

# The Marriage of National Health Insurance and *La Médecine Libérale* in France: A Costly Union

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IF ONE WERE TO ASK, AS AN INTELLECTUAL EXERCISE, how to design a cost-maximizing health care system, a likely response might be to cite at least three conditions: 1) national health insurance (NHI); 2) private fee-for-service medical practice and professional autonomy—what the French call *la médecine libérale*; and 3) minimal state intervention to regulate physician fees, monitor the volume of medical services rendered, and more generally influence the social organization of medicine. The first two conditions are distinguishing features of the French health care system. The third condition does not hold; quite the contrary, since World War II the French State has actively intervened in the health sector. It has established a negotiating system to set physician fees and a system of physician “profiles” to monitor the volume of care; it has examined the criteria by which health resources should be allocated; and it has tightened control over hospital reimbursement rates, hospital investments, and capital expenditures for medical technology. Since 1960, however, the average rate of increase of French health expenditures has exceeded that of the United States (see Table 1), and the trend appears likely to continue (Sandier, 1979).

Clearly, French policy makers have failed to contain rising health care costs. They have pursued contradictory policies. On the one hand, they have protected the right of access to medical care by extending

TABLE 1  
Health Care Expenditures and Related Variables: Average Annual Rate of Change (%), 1960-1973

Types of Services	Expenditures at Current Prices				Expenditures Deflated by CPI				Volume Expenditure Deflated by Price Index				Price Index Deflated by CPI			
	Total		Per capita		Total		Per capita		Total		Per capita		Current		U.S. France	
	U.S.	France	U.S.	France	U.S.	France	U.S.	France	U.S.	France	U.S.	France	U.S.	France	U.S.	France
Physicians' services	9.4	12.7	8.1	11.5	6.0	7.8	4.8	6.6	4.6	5.8	3.3	4.7	4.6	6.5	1.4	1.9
Laboratory tests	—	17.8	—	16.5	—	12.6	—	11.4	—	13.7	—	12.5	1.6	3.6	-1.5	-0.9
Other professional services	6.3	20.2	5.0	18.9	3.0	15.0	1.8	13.8	1.6	15.7	0.4	14.5	4.6	3.9	1.4	-0.6
Dentists' services	8.9	13.2	7.6	12.0	5.5	8.2	4.3	7.1	4.7	7.9	3.5	6.8	4.0	4.9	0.8	0.3
Ambulatory care services	9.0	13.6	7.7	12.4	5.6	8.7	4.4	7.5	4.3	7.6	3.1	6.4	4.5	5.6	1.3	1.0
Drugs and drug sundries	7.4	13.5	6.2	12.3	4.1	8.6	2.9	7.4	7.8	12.6	6.5	11.4	-0.3	0.8	-3.4	-3.6
Eyeglasses and appliances	7.9	9.1	6.7	7.9	4.6	4.3	3.4	3.2	4.5	5.8	3.3	4.7	3.3	3.1	0.1	-1.4
Hospital care	11.7	14.7	10.4	13.6	8.3	9.6	7.0	8.5	6.6	8.1	5.3	7.0	4.8	6.1	1.6	1.4
Personal health care	10.5	14.2	9.2	12.9	7.1	9.2	5.9	8.0	6.3	9.1	5.0	7.9	4.0	4.6	0.8	0.1

Source: Adapted from Rösch, G., and Sandier, S. 1975. A Comparison of the Health Care Systems of France and the United States. In Teh-wei Hu, *International Health Costs and Expenditures*. Proceedings of an International Conference on Health Costs and Expenditures. Sponsored by the John Fogarty International Center for Advanced Study in the Health Sciences, National Institute of Health, Bethesda, Maryland, U.S.A., June 2-4, 1975. DHEW Publication No. (NIH) 76-1067.

health insurance coverage; on the other, they have protected the prerogatives of *la médecine libérale*. The simultaneous pursuit of these policies has been costly, both economically and politically, and for that reason the combination of French NHI and *la médecine libérale* is not likely to endure.

To explain this view, I will examine 1) the ideological and institutional roots of the French health care system, 2) the evolution of French health policy, 3) the effect of reimbursement incentives on physicians and hospitals, and 4) the politics of cost control.

### Ideological and Institutional Roots of the French Health System

Two conflicting ideas underlie the French health care system: liberal-pluralism and solidarity. "Liberal" refers not to the twentieth-century American sense of social reform and government intervention, but rather to the nineteenth-century European sense of *laissez faire*, individualism, and free choice. "Pluralism" refers to the existence of organizational diversity and dispersed centers for making decisions. In the health sector, the term liberal invokes a set of principles: selection of the physician by the patient and vice versa, freedom of prescription by the doctor, and professional confidentiality. These characteristics presumably ensure a personal, symbiotic doctor-patient relationship. The term pluralism justifies a variety of health-insurance funds offering a range of benefits and a diversity of health care delivery modes such that physicians can preserve their autonomy as individual professionals in their work and maintain control, as a group, over the structure of medical care organization. Together, these components of liberal-pluralism have cemented the French State's commitment to *la médecine libérale* (Caro, 1969).

The idea of solidarity—*solidarité*—is a peculiarly French concept that refers not to the American trade-union sense of "solidarity forever," but rather to the belief in mutual aid and *national* cooperation (Hayward, 1959). It conflicts with the idea of liberal-pluralism because it questions the virtues of *laissez faire* and professional autonomy in the name of a higher ideal: collective action to serve a concept of social justice. In the health sector, the idea of solidarity has provided the ideological foundation for the French NHI program and the social

security system of which it is a part (Schorr, 1965). It suggests that health insurance is a right for all—sick and well, high and low income, active and inactive—and that premiums ought therefore to be calculated on the basis of ability to pay, not anticipated risk.

After World War II, in the spirit of solidarity, the Social Security Ordinance of 1945 was passed, calling for NHI under one unitary fund (Bridgman, 1971). Virtually the entire French population (99 percent) is now covered. The majority (75 percent) are covered by the *Caisse Nationale d'Assurance Maladie des Travailleurs Salariés* (CNAMTS)—the national health insurance fund for salaried workers.\* Although the CNAMTS is only one of several NHI funds within the French social security system, it finances the bulk of health services—roughly 70 percent of total health expenditures and 30 percent of the capital for hospital construction and modernization. In French administrative law, the CNAMTS is a private organization charged with managing a public service. But in reality it is quasi-public since it falls under close ministerial supervision; and it is parafiscal since it is financed not directly from government revenues but almost entirely by employer and employee payroll taxes. As of August, 1979, employees contributed 4.5 percent of their total salary and 1 percent of their salary below a ceiling of 4,470 francs (\$1,200) per month. Employers contributed 4.5 percent of the total wage and 8.95 percent of the wage below the ceiling (*Le Monde*, 1979).

Established in 1967 as part of De Gaulle's administrative reform of the entire social security system, the CNAMTS was designed to exercise greater authority over the previously independent regional and departmental sick funds and to ensure 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 a national board of directors and the entire institution was placed under stricter supervision by the Ministry of Labor and Social Security. Despite De Gaulle's reform, the social security system is one of those rare French administrative structures in which a tradition of accountability, decentralization, and regional autonomy is strong (Catrice-Lorrey, 1979). Indeed, before the centralization achieved under the 1967 reform, members of the regional and local sick funds were elected (Galant, 1955). It is surely for this

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\* A key to the acronyms used in this paper appears on page 43.

reason that the CNAMTS has always been more concerned with assuring its subscriber population of access to medical services than with pursuing explicit policies to control rising health care costs.

In spite of attempts by French legislators to devise a unitary NHI fund under the banner of solidarity with equal benefits for all, the commitment to liberal-pluralism exacted compromises. To begin with, in addition to the CNAMTS, agricultural workers (8 percent), the self-employed (7 percent), and a set of special interest groups (9 percent) have their own health insurance funds. Also, flagrant disparities persist in levels of health insurance benefits and copayments between and even within health insurance funds. For example, the self-employed are eligible for fewer benefits and required to pay higher copayments than salaried workers and numerous special interest groups such as miners, merchant seamen, subway workers, railway workers, veterans, and public employees, all of whom still maintain their right to more favorable benefits. What is more, the process of extending health insurance coverage has taken almost thirty years and is still not complete. As late as 1970, a national survey (Guibert, 1973:46) indicated that more than 1.6 percent of the population—over 800,000 residents of France—were not eligible for benefits under NHI. At the present time, roughly 1 percent of the population remain ineligible for NHI benefits but are covered by welfare programs administered by the Ministry of Health.

It should not be surprising that the idea of liberal-pluralism exacted compromises. Organizational arrangements for the delivery of medical care in France are supported by strong physician and hospital associations. Efforts at health care reform have provoked conflicts between the medical profession and the state, between representatives of public and private sectors, and more generally between the ideas of liberal-pluralism and solidarity. Indeed, these conflicts have shaped the evolution of French health policy.

## Evolution of French Health Policy

Since World War II, as in other industrially advanced nations, the French medical profession has practiced in a socioeconomic context whose growth and changing patterns have transformed the health sector from a *gemütlich* "cottage industry," composed of entrepreneurial

physicians providing most of their services in the patient's home, to a major industrial complex organized around hospitals that support highly specialized staff and affiliated activities such as the pharmaceutical industry, biomedical laboratories, and firms producing and marketing medical technology. In the presence of such change, the French State has wavered between protecting the interests of *la médecine libérale* and adapting the health sector to the demands of a modern economy.

### *The Medical Profession and the State*

General practitioners and specialists in France are free to set up practice wherever they like.<sup>1</sup> And consumers are free to choose among physicians in private practice, in public hospital outpatient departments, or in any one of 592 health centers (CNAMTS, 1977:47) established and managed by municipalities, trade unions, and nonprofit associations. In addition, local health insurance funds also manage dispensaries that provide preventive services such as checkups, screening, and laboratory tests to roughly 1.2 percent of the total population (IGAS, 1974). But diversity notwithstanding, under the banner of free choice the bulk of ambulatory care is provided by physicians in private practice.

Upon visiting their physicians, consumers pay the full charge of their visit, as set by a negotiated fee schedule. In return, the physician gives them a receipt to present to their local health insurance fund, either by mail or in person. The fund then reimburses the consumer 75 percent of the charge as set in a national fee schedule. The remaining 25 percent represents a consumer copayment. In general, the size of the copayment depends on the kind of medical service consumed. For most laboratory tests, dental care, and drug prescriptions, the copayment is 30 percent; for specially designated or particularly

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<sup>1</sup> In modern France, as in ancient Rome, not only do all roads lead to the capital city but consumption of goods and services is concentrated there as well. In addition to its other attributes, Paris is renowned for its high density of physicians. Lyon, too, as well as the Riviera, are centers around which *la médecine libérale* has thrived. More precisely, the geographic distribution of physicians ranges from 59.1 per 10,000 population in Paris to 9.6 in Haute-Saône (in the west of France between Alsace and the Alps) (Ministry of Health, 1978).

expensive drugs it is 20 percent; and for hospital services it is 20 percent unless the hospital stay exceeds thirty days or requires costly therapy for prolonged illness such as diabetes, polio, and cancer, in which case medical care is free of charge to the consumer. To be insured against the copayment, French consumers may join any one of 7,840 mutual aid societies (Ministry of Health, 1979:56) or purchase commercial insurance. Some mutual aid societies, e.g., the *Mutuelle Générale de l'Education Nationale (MGEN)*, provides comprehensive health care services, in kind, thus supplementing the normal range of benefits provided under the NHI program. Estimates indicate that in 1974, roughly 32 million (over 60 percent of the French population) subscribed to some form of supplementary insurance (IGAS, 1975:218).

Since 1928, when the first French health insurance bill was passed, there have been periodic conflicts within the medical profession and between medical trade unions and the state over the conditions of medical practice under health insurance. Henri Hatzfeld (1963) argues that these conflicts have resulted in the taming of the French medical profession. Others, including physicians, even speak of proletarianization insofar as conditions of medical practice have been substantially altered (Steudler, 1973). Still another point of view, albeit in the minority, is that the medical fraternity continues to dominate health policy, but that physician trade unions, themselves, will soon demand a shift from fee-for-service to salary reimbursement (Stephan, 1978). These issues are explosive. But there is a growing consensus on one point (Hatzfeld, 1963:297), that "the physician appears condemned to lose a part of his professional autonomy: his activities and income will no longer be determined by his freedom to set charges and by his success; he will become a man employed on a salary based on status or a man hired on contract; his place in social organization will become more precise, more established."

The growth of biomedical knowledge and technology has changed the employment structure in the health sector by increasing the division of labor and hierarchy and reinforcing technician-type services performed by paraprofessionals. *La médecine libérale* is gradually receding behind new forms of collective and often salaried practice. Group practice has emerged over the last fifteen years to include roughly 30 percent of all physicians in private practice (*Le Monde*, 1974:24). Other forms of ambulatory care are also growing: hospital

outpatient departments, home care programs, and day-long hospital procedures, e.g., ambulatory surgery.

As early as 1929, in a letter to the minister of labor, Paul Cibrie, the secretary general of the first medical trade union, *Confédération des Syndicats Médicaux Français* (CSMF), expressed concern over the emergence of third-party payment (Cibrie, 1954:68):

The medical profession is under no illusions about the consequences of the contractual liberty allowed for under the law. We understand administrative procedure well enough to know that the [health insurance] funds will want to impose allowable charges and third-party payment. And we have great difficulty identifying an impartial institution capable of arbitrating between the opposing positions of the medical profession and that of the health insurance funds.

Until 1960, French physicians in private practice remained free to set their own fees. With the Ministerial Decree of May 12, 1960, de Gaulle expanded the regulatory power of the state and, to qualify for reimbursement under NHI, the medical profession was forced to accept a national negotiating system of annual contracts with price ceilings on uniform fees (Stuedler, 1977). This system not only ended the traditional freedom of physicians to set their own fees; it also destroyed the unity of medical trade unions, for strong partisans of *la médecine libérale* opted out of the NHI system and formed a rival trade union—the *Fédération des Médecins de France* (FMF). But by 1964, 85 percent of French physicians, including most members of the FMF, were participating in the NHI program.

In 1971, when the present negotiating structure was devised, the CSMF struck a new agreement with representatives of the NHI funds and the state (Glaser, 1978:39–50). Once again, the FMF demanded the freedom for doctors to determine their own fees; once again, they ended up participating in the NHI program. At present, 98 percent of French physicians have agreed, in principle, to accept the national fee schedule. If consumers choose to seek medical care from doctors who are not participating in the NHI program, they will be reimbursed roughly 25 percent of the rate established by the fee schedule; thus their copayment will be significantly higher. In return, physicians are covered under NHI and the health insurance funds have agreed not to compete directly with *la médecine libérale* by establishing new primary care dispensaries. In addition, physicians are granted the right



to exceed the uniform fees under two conditions: 1) when the patient presents unusually high demands, and 2) when the doctor is considered prestigious. As of 1977, 28 percent of specialists and 5 percent of general practitioners in France were considered prestigious, on the basis of criteria such as university degrees and honors conferred (CNAMTS, 1977:31).

Thus, despite concessions by physicians in private practice, *la médecine libérale*—at least through 1971—not only survived but prospered.

### *Hospitals and the State*

Hospital care in France is provided in public hospitals, in proprietary hospitals known as *cliniques*, and in private nonprofit hospitals that are a cross between the public hospital and the *clinique*. Roughly one-third of acute hospital beds are in the private sector; over one-half of private-sector beds are in *cliniques*.

In 1977, there were 10.8 hospital beds per 1,000 population in France as compared with 6.5 in the United States. This difference may well be due to the fact that, since France has no nursing home industry comparable to that in the United States, French hospital data reflect beds that are used in a nursing-home capacity. If one includes nursing home beds in the United States data, there are 12.0 hospital beds per 1,000 population in the United States (Sandier, 1979:62).

Whether an individual is referred to a public or a private hospital for inpatient care, payment is not required upon admission. Instead, 80 percent of the charges are billed to the patient's health insurance fund and the other 20 percent directly to the patient. This same procedure is used for diagnostic hospital services provided on an outpatient basis and for costly drugs and laboratory tests. Moreover, after three days of hospitalization, as part of an incomes policy, French patients are eligible for a supplementary sickness benefit. Beginning on the fourth day, the health insurance fund will pay cash benefits for up to a year, and in some cases for up to three years.

French hospitals have not escaped the changes occurring in the health sector; indeed, they have led the way. As the public hospital has shed its former image of a philanthropic warehouse caring for (and sometimes experimenting on) the indigent sick, it has become

the medical specialist's workshop, an institution where the most prestigious functions of the health care system are performed: teaching, basic research, and diagnosis and therapy for complex illnesses. In 1958, with the passage of the Hospital Reform Act, university medical schools were merged with the best-equipped public hospital facilities (Jamous, 1969). The new institution, called a *Centre Hospitalier Universitaire* (CHU), was assigned the responsibility for providing high technology medicine and superspecialty services to regions with populations of over a million.

One of the principal provisions of the Hospital Reform Act was to initiate a shift in the reimbursement of hospital-based physicians from fee-for-service toward salary payment. During the legislative debate on the proposed reform, the medical profession opposed the bill on the grounds that the shift in reimbursement mechanisms would gradually turn all physicians into civil servants. Some of the younger physicians, however, supported the reform as an attack on the feudal hierarchy of the university, and on the values of *la médecine libérale* as well. The highest ranking clinical professors, *les grands patrons*, resisted vigorously, and succeeded in conserving that part of *la médecine libérale* that they considered most dear—the right to hospitalize their private paying patients in “private” beds within their *service* at the public hospital. Nevertheless, 30 percent of French physicians are now fully salaried and roughly one-half of the remaining 70 percent are employed part time on a salaried basis, largely in public administration and public hospitals.

Like the Flexner Report and Regional Medical Programs in the United States, the Hospital Reform Act had important effects: to consolidate and control the diffusion of high-technology medicine and to reduce the gap between biomedical knowledge and its application. During the first fifteen years of the Fifth Republic (1958–1973), health planners in the Ministry of Health embarked on a major hospital construction program. In addition to the institutional reform, they pursued a policy of hospital modernization, including conversion of communal wards into private rooms. This was known as *l'humanisation des hôpitaux*. However, as late as 1970, almost 15 percent (80,000) of public hospital beds were still in bleak communal wards (Castaing, 1975). Despite efforts to “humanize” the public hospital and provide it with the most up-to-date medical equipment and specialty services, in the late sixties, even the most prestigious public hospitals, such

as those of *l'Assistance Publique* (AP) in Paris, were losing patients to the *cliniques*, largely because material conditions there were far superior to those in the public sector, but also because part-time salaried physicians often referred their patients to *cliniques* to avoid queuing.<sup>2</sup> Moreover, in the private sector, the patient ostensibly chooses his doctor whereas in the public sector he does not have the prerogative of exercising free choice.

*Cliniques* have been the strongest refuge for *la médecine libérale* in the hospital sector. They differ from public hospitals in terms of size, case mix, and occupancy rates. The average *clinique* has 38 beds (Ministry of Health, 1973a); the average public hospital has 240 (Ministry of Health, 1973b). *Cliniques* have only 10 percent of all medical beds and almost half of all surgical and obstetric beds. They tend to avoid emergency care and specialize in routine cases, especially maternity care and noncomplicated surgery. Also, they tend to have higher occupancy rates than public hospitals. In terms of organizational strategy, *cliniques* have served as an institution within which the medical profession has retained control over its own work outside the bureaucratic structures of the public sector.

Throughout the sixties and early seventies, hospital capacity in the *cliniques* grew at an even faster rate than in public hospitals. In 1963, *cliniques* represented 26.4 percent of all acute hospital beds; in 1978, they had grown to include 34.8 percent (de Kervasdoué, 1980). This growth in number of beds was accompanied by increasing ideological conflicts between public and private sectors and growing polarization between a new "medical technostructure" (Stuedler, 1974) of salaried physicians in public hospitals and physicians practicing in the *cliniques*. Ideological debates on the relative virtues of the private and public sectors have frequently been published in the press (*Le Monde*, 1976a). Associations of private *cliniques* have released studies showing that *cliniques* are managed more efficiently than hospitals, and have argued that the state should consequently encourage their growth. Representatives of the public sector have pointed out the limitations of such analyses and reminded their private sector colleagues of the burdens

<sup>2</sup> In 1973, the public image of *l'Assistance Publique* in Paris 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 to 80,000 Parisians to 28 of AP's 37 hospitals (AP, 1973).

of teaching, research, and high-cost illness, all of which must be borne by the public hospital (FHF, 1976). The state's ambivalent response to these debates has led simultaneously to frequent denunciation and to rapid growth of the private sector at public expense.

In 1970, the Hospital Law was passed in an effort to control rising health care costs. This legislation sought to improve management in public hospitals and regulate the private sector so as to promote a "harmonious" distribution of hospital beds. To do this, an elaborate planning and regulatory machinery was established (Brumter, 1979). Also, the hospital law called for reform of provider reimbursement mechanisms to create financial incentives for redistributing health resources in conformance with national and regional hospital plans.

The effect of this legislation has been to move French hospitals toward a public utility model of organization. Local hospitals are losing their autonomy as they become consolidated within broader administrative structures. Hospital planning is growing more important as investment decisions are increasingly scrutinized by regional commissions as well as the Ministry of Finance. However, the state has not yet developed provider reimbursement incentives for implementing the bold aims of the hospital law (Rodwin, 1978a; 1981).

### Provider Reimbursement Incentives

The structure of the French health care system and the failure to contain rising costs cannot be explained by considering only explicit state policies. We must also examine the provider reimbursement incentives under French NHI to discern the implicit policies that underlie the health system.

#### *On Paying the Doctor*

Fuchs (1974) has observed that physicians are the most important determinant of both the level and the configuration of health resources: they decide who shall be hospitalized and they prescribe medical procedures, laboratory tests, and drugs. There is a wide range of methods of physician remuneration ranging from fee-for-service to capitation or salary payment, or some combination of these. Since there is much evidence that reimbursement incentives affect physician

behavior at the margin (Contandriopoulos, 1979; Monsma, 1970), it is important to devise reimbursement systems to encourage good medicine, prevent abuse, and discourage neglect (Glaser, 1970).

In the French fee-for-service system, the fee schedule, or relative value scale, is known as the *Nomenclature Générale des Actes Professionnels*.<sup>3</sup> Originally written by the CSMF in 1930, it classifies medical procedures by so-called key letters. For example, C signifies a consultation with a general practitioner; B signifies laboratory tests; Z signifies all radiological procedures; and K signifies surgical and specialty procedures. The Bs, Zs, and Ks are always followed by a coefficient that is supposed to reflect their relative value on an elaborate scale of medical procedures. For example, an appendectomy or simple hernia operation is coded as K-50, whereas the surgical removal of an ingrown toenail is coded as K-10. Physician fees are equal to the coefficient times the value of the key letters that serve as the explicit object of bargaining during the national fee negotiations.

Relative value scales such as the *Nomenclature* are based on an implicit concept of medical practice that assumes that physician activities can be disaggregated into a precisely defined hierarchy of medical procedures. Such a concept fits comfortably the notion of *la médecine libérale*, for it calls attention to the choice and diversity of medical procedures. Moreover, it fits well within a system of strong state intervention and tightly controlled prices, for every effort made by physicians may be called a "procedure" and assigned a price. Unlike England, where the combination of capitation and salary reimbursement of physicians provides virtually no routine data collection on the volume of physician activity, in France it is impossible to engage in health services research without encountering utilization data (based on billings) classified by key letters and coefficients of medical procedures.

Economists suggest that fee schedules be designed so that relative value points reflect relative costs (Reinhardt, 1975:167). By this criterion, the *Nomenclature* is a crude instrument. For example, the value of a particular K procedure is constant, regardless of whether it is performed by a general practitioner, a certified surgeon, or a car-

<sup>3</sup>The most recent version of the *Nomenclature* is published in *La Revue du Practicien* (1979:1-154). As of February, 1979, the C was equal to 40 francs (\$10.00); the V was equal to 53 francs (\$12); the K was equal to 8.30 francs (\$2); and the Z to 5.20 francs (\$1.25).

diologist, and regardless of the presence and degree of pre- or post-operative complications. In contrast, pricing rules for the Z category of procedures are more refined. They not only distinguish between reimbursement rates for radiologists versus gastroenterologists but also include amortization and operating charges based on the capital value of the technology and equipment required by the procedure. As for consultations and home visits (C and V), their rate of reimbursement is constant, regardless of whether the doctor spends five minutes or an hour, thus encouraging "fast medicine." There is an additional problem with the French *Nomenclature*: the relative values are not annually readjusted to account for changes in technology—for example, economies of scale in the production of laboratory tests or the introduction of microprocessors that reduce the unit cost of radiological equipment. Thus, there are built-in price distortions in the physician fee schedule that do not encourage good medicine, prevent abuse, or discourage neglect.

Since changes in both the relative value scale and the value of the multiplier are the result of a bargaining process between a monopoly (the medical profession) and a monopsony (the NHI funds), fee-setting in this context leads to a classic bilateral monopoly situation that, in economic theory, is "indeterminate." The resulting fees are largely determined by ability to bluff, skill in bargaining, and, above all, power, all of which fall outside the economist's preoccupations (Ruderman, 1976). In France, as Jean-Claude Stephan (1978:130) argues, the medical profession—at least until 1976—succeeded in maintaining its accustomed level of income, "thanks to a multiplication of procedures."

In the United States, studies have demonstrated how the existing reimbursement structure encourages costly institutional care, specialized services, and excessive use of technology (Blumberg, 1978; Schroeder and Showstack, 1978). In France, there are no equivalent studies. However, the average annual rate of increase in the volume of radiological procedures and laboratory tests has been respectively two and three times that of physician consultations (Lecomte and Sandier, 1976:218). As a percent of the total volume of services in the private sector, radiological procedures increased from 17.2 in 1968 to 23.4 in 1977 (Sandier and Tonnelier, 1978:19). Surely this may be a sign of technological "progress," but it is also the result of favorable reimbursement incentives.

A comparative study of France and the United States (Lenoir and Sandier, 1976) concludes that the volume of per capita drug consumption in France is even higher than that in the United States, where pharmaceutical consumption is often considered excessive (Silverman and Lee, 1974). Anecdotal evidence reported in France's leading consumer advocacy magazine suggests that French physicians have a tendency to err on the side of "overprescription" (*Que Choisir*, 1978). Whether such overprescription of laboratory tests, diagnostic procedures, and drugs would occur under a different reimbursement structure is hard to say. What is clear is that the volume of medical care and ancillary services in France is high. During the 1971 negotiations between physician trade unions and the state, French policy makers acknowledged this problem and made regulation of the volume of medical services a central issue.

Since 1971, the French health insurance funds have established a system of "profiles" on the procedures performed by each physician. The objective of this style of regulation is symbolic: to sensitize physicians to the financial implications of their activities. The system is based on finding irregularities in medical practice and issuing sanctions to doctors who overprescribe tests and drugs. But this is exceedingly difficult because criteria on proper work loads have not yet been agreed on. If the entire medical profession is influenced by reimbursement incentives to increase medical procedures, particularly specialty services and high-technology medicine, the effect of the profiles will be negligible.

Since the 1976 negotiations, the system of physician profiles has been computerized. Enormous amounts of data have been collected on patterns of physician activity. After several years of sorting out technical problems, the system is now operational and is most often described as a first step in implementing a system of quality control, similar to professional standards review organizations (PSROs) in the United States. However, in France medical confidentiality is a sacrosanct principle, and physicians have tenaciously refused to divulge data on patient diagnoses, even under anonymous statistical codes. As a result, it is virtually impossible to judge the validity of most medical decisions and, consequently, the quality of medical care. Thus, the physician profiles are not likely to control the volume of medical services.

### *On Paying the Hospital*

From 1950 to 1978, expenditures, in current prices, on hospital care in France have increased at an average annual rate of 15.1 percent as compared with 10.4 percent in the United States (Sandier, 1979:83). Hospital expenditures now represent almost 50 percent of total health expenditures. Just as the financial incentives built into the *Nomenclature* have contributed to the growing volume of medical services, so methods of hospital reimbursement have favored the growth of inpatient hospital care and affected the structure of the hospital sector.

As in the United States, hospitals in France are paid largely on the basis of costs incurred. In public hospitals, although certain nonmedical specialties such as laboratory and radiological departments bill NHI funds on a fee-for-service basis, the principal unit of reimbursement is the patient day. Its value is calculated by dividing total operating expenses, including teaching, research, and administrative costs, and a range of ancillary services, by the total number of patient days. In the private proprietary sector, the patient day is less of a catchall category for, in contrast to the public hospital, operating-room costs, expensive drugs, laboratory costs, blood transfusions, and prostheses are all billed separately on a fee-for-service basis.

Until 1968, the NHI funds negotiated the rate of a patient day for *cliniques* on the basis of the daily fee of the closest public hospital. Since the public hospital must, by law, keep its occupancy rate under 95 percent, be equipped to handle all emergencies, and be open twenty-four hours a day, the average costs of public hospitals tend to be significantly higher than those of *cliniques*. This system of hospital reimbursement enabled the medical entrepreneur to skim the cream off the market. Since 1968, the NHI funds have allowed increases in patient-day rates for *cliniques* only when authorized by the Ministry of Finance. Such price control has restricted the windfall profits of the sixties. But the *cliniques* responded by removing as many procedures as possible from inclusion in the patient-day rate. This practice explains the finding of Lévy et al. (1977:108) that the activity of *cliniques* is best characterized by the quest for both high revenues and long lengths of stay during which a large number of medical procedures are performed.



Aside from favoring the private sector through reimbursement of patient-day costs, the NHI funds have systematically underestimated the amortization rate for capital expenditures in public hospitals as compared with *cliniques* (Ministry of Health, 1970; Brunet-Jailly, 1976). There is a justification. Representatives of the NHI funds argue that they already overpay the public sector by subsidizing teaching and research expenses through reimbursement of the patient-day fee. Despite these subsidies, however, and their impressive hospital construction and modernization program throughout the sixties and early seventies, public hospitals have been chronically short of investment funds.

Beginning in 1973—three years after the passage of the Hospital Law—increasing regulation of capital expenditures in the private sector constrained the development of *cliniques* to the point where certain banks no longer consider them a good investment opportunity (Beau, 1979). This situation is probably more an indication of the present containment phase of health sector development than an anti-*clinique* policy on the part of the state. The Ministry of Finance has also pressured public hospitals to tighten regulation over patient-day rates and to improve hospital management.

It is unlikely, however, that managerial and administrative technologies can be adapted to the practice of medicine, for there is consensus neither about what outputs are being produced, nor about how one might measure them (de Kervasdoué, 1979). In addition, hospital managers are bound by rigid regulations (e.g., those governing civil service employees) that restrict their capacity to innovate and to be flexible. Since they work within a system of cost-based hospital reimbursement, hospital managers have a financial incentive to maintain high hospital occupancy rates in order to increase revenues. Despite symbolic efforts to initiate home-care programs and day-long hospital procedures, financial incentives discourage the development of ambulatory surgery (Stein, 1979) and extensive outpatient departments.

Since the passage of the Hospital Law, there have been efforts to devise new payment incentives such as prospective budgets for public hospitals. As for the private sector, since 1968 policy makers have classified *cliniques* in various ways in order to devise more sophisticated methods for calculating the patient-day rate. But despite exhortation

in the public sector and elaboration of new payment rules in the private sector, the basic principles of hospital reimbursement remain unchanged. Financial incentives in France tend to encourage hospital-based care and generous provision of medical procedures. In short, in France as in the United States, controlling health care costs is a perpetual uphill battle.

## The Politics of Cost Control

Health expenditures of the CNAMTS are big and growing bigger. Eighty-one percent of total health expenditures in France are financed by third-party payers—71.1 percent by the NHI funds, 3.2 percent by welfare, 3.7 percent by mutual aid societies, and roughly 3 percent by private insurance (CREDOC, 1979). This leaves 19 percent that are financed directly by the consumer, compared with 30 percent in the United States (Sandier, 1979). In addition to health expenditures, pensions and family allowances contribute to the vast income and expenditure flows administered by the social security system. After 1971, the “social budget”—all state welfare expenditures and social security transfer payments—exceeded the state budget as a whole (Ministry of Health, 1974:474), and at present it equals one-fourth of the French gross domestic product (GDP) (Ministry of Health, 1979b).

The Ministry of Finance has not ignored the growth of such expenditures and indirect taxes, for they lead to social security deficits, increase fiscal and parafiscal pressures (from income and payroll taxes), and affect both disposable income and the production costs of industry. Increasing costs of production get passed on to consumers either through real wage losses or price increases, and this runs counter to the Ministry of Finance’s goal of promoting industrial development and international competitiveness. Continued growth of health expenditures has forced consideration of two central economic questions for national health policy: 1) Should the rate of increase of the social budget be permitted to exceed the rate of increase of GDP? 2) Are the marginal benefits worth the rising costs to patients and taxpayers? In a section entitled “The Limits of Solidarity,” the Finance Committee of the Sixth Plan (NPC, 1971) answered both questions with

a categorical no; so did the 1976 economic plan of Prime Minister Raymond Barre (*Le Monde*, 1976b). However, translating economic decisions into palatable political programs is no easy task.

### *Political Stalemate*

In their paper on "permacrisis" in French social security, Cohen and Goldfinger (1975:66) argue that "the lack of smooth fit between the imperatives of the economic system and the necessities of the political system is the key to understanding the contradictions of social security." In the health sector, the contradiction is expressed by economic pressures to keep rising deficits under control in a political environment of increasing social demands on the NHI funds.

Proposed stopgap measures to increase the CNAMTS' revenues have included providing state subsidies, increasing health insurance premiums (payroll taxes), and raising the wage ceilings to which these payroll taxes are applied. However, such measures provoke political resistance. The Finance Ministry wants to reduce state expenditures in order to keep a more balanced budget. Employers resist increased payroll taxes, for such taxes increase wage costs, leading to higher production costs and prices, and thereby hurt their competitive position. Wage earners fight increased payroll taxes through trade unions; upper-level executives refuse to consider elimination of the wage ceilings; and special beneficiaries such as miners, merchant seamen, and railway workers do not merely oppose increasing the rate of payroll taxes; they also fight to protect their own particular and often advantageous insurance benefits. Beneficiaries of health insurance agree on only one point—that their premiums not be increased.

Despite these pressure groups, the state has taken a judicious combination of all of the proposed stopgap measures in order to raise the revenues to finance rising health care costs. The result has been to leave the delicate balance between interest groups unaffected. A political stalemate has emerged whereby short-term financial deficits are reduced while the basic structure of French health insurance stays the same.

In November, 1976, a blunt internal memorandum from the Finance Ministry (1976) advised the following cost control measures: 1) reduce the growth of medical personnel, especially physicians; 2) stabilize the aggregate number of hospital beds; 3) review and

strengthen the system of physician profiles; and 4) limit the allowable number of medical procedures performed per physician. The Council of Ministers announced their support for these measures in April, 1977. In addition, they established several experiments with alternative modes of hospital reimbursement, proposed a copayment fee for each day spent in the hospital, froze patient-day rates for hospitals and *cliniques*, and reduced reimbursement rates for certain “nonessential” drugs from 70 to 40 percent of the controlled prices.

Subsequently, in the last days of July, 1979, the Council of Ministers announced a new plan for salvaging the NHI funds as well as the entire social security system. Launched while physicians and labor leaders were on vacation, this plan raised health insurance premiums, imposed a cap on public hospital expenditures, and froze the patient-day rates of *cliniques* (*Le Monde*, 1979). In addition, the Council of Ministers broke the government’s agreement with physician trade unions by denying a previously scheduled fee increase for October, 1979, and January, 1980, and by refusing both to raise fees and to sign a new agreement (scheduled for 1980) until physicians and hospitals agreed to work in a closed budget system within which the volume of prescribed procedures would be more tightly controlled.

These measures provoked prompt and vitriolic response from the medical profession. The association of public hospitals (*Fédération Hospitalière de France*) condemned the concept of closed budgets for hospitals (Raynaud, 1979). The CSMF protested against this “threat to the quality of care, to professional autonomy and to free choice” (Bles, 1979). Such reactions are predictable. What is more difficult to predict, however, is whether *la médecine libérale* will continue to prosper in the face of serious government efforts to control health care costs.

## Concluding Observations

### *The Business of Medicine*

Medicine in France has been not only big business but also good business. The level of physicians’ income is a good indicator of the medical profession’s strength and the returns to *la médecine libérale*. Brunet-Jailly’s (1976) analysis indicates that the average net income of physicians reimbursed by the CNAMTS was approximately twice

as large as the average salary of top-level executives in the sixties. According to a study by CREDOC (Glarmet-Lenoir, 1979:26), the average income of physicians was 51 percent higher than that of top-level executives and 114 percent higher than that of engineers in 1975. More recently, a study by the Organization for Economic Cooperation and Development (OECD) (1976:24), using 1974 data, indicated that the ratio of an average doctor's income to that of an average production worker's was higher in France than in all other OECD countries—7.0 compared with 5.6 in the United States and a low of 2.7 in the United Kingdom. Data from the French equivalent of the Internal Revenue Service (*Direction Générale des Impôts*, 1978) reveal that, from 1973 to 1976, physicians' income increased faster than that of other professions such as lawyers and engineers. Finally, the CERC study (1976) estimates the average net income of the French general practitioner at 200,000 francs (\$50,000) and the average net income of the French specialist at 225,000 francs (\$56,000) in 1976.

### *Cost Control Policies*

In a system characterized by fee-for-service payment under NHI, to control costs it may be necessary, as Thorsen (1974) suggests, to devise a mechanism for controlling physicians' fees. However, there is no evidence that such a strategy is sufficient. On the contrary, the French experience suggests that the success of cost control policies is likely to depend both on the outcome of the fee negotiations and on the extent to which the volume of medical procedures can be restrained. Thus far, the system of physician profiles has not reduced the proliferation of medical procedures. And proposed changes in hospital reimbursement incentives have yet to be enacted, let alone alter the configuration of health resources.

In 1979, as part of a long-run cost-containment strategy, the French government passed legislation reducing the number of physicians trained by cutting enrollments in medical school (*Le Monde*, 1979). At the present time, two other legislative bills are pending. One bill proposes to grant the Ministry of Health authority not merely to authorize new hospital beds but also to close "unneeded" ones. The other proposes to change, once and for all, hospital reimbursement incentives by introducing prospective budgeting for all public hospitals.

Effective control of health costs depends on the state's ability to

control the many factors that account for mounting costs (Lévy et al., 1978). In addition, it depends on the extent to which the state is able to link its explicit policies to the implicit incentives that govern provider reimbursement. This, in turn, depends on political forces, for manipulation of financial incentives at the national level is constrained by pressures to which the state and the entire social security system, including the CNAMTS, must respond (Rodwin, 1978b). For the time being, the politics of cost control is in limbo.

### *NHI: Cui Bono?*

The introduction of NHI in France was no doubt a progressive contribution to social policy for it eliminated financial barriers to medical care. It did not, however, reduce social class disparities in medical care consumption; in fact, it made them worse. Between 1965 and 1972 the social class disparities in per capita consumption of all goods and services stayed roughly the same, whereas the disparities in per capita medical care consumption increased. Per capita medical consumption varies by a factor of 50 percent between income levels; it varies by twice that amount between occupational groups (Brunet-Jailly, 1976). This variation is largely explained by the propensity of higher occupational groups to use proportionately higher volumes of specialized medical services (Lecomte and Sandier, 1976).

As we have seen, provider reimbursement incentives under French NHI have reinforced existing patterns of medical care organization by benefiting *la médecine libérale*. Moreover, the growth of NHI appears to have been more successful in enriching the CNAMTS' most powerful beneficiary—the medical profession—than in assuring the CNAMTS' subscriber population equal access to medical care. Under the pressure of rising costs, however, the Ministry of Finance may soon persuade the CNAMTS to reduce the level of health insurance benefits, impose a closed budget on all hospitals and participating physicians, and allow dissenting physicians to opt out of the NHI program while recovering reimbursement for allowable charges. This policy option would encourage the growth of a two-tiered medical system in France; yet it is receiving serious consideration as a strategy for preserving *la médecine libérale*. Indeed, the critical question for the future is whether *la médecine libérale* can survive at all as a distinguishing feature of the French health system.

### *The Prospects for la Médecine Libérale*

As the French State attempts to break the stalemate over cost control, it is likely to reconsider its commitment to *la médecine libérale*. Once this happens, the business of medicine may turn bad. In spite of the new legislation reducing enrollments in French medical schools, projections indicate that the rapid influx of new medical school graduates will double the number of physicians between 1970 and 1985 (CES, 1979). Together with tougher cost containment policies and growing efforts to control the volume of medical services rendered, more physicians may contribute to lowering average physician income. Indeed, there is evidence that this is already beginning to occur (Glarmet-Lenoir, 1979:41).

In France, the idea of solidarity has justified NHI as well as increasing state intervention to rationalize the organization, centralize the financing, and preside over the transformation of the health sector. The idea of liberal-pluralism has not only restricted state efforts to create a unitary NHI fund with equal benefits for all; it has also restricted efforts to control costs by forcing accommodation to the demands of powerful interests in the health sector. As we have seen, the conflict between these ideas has supported contradictory policies. But the situation is now at a turning point.

In the future, *la médecine libérale* in France is likely to erode and, within the health sector, the notion of liberal-pluralism will wane. Whether or not this is a change for the better depends on how social choices about the allocation of health resources will be made. As for the past, it seems safe to conclude that the marriage of NHI and *la médecine libérale* thwarts efforts to control rising health care costs. Costly unions—at least in the present era—do not tend to be eternal.

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## Key to Acronyms

AP	<i>Assistance Publique</i>
CERC	<i>Centre d'Etude des Revenus et des Coûts</i>
CES	<i>Council Economique et Social</i>
CHU	<i>Centre Hospitalier Universitaire</i>
CNAMTS	<i>Caisse Nationale d'Assurance Maladie des Travailleurs Salariés</i>
CREDOC	<i>Centre de Recherche pour l'Etude et l'Observation des Conditions de Vie</i>
CSMF	<i>Confédération des Syndicats Médicaux Français</i>
FHF	<i>Fédération Hospitalière de France</i>
FMF	<i>Fédération des Médecins de France</i>
GDP	Gross Domestic Product
IGAS	<i>Inspection Générale des Affaires Sociales</i>
MGEN	<i>Mutuelle Générale de l'Education Nationale</i>
NHI	National Health Insurance
NPC	National Planning Commission
OECD	Organization for Economic Co-operation and Development
PSRO	Professional Standards Review Organization