just to a particular health insurer or organization, as in the United States, but rather to the whole health care system, including underserved areas known as "medical deserts."[27] The challenge, however, in a NHI system deeply committed to liberal-pluralism, is whether the state can consolidate sufficient power to control the spatial distribution of health professionals and the volume of health services provided (and billed for) in private practice as well as in hospitals.

Challenges for the Future

Even before UNCAM increased the state's power to set physician fees, they have been exceedingly low compared to most OECD nations. Thus, one of the persistent challenges for French policymakers has revolved around the question of how to respond to physician pressure to raise their fees while controlling expenditures of CBAC. Examples of fee increases in recent national agreements with physicians involve the addition of FFS codes to improve care for patients requiring more physician time, for example, those aged 80-years old and over with chronic diseases. Negotiations with physicians have led to increased fees for all GPs who provide community coverage on weekends, holidays, and evenings. Likewise, there are now higher payment rates for complex consultations—children 3–12 years of age at risk of obesity, newborns within the first 28 days of life, females aged 15–18 for contraception (imagine that in the United States!) and all patients to prevent sexually transmitted diseases. Also, payment rates were increased for long consultations—couples with fertility issues, patients with asthma or severe eye problems, and

when physicians discuss specific conditions, e.g., before kidney transplants, cancer diagnoses, fetal malformations, or Alzheimer's and other neuro-degenerative disorders.

In addition to fee schedule adjustments, over the past decade, many policy analysts have advocated replacing FFS payment with alternative payment modalities (APMs). In a nation as firmly wedded as France is to FFS payment, such a change is difficult to imagine. Nevertheless, since 2010, health policy experts in UNCAM and MOH, in collaboration with the GP trade union, have succeeded in introducing APMs, for example, lump sum payments to supplement FFS physician income in exchange for physician buy-in to achieve a range of disease management and other public health goals. These payment changes should not be construed to mean that France is on the verge of abandoning FFS payment. They have been implemented at the margins of France's mainstream health system.[28]

Beyond tinkering with fee schedule adjustments and APMs, as in other OECD nations, French policymakers face the challenge of adapting their health system to meet four profound changes: (1) demographic shifts resulting in population aging due to declining birth rates and increasing longevity; (2) acceleration of computing capabilities, communication technologies (the internet, social media) and digitalization; (3) technological progress in bio-medical research (e.g., genomics) and artificial intelligence (e.g., Chat GPT); and (4) preparedness for future pandemics and crises precipitated by climate change.

The impact of these changes on medical practice and health systems has already been enormous. In response, policymakers in most OECD nations recognize that the secular growth of health care expenditures will continue and that they must rely on some form of collective financing that sustains universal NHI. There is widespread agreement that health policy should—at least in principle—aim to achieve value for money in the allocation of health care resources and equity in their distribution. In practice, defining "value" and "equity" is necessarily contentious as all students of health politics and policy can understand! In France, this challenge is complicated by three additional factors.

First, financial access to care is no longer a sufficient goal because even after eliminating financial barriers to access, multiple studies have documented inequalities in access to care among regions and among socioeconomic groups. Second, patients increasingly recognize that quality of care varies enormously among hospitals and regions. This problem is exacerbated by patients' awareness of new diagnostic and therapeutic options; their freedom to seek care wherever they choose, among a bewildering diversity of health care providers; and their confidence that health services, including prescription drugs, are paid for under NHI. Third, since the 1980s, the rise of patient advocacy groups led to a law promoting "health democracy" and a role for them in the governance of hospitals and other health care organizations, including new government agencies established in response to public health crises.[29]

In addition to these challenges, French policymakers face physician shortages that stem partly from their decision, in 1971, with support of medical trade-unions, to lower the number of students admitted to medical schools. Their number decreased from a high of 8,500 to 3,500 in 1993, after which it has gradually increased to 9,000 in 2020. Since it takes over a decade to complete medical schools and develop a private practice or obtain a hospital position, the effects of the 1971 decision are still apparent. Together with pressures due to population aging and the growing prevalence of chronic disease, the consequences of limiting the pipeline of medical students and pursuing cost-containment policies has demoralized physicians—in private practice, as well as in hospitals and their emergency rooms. Along with hospital interns and nurses, physicians began to suffer from overwork and burn-out even before the COVID-19 pandemic. Successive governments have initiated modest efforts to improve working conditions and respond to these problems. For example, the state has encouraged physicians to locate in medical deserts, funded training for advanced practice nurses, reimbursed tele-health, financed health centers that emphasize cooperation among doctors and paramedics through skill mix and task shifting. Despite these efforts, there have been multiple demonstrations and strikes. All of these issues remain on the health policy agenda.

Étatisation—The consolidation of state control: Since the Fifth Republic and de Gaulle's presidency, France's executive branch grew more powerful. After the Juppé decrees, government ministers, irrespective of party affiliation, relied increasingly on the upper echelons of the civil service to manage the health care system. Since parliament has limited technical expertise in the arcane complexities of pensions, health insurance, and new hospital payment methods based on diagnosis-related groups (DRGs), these elite civil servants gained more influence. They took the lead, together with their technical staffs in the DSS, MOH, and UNCAM, in devising a program of politically feasible health sector reform. Throughout the 1990s, these high-level civil servants consolidated state power by transforming the traditional social security bureaucracy beholden to multiple trade union interests and the MOF bureaucracy wedded to strict accounting and budgetary approaches to health policy, into a health technocracy with expertise in new management tools, health economics, and NHI reimbursement policies.[30]

The health technocracy supported the creation of many new government agencies to deal with technical issues of public health, hospital accreditation, assessment of medical technologies, oversight of hospital information systems. In collaboration with these agencies much progress was achieved in measuring hospital and physician performance, quality of health services and encouraging experiments to coordinate hospitals and CBAC. Moreover, since 2008 the state successfully kept the lid on hospital costs and physician fees until the COVID-19 pandemic. But this "success," as noted earlier, has led to demoralization and vigorous resistance from health care providers.

With respect to physicians, *étatisation* strengthened the state's collaboration with UNCAM in fee negotiations that have nudged physicians to accept alternative payment modalities (APMs) based on pay-for-performance (P4P) objectives. In addition, the state has introduced incentives to increase the number of health centers (*maisons de santé*) that include GPs, nurses,

and social workers and provide better access to health services during weekend hours and evenings. Many of these centers have also developed multispecialty team practice and share medical information among providers. The state has also persuaded some (but not enough) physicians to accept subsidies to establish new private practices in medical deserts. In return, the practice must be open at least four days a week and the physician must commit to staying in the underserved area for at least five years.

With respect to hospitals, since the HPST Law, the French state's centralizing control over all public hospitals—substantial since the Revolution—has increased to the point of stripping these institutions of their autonomy to innovate and devise local strategies to collaborate with CBAC in their surrounding communities. All hospital directors are appointed by the MOH on recommendation of the RHAs, their authority over hospital physicians has increased leading to significant lowering of morale among the medical staff, and almost all hiring and firing continue to involve complex and slow civil service procedures. Moreover, *étatisation* has imposed paralysing bureaucratic procedures and excessive performance measures, which have contributed to sapping the morale of physicians and nurses.

Over the 1981–2020 period, the shift in health care financing, as a percent of NHI expenditures, from payroll taxes (82% to 56%) to fiscal taxes (17% to 44%), has reinforced the state's legitimacy over the NHI system.[30] A recent study traces how civil servant elites completed the extension of health insurance to all legal residents and clamped down on hospital expenditures until the Covid-19 pandemic.[30] But in spite of such "success," *étatisation* appears to have gone too far in containing cost increases and imposing bureaucratic procedures and performance indicators. Indeed, the question of whether the consolidation of state control over hospitals is excessive is one of the foremost health policy issues faced by President Macron.

Conclusion

Although the Laroque Report was instrumental in laying the foundations for a NHI system based on the idea of national solidarity, unlike the Beveridge Report, it did not reassess the state's responsibility for general welfare, and it preserved a far more important role for the private sector and pluralist interest groups than Beveridge had envisaged. While the British state increased its control over the health system in one swoop through the nationalization of hospitals and the creation of the NHS, in 1948, the French state increased its control more gradually. From its 1945 goal of developing a system of social democracy managed with significant input from salaried employees and employers, the system developed into one more responsive to parliamentary democracy, albeit led by an increasingly centralized and growing technocracy.

Douglas Ashford observed that Britain created its welfare state "by intent" and France "by default."[30] The paradoxical result is that Britain, the welfare leader after World War II, has spent less, per capita, than France since the 1960s. This is not surprising because it is easier to contain costs in a system that allocates health care spending as part of the state budget than in a social insurance system with statutory entitlements funded by payroll taxes. In the course of catching up with Britain, France developed a prosperous health sector, and in some respects, the French state goes further than Britain's NHS, for example, in its centralizing control of public hospitals. But France does not have an NHS, and given the capacity of *la médecine libérale*, private for-profit hospitals and private complementary insurers to defend their interests, is not likely to develop one.

French health policy-makers have veered between defending strong state intervention in the name of national solidarity, and supporting *la médecine libérale*, along with the private hospital and complementary health insurance sector, to protect the values of liberal–pluralism. Strong state intervention succeeded in implementing universal NHI by expanding coverage incrementally. Likewise, the state led the process of health sector modernization while refining its methods of control over physician fees and hospital spending. State support for private complementary insurers, private for-profit hospitals, private FFS practice, as well as health centers, has ensured institutional diversity thereby allowing supply side pluralism, competition, and significant consumer choice of health providers.

Until recently, policymakers claimed to have reconciled the conflicting ideas and values of liberal-pluralism and solidarity. This may no longer be possible because the bio-medical knowledge explosion, the proliferation of medical specialties and rapid evolution of information technology, along with innovations in medical practice and tele-health, make the present organization of hospitals and *la médicine libérale* seem anachronistic and unprepared for the future. Nowadays, there is broader agreement among diverse groups that there should be better coordination among hospitals, CBAC and social services. The Commission on the Future of NHI (HCAAM) recognizes the problems of hospitals and their ERs, medical deserts, workforce overwork and burn-out. Among their panoply of recommendations, they have called for community-based multispecialty teams to establish stronger ties to the most appropriate hospital services.

As pressures mount to preserve the system by making more decisive changes in how it is financed and organized, and how physicians and hospitals are paid, French health policy has reached a turning point that raises fundamental questions: Can the balance between liberal-pluralism and national solidarity be maintained while health care costs are kept under control and the cherished features of the present system are sustained? Can the French state adapt its health system to the exigencies of technological and economic change without provoking insurmountable opposition from well-organized private interest groups? The future of the health system in France will be determined by the answers to these questions.

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Study Questions

1. What is the idea of liberal-pluralism as described in this chapter?
2. What is the idea of solidarity? How does it differ from liberal pluralism?
3. From the French perspective, what are the three biggest problems of the American health care system?
4. What was the effect of pro-market reform ideas in France?
5. The author suggests that the French health insurance system resembles the Medicare Program in the United States. Explain.

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