Hospital Reforms in France under a Socialist Government

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SINCE THE SOCIALIST, FRANÇOIS MITTERRAND, was elected president in May 1981, and the Socialist Party won a majority of seats in the National Assembly elections the following month, the field of health care has been the object of many laws and regulations. Although the preceding government had already been studying many of these proposals, the new cabinets formed by the Socialists—at first by P. Mauroy with the Communists and, since July 1984, by L. Fabius without them—have left their ideological prints upon these proposals and have formulated still others. These reforms have been directed toward the field of health care in general but aimed at the public hospital system in particular.

Although the impact of these reforms cannot yet be assessed, it is possible to observe to what extent they have been applied and to compare the effects with the reformers' initial intentions. Herein, such an analysis has been made of the reforms that have to do, far or near, with public hospitals. Before proceeding, it is necessary both to describe the major characteristics of this hospital system before the reforms and to comment upon the political and economic situation that the Socialists have had to face.

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Public Hospitals within the Health Care System

Most public hospitals provide acute or chronic care. They compete with private nonprofit establishments, which, though many in number, are small in size. The latter mostly concentrate in surgery and obstetrics. In comparison, public hospitals account for 71 percent of the beds and 71 percent of all hospital expenditures, in other words, 37 percent of all health care expenditures.

Public hospitals are classified into three principal categories as a function of specialization. In the top category are the establishments grouped within regional hospital centers (*centres hospitaliers régionaux* [CHR]). Most of them are affiliated with public medical schools and thus also serve as teaching hospitals. Their medical vocation is to offer the entire line of the most advanced and specialized health care services to a population ranging from half a million to several million people. Next in order, the general hospital centers (*centres hospitaliers généraux* [CHG]) are located in small cities with between 20,000 and a few hundred thousand inhabitants. Under agreements with medical schools, they may accept students for clinical training. They are furnished with the technical equipment and laboratories necessary for routine checkups. Their calling is to deliver care in, at least, general surgery, internal medicine, and obstetrics, but many of them also have other specialties. In the third category are small local hospitals where private general practitioners may treat minor cases.

Public hospitals are municipal establishments with an autonomous administration; each hospital has its own governing board made up of representatives from the Ministry of Social Affairs (formerly called the Ministry of Health and, herein, referred to as the public health administration), from local Social Security boards (*caisses primaires d'assurance maladie*), and from the personnel. The mayor, who normally presides over this governing board, has power insofar as he can muster local and national political connections so as to intervene with the government. In contrast, the hospital director is a civil servant trained in hospital management at the National School of Public Health, nominated by the Ministry of Social Affairs, and approved by the governing board. His position is ambiguous, for he owes loyalty to the hospital but will be reprimanded if he does not follow instructions from the public health administration. He has to manage a medical staff of employed doctors, most of whom work full time.

In terms of medical organization, a public hospital is divided into clinical and technical services. A clinical service is a unit of from 20 to 80 beds that groups cases involving the same specialty. Since 1981, many heated arguments have broken out about the medical responsibility for this unit. Reforms have been intended to put an end to a situation wherein this responsibility falls upon a single doctor who has been appointed for life as *chef de service.* Doctors filling this position, especially in teaching hospitals, have much influence, because of their reputation, among politicians and within the public health administration, to which they often serve as counselors.

To explain how public hospitals are funded, it is necessary to distinguish between current operating costs and capital outlays.

From 1979 until 1983, when one of the reforms to be discussed went into effect, current operating budgets were drawn up as follows. Each year, the Ministry of Social Affairs along with the Ministry of Finance set a national rate of increase for the current operating budget of the public hospital system. As a consequence, for instance, new hirings in hospitals were refused if expected costs overshot this rate. Each hospital divided its current operating budget by the predicted number of days of stay in order to calculate its per diem rates as a function of the type of care (in specialized surgery, intensive care, etc.). The hospital then submitted its rates for approval to the public health administration. The per diem bed rate was used to charge patients, but under a third-party payment system, the bills were sent to the local Social Security boards where patients were enrolled. In most cases, hospitalization costs are fully covered by Social Security's health fund.

Social Security contributions, it should be pointed out, are raised through compulsory payroll taxes upon both employers and employees. Most of the population is thus provided health, medical, and hospital coverage, as well as workmen's compensation and old-age pensions. Although the Social Security system belongs to the sphere of private law and its various funds are managed by representatives from both labor unions and employer organizations, its activities are closely regulated by public authorities. In particular, the ministries of Social Affairs and of Finance fix the rates both of withholding taxes and of reimbursements for medical goods and services.

The capital budget is tightly controlled, too. Outlays for beds and major equipment (scanners, dialyzers, and so forth) are programmed

over five years. This planning mainly turns upon the ratios of beds and of machines to population. Authorized purchases are then funded partly through general revenues and partly through Social Security funds. The latter could also extend low-interest loans to the hospitals, but in 1983 the government took away this power in order to limit capital expenditures.

This outline of the public hospital system in France suffices for present purposes. The interested reader will find a fuller description in de Pouvourville (1983) as well as in de Pouvourville and Renaud (1985).

The Public Hospital Crisis: When Growing Pains Stop, the Pain Starts

During the past twenty years, the field of health care has been enlarged, the provision of services improved, and the public hospital system developed. The ending of this period of growth has created the conditions for a crisis.

The first condition is financial. As in most developed countries, hospital expenditures and, in general, health costs have risen faster than the nation's wealth. By itself, this differential is not at all blameworthy, for it reflects the deeply changing patterns of consumption, especially of services, within such countries (Levy et al. 1982). During a period of economic stagnation and of high unemployment, however, these rising expenditures have plunged the boards and funds that finance social services, in particular health care, into the red. Since the health care system is mainly financed through payroll taxes, raising the withholding rate would increase labor costs and, therefore, lessen the competitiveness of French firms. The principal therapy administered in France, as elsewhere, has been to ration hospital resources of all sorts. Since 1979 the Ministry of Social Affairs has assumed the regulatory powers of reducing the number of beds. New budgetary measures have been instituted, as we shall see, and restrictions placed on creating new jobs for medical and paramedical personnel. General revenue subsidies for capital investments have stagnated. Nonetheless, from 1979 to 1981, public hospital expenditures still leaped upwards:

20 percent from 1978 to 1979, 19 percent in 1980, and 19.4 percent in 1981 (Ministère des Affaires Sociales 1984a)!

The second condition underlying this crisis has to do with the rising number of doctors: from approximately 65,000 in 1971 to 110,000 ten years later (Ministère des Affaires Sociales 1984b), in other words from 128 per 100,000 inhabitants to 201. The number of specialists rose slightly faster than that of general practitioners, and the number of public hospital doctors faster than that of private practitioners. Meanwhile, the time had come to stop the growth of the public hospital system. Since 1982 authorizations have seldom been given for the creation of new jobs, and no new public hospitals have been set up. As a consequence, students who began studying medicine between 1965 and 1975 have little hope of someday filling the much coveted position of *chef de service*, or even of finding work in public hospitals. Many of the persons who hold this lifetime position are hardly any older than their assistants, but they will reach retirement with a salary about 1½ times higher than the latter who, by the end of their careers, will perhaps never have been given positions of responsibility. Of course, these assistants can quit the hospital and take up private practice. If they do, the public hospital system will suffer. Besides, many hospital doctors now between 30 and 40 years old have realized that their salaries are about equal to those paid to middle-level white-collar workers in industry or even in the civil service, and that they earn from 1½ to 3 times less than age-mates in private hospitals. Career prospects are not very promising, the pay is not very attractive: a crisis has been in the making.

The cure? To transform the medical hierarchy by putting an end to lifetime appointments as *chef de service*, by compressing salary differentials and by redistributing medical positions in the hospitals. Another remedial measure has called for slowing down the number of graduates in medicine, especially by admitting fewer candidates to medical schools. Indeed, from 1977 to 1981, admissions fell from about 10,000 to 7,000 a year, and this trend is continuing. However, this remedy has caused another ailment. Public hospitals have been able to develop, thanks to, along with other factors, the assistance of the large numbers of medical students who, before graduating, have to undergo hospital training. As these numbers have fallen off, routine chores now risk being left undone because students have not been replaced by certified doctors.

What Is Left, or Right, in Reforms?

Once the decision was made to halt the rising costs of health care by limiting its supply, particularly through public hospitals, no government, whether left or right, could have avoided the aforementioned crisis. In this respect, the trend before 1981 has continued since. True, the new government did have some intentions about changing the ways that medical care is provided outside hospitals. This change was to be effected by having municipalities finance "integrated health centers" that would compete with private practitioners. These intentions were not put into practice. Instead, reforms have been mainly aimed at the public hospital system.

The trend before 1981 has also continued because the Socialist government adopted the laws and regulations necessary to accomplish reforms that were underway, namely those about global budgets, medical education, hospital practitioners' careers and "departmentalization." In addition, it passed an ideologically neutral reform that adapts diagnosis-related groups (DRGs) to France.

Nonetheless, it would be false to state that there has been no notable difference between governmental actions under Mitterrand and, for instance, under Giscard d'Estaing had he been reelected. The essential differences have to do with, on one hand, the language and arguments used to justify reforms and, on the other hand, the relationship of the medical profession with politicians.

In 1981 and 1982, the new government let up on the belt-tightening measures that former Prime Minister Barre had been enforcing since 1977. Thanks to this new policy of stimulating economic growth through consumption, budgetary restrictions were temporarily loosened in public hospitals, where jobs were created and cost overruns were covered by end-of-the-year allocations. Howbeit, this policy was soon replaced by sterner measures.

In their arguments, both the Socialist and Communist parties advocated more democracy at the work place and in public affairs. This theme has undeniably suffused the decentralization reform, which calls for transferring jurisdictions as well as powers of decision and of management from national, central authorities in various ministries toward locally elected (regional, departmental, or municipal) officials. Accordingly, the regulation of the delivery of health care should be entrusted to regional executive bodies made up of such officials. Likewise,

representatives to the local Social Security boards that oversee, in particular, the health and sickness fund are now, once again, elected by insurees themselves. This reform was presented as a return to the original principles underlying Social Security, namely local management by wage earners themselves (de Pouvourville and Renaud 1985). Since hospitals are financed largely through these boards, this decentralization could have far-reaching effects. This same theme of democracy runs through the reform for setting up departments within hospitals, as borne out by the *Projet Socialiste pour la France des Années 1980-1981:* (Club Socialiste du Livre 1981).

> The internal activities of establishments must give up a rigid, hierarchized structure. In place of services, which are fiefs, there should be basic units grouped in departments under the direction of a person elected for a limited term. Instead of existing wage differentials and statutory differences, there should be team work.

As for the relationship of the medical profession with politicians, most doctors, whether working in public hospitals or in private practice, lean toward centrist, liberal, or conservative parties. Even though various categories of doctors may have diverging interests, the profession stands united in opposition to any public decision that is felt to reinforce control by lay institutions. Ever wary of the government's overreaching ambitions, doctors, nonetheless, have less tense relations with parties to the center or on the right. With them, differences are solved through negotiations, compromises, and friendly agreements; and the elite in teaching hospitals have special access to these politicians. To give an example, departmentalization, a touchy issue since it modifies the hospital hierarchy, has been much discussed since 1970, but no effectively compulsory text had been proposed before 1981. In short, doctors are wary of all public authorities but leery of leftist ideologies.

In this hostile context, the Socialist government purposed to enact proposals from its electoral platform that were aimed at both hospital and private medicine. Three events would take on symbolic value. First of all, the minister of health in the first government formed by P. Mauroy after the parliamentary elections of June 1981 was Jack Ralite, a member of the Communist Party. As such, the medical profession took him to be the spokesman of the hospital labor unions

that object to the existing hierarchy. Second, the first hospital reform to be applied drove the private sector out of public hospitals; heretofore, public hospital doctors—especially those in teaching hospitals who form the elite of the medical profession—had been able to treat or even hospitalize private cases in their "services." They thus earned fees in addition to their salaries. This privilege was abolished. Third, the already mentioned proposal about setting up integrated health centers was put on the agenda.

The medical profession, ill-disposed as it was toward the Socialist government, saw proposals for reforms as a signal of attack. At first, it reacted through campaigns in the newspapers, demonstrations in the streets, and very limited strikes in certain hospitals. In the spring of 1983, a larger, more spectacular conflict broke out: medical students went on strike to protest against the medical education reform. In teaching hospitals, the two lower categories of doctors (*internes* and *chefs de cliniques*) also struck against a reform affecting their career prospects; and at last, the elite category (*chefs de service*) participated in the movement in order to oppose a bill for reforming medical schools. This four-month-long movement only affected teaching hospitals, but these were not closed down. The outcome was that the government made significant concessions about the reforms and the Communist minister of health left the Cabinet. A period of temporization followed until early 1985. In the meantime, the government had been overhauled, and all Communist ministers had left in July 1984. The new, entirely Socialist government would take time to reexamine proposals.

Meanwhile, the government's initial popularity was wearing away, as borne out by the losses that the Socialist and Communist parties suffered in various elections. As general parliamentary elections drew nigh in March 1986, hospital doctors stiffened their resistance. The parties now in the opposition, assured by public opinion polls of winning, have promised to undo the most controversial reforms. Time is no longer on the side of those who advocate major changes.

Public Hospitals under Operation

How have proposed reforms remedied the aforementioned problems? Are they compatible with the language and arguments used by the

Socialists? Let us keep these questions in mind as we look at specific measures.

The Reform of Medical Education

Before 1981 the curriculum in medical schools was organized in three levels (Baszanger 1985). Right after secondary school, students devoted two years to studying basic sciences. At the end of this first level, they sat for a very selective examination for admission to the second level. During the next four years, they began learning medicine and undergoing training in hospitals. For those who wanted to become general practitioners, the third cycle amounted to an additional year of hospital training during which they were usually paid. At the end of this seventh year, they graduated and could then set up office. Those who wanted to become specialists faced an alternative. As early as the fifth year of medical school, they could sit for an examination (*concours de l'Internat*) that opened the way to a certain number of full-time, paid positions as *internes* (not to be confused with English "interns") in public hospitals. During this residency, which lasted four years, training mainly consisted of clinical assignments to specialized services. Alternatively, would-be specialists could, after the second level, enroll in their chosen specialty at medical school. This program, which normally lasted three years, mainly consisted in theoretical instruction. These students were not sure to receive clinical training and, if they did, they were not paid. They eked out a living by doing replacements for general practitioners or by working under temporary contracts with hospitals (especially by being on call). In contrast to the very practical training that *internes* received, these students had to pass university examinations. Furthermore, they had fewer chances of making their careers in hospitals.

The medical education reform, which was mainly directed at the third level, had been under study for ten years. The Socialists passed it without altering its fundamental principles.

Initially, one of the motivations underlying this reform was to bring France in line with European norms. The training of specialists was, given the aforementioned alternative, either too practical or else too theoretical and too short. This normalization has been achieved by providing a paid period of residency to all specialists-to-be. During four years of specialization, which begins at the end of the second

level, theoretical courses take up more time than under the *internat*. This reform has put an end to the inequality between the two types of specialization.

A second objective was to improve the education of would-be generalists by making them pass an additional year of clinical training. For such training during the last two years of medical school, these students were to be paid as much as residents; but the March 1985 strike by *internes* in teaching hospitals forced the government to reestablish a wage differential. Another change is that this clinical training may also take place in the offices of private practitioners.

The final objective of this reform was to limit the number of specialists graduated each year and, in general, the number of doctors entering the labor market. Everyone now agrees that too many students graduated in medicine during the 1970s and that the country has enough doctors. Since 1977 the Ministry of Education has been restricting admissions to the second level of medical school. Moreover, there is now a budgetary constraint inasmuch as students undergoing clinical training during the third level are to be paid. For similar reasons, the number of students in specialization has been reduced. Studies have shown that the installation of new specialists—but apparently not of general practitioners—usually stimulates the consumption of medical goods and services.

The Reform of the Statutes Governing Hospital Practitioners' Careers

Changing the statutes that concern hospital doctors' careers, in a way, logically follows from the medical education reform. The latter, in particular by unifying the training of specialists, set the conditions for eliminating statutory differences within the ranks of hospital doctors, especially the differences between those employed in teaching hospitals and the others.

Previously, hospital doctors' careers had four possible courses. Graduates who had finished the *internat* could be employed under temporary contracts while undergoing further training in the hospital or while waiting for job openings there. If they managed to be recruited as *chefs de clinique* in a teaching hospital, they could, four years later, aspire to tenure with medical duties or, of greater prestige, with teaching duties, too. Those who combined both earned two salaries.

Otherwise, they could submit applications for definitive positions in ordinary hospitals.

The reform abolishes these statutory differences by opening a single career path based upon seniority and faster, merited promotions. In fact however, hospital doctors with teaching duties still follow a different path. Young doctors can obtain tenure sooner by sitting—right after residency instead of four years later—for a national examination used to fill a given number of job openings.

Before this reform, rank and function within the public hospital system were automatically correlated. For instance, at the top of the medical hierarchy was the *chef de service*. a lifetime position as head of a service. According to the statutes, this appointee had sole responsibility for patients in his service. Not only does the Socialist philosophy consider this position of authority to be archaic, but also several critics question, in addition, the organization of hospitals into services. Out of these criticisms came the departmentalization reform.

Departmentalization

Services are a major factor of the overspecialization of hospital medicine. To have a career, a young doctor either has to wait for his *chef de service* to retire or die, or else has to learn a specialty different from the latter's in the hope that his efforts will, someday, be crowned by the opening of a service in this new field. This uncontrolled overspecialization has generally been thought to be a cause of rising hospital costs. Critics also point out that it leads to a compartmentalization of activities: each service is usually an expensively equipped "estate" or "fief." In the area served by the hospital, the likely result is overequipment and underutilization. Criticism also bears down upon the kind of care delivered to patients in hospitals, where the special doctor-client relationship does not exist. Examined by several specialists, the patient is no longer a single, whole case; he has become a juxtaposition of organs, of clinical symptoms.

The departmentalization proposal is intended as a response to these criticisms. By separating rank and function, the modified statutes have, as mentioned, tended to equalize the opportunities that doctors have when seeking positions of responsibility. Departmentalization should go even farther by setting up a new structure for coordinating medical teams, treating patients, and sharing equipment. To create

these larger units of cooperation, the compartments separating services must be torn down. This reorganization must not stop at structural transformations; it must go on to change managerial methods so as to introduce greater democracy within hospitals through, for instance, elections to fill representative "colleges" by the personnel concerned in a coordination based upon shared objectives. In order to develop a "global medicine," a medicine of the whole person and not just of his organs (Gallois and Taïb 1981), departments should be created, each one made up of so-called "functional" basic care units smaller than existing services. Elected for a fixed term, the department head, or coordinator, would be assisted by a council whose members would be chosen by the aforementioned colleges. This council would deliberate the department's medical "policy." The department would manage the resources of its units, and the doctor in charge of it would coordinate the work of the various persons who have dealings with the patient and see to it that medical care is "personalized."

Global Budgeting

Globalizing current operating budgets and adapting the diagnostic-related groups (DRGs) to France are procedures that follow from the preceding reform inasmuch as it called for changing managerial methods.

The central idea underlying the global budget is simple. The aim was to break with past practices of annually readjusting per diem rates and allocating supplementary end-of-the-year credits so as automatically to cover hospital expenditures. Given these practices, expenditures, as might be expected, never fell in line with predicted costs. The global current operating budget is a block appropriation made at the start of the year once and for all. Hospitals can no longer hope to obtain additional allocations to make up for overruns. Furthermore, the deficit from one year is not automatically covered by appropriations the following year. In turn, the cash flow of hospitals has significantly improved because Social Security boards make monthly installments equal to one-twelfth of the current operating budget.

This simple idea was backed by arguments about modernizing the way hospitals are managed and about allocating resources as a function of targeted objectives. In principle, the current operating budget should come out of a process of negotiations between each department head and the hospital director. During this process, the former should

set his objectives for the coming year and link them to the means necessary for reaching them. Hospital managers, in particular, have been arguing that hospitals, like companies, must no longer be run on archaic, counterproductive managerial methods. The public hospital should no longer be a juxtaposition of medical entrepreneurs, the *chefs de service*, who, though excellent specialists, are all too eager to grasp new opportunities without thinking about how they fit into an overall scheme. A hospital should be an organization wherein the projects of each and all are assessed with reference to its general policy.

The proposal about adapting DRGs to France fits within the same rationale, for public hospitals and the public health administration should have the means of measuring hospital activities. At the initiative of a top civil servant in the Ministry of Social Affairs who has had many contacts with the United States, the decision was made to transplant DRGs to France. Unlike under American Medicare however, the DRGs are not to serve as a method of prospective payment; in theory, global budgeting has put an end to billing Social Security for medical care. The ministry has not yet specified how DRGs will be used. In addition to comparing hospitals with each other, they might be used to calculate annual budgets.

Have These Reforms Taken Effect?

The foregoing remarks show how these reforms are interlinked. Discussion has centered upon initial objectives and underlying principles. But how far have these measures come through the legislative and executive processes? Have they come into force? Have they taken effect?

Health care has been less affected than other fields by decentralization. The jurisdictions of the central administration and of local authorities over public hospitals have not changed. In practice, however, centralism has been reinforced.

The reform of medical education came into force in October 1984; that of hospital practitioners' statutes, on January 1, 1985; and global budgeting has been applied to regional hospital centers since January 1983 and to the other hospitals since January 1984. After several reformulations, the regulatory texts pertaining to departmentalization were published in December 1985; departments are to be created by

September 1986 at the latest. The prerequisite texts for adopting the DRGs date from 1984 and 1985, but this reform, which actually began in 1982, will be applied slowly because, for one thing, French hospitals, unlike American ones, are not obliged to provide regular discharge abstracts.

This short overview says little about the debates that these measures have fueled. Nor does it say much about how these reforms have been implemented. These two aspects will now be discussed with respect to global budgeting and departmentalization.

Global Budgeting in Order to Modernize Managerial Methods or Ration Resources?

This reform was already well underway in 1981. In 1978 a law enabled the government to experiment with two new formulas for financing hospitals and setting rates. The aim was to replace the fixed per diem rates, which the public health administration had been severely criticizing since 1970. The one formula was the global budget for which Quebec served as model, and the other the unbundled pricing system. As the former has already been discussed, a word needs to be said about the latter. This formula was aimed at doing away with the fixed per diem rate as a kind of approved or certified lump sum and at calculating the actual costs of each service that go into hospital expenditures.

Since 1979 block allocations similar to global budgets were granted to hospitals. Previously, the government used to set a permissible annual increase in per diem rates without, however, controlling resulting budgets since these, by definition, were equal to the per diem rate multiplied by the number of days of hospitalization. This procedure was replaced by the one described at the beginning of this article.

Following a report to the minister of health in late 1982, the decision was made to adopt global budgets for public hospitals in two phases, as already pointed out. At that time, this reform had two major characteristics. First of all, until all directions were issued, the budgetary procedure would remain based upon the national rate of increase for the current operating budget of the public hospital system, this rate being fixed as a function of general requirements. This was a far cry from a decentralized procedure that would have

taken into account disparities among establishments and among local areas. Instead, this procedure continued a trend from the past. Second, the principal advocates of this reform belonged to a generation of young hospital directors who wanted to impose a managerial view of how public establishments should be run. For them, global budgeting had many potential advantages. In particular, it separated the problem of rates from questions of internal management. Instead of reacting to regulatory and, therefore, arbitrary prices by creative accounting, they hoped to set up a form of participative management in terms of objectives. Every year, the hospital director should negotiate with each department (and no longer the service) head the allocation of resources as a function of the medical objectives that the latter set. Afterwards, at the level of the whole organization, interdepartmental "arbitration" would lead to proposing a budget to the public health administration. The hospital director would then see to it that adopted objectives were reached. This reform was also intended to help simplify the relations between hospitals and Social Security boards. Instead of paying a hospital for medical "acts" billed to patients, these boards would make regular monthly installments based upon the yearly budget. Since it should no longer be necessary to make out invoices, savings in terms of management could be made.

In fact, however, events turned out differently. At the national level, it took a long time to draw up the texts defining the new procedure in detail. At the local level, the application of these texts has taken even longer. It has absorbed the time and energy of managers, who have seldom been able to open negotiations with doctors as they had wanted to. Rather than simplifying relations with Social Security boards, this reform has complicated matters, for hospitals have been forced to make out dummy invoices so that costs can be shared among various Social Security funds (for employees, for farmers, for the self-employed). In addition, these boards now require regular bookkeeping records of actual expenditures. Finally, the government, in order to improve the cash flow of these boards, has recently authorized them to modulate their monthly installments. This decision has subordinated, once again, hospitals to the factors weighing down upon Social Security.

Transplanting DRGs to France has also raised problems. Not only does the government control global increases in hospitals' current operating budgets, but also it now has, thanks to the DRGs, a method

that could be used to control items within these budgets. Because the government has not yet given clear directions about how the DRGs are to be used, managers and doctors fear lest they serve as a basis for mechanically calculating budgets as a function of observed or standard costs.

For the time being, global budgeting seems to be nothing other than a simple and blind method of curbing costs. Rich hospitals are still rich, whereas poorer ones have little hope of seeing national resources redistributed. Apparently, this method has been effective, since current operating expenditures have been slowing down: 14.6 percent in 1982, 12 percent in 1983, and 7.6 percent in 1984 (Ministère des Affaires Sociales 1985). However, the number of days of hospitalization has also significantly decreased. Whether or not this measure has been effective is yet to be proved.

Departmentalization: Changing Hospitals by Law

This reform also reaches back in time. The term "departmentalization" appeared for the first time in a regulatory text in 1963. Nonetheless, the conception of a department as a unit for coordinating medical activities did not appear till 1970 in a text about grouping rheumatologists, orthopedists, and physical therapists. By 1981 this brief had not come as far as we might have expected. The term "department" has provoked many debates that turn upon differing expectations about how, from a medical point of view, hospitals should be reorganized. There has been general agreement about the need to discuss this matter but not about the objectives of any such reform.

The first argument in favor of this reform had to do with the problem of hospital doctors' careers which, as mentioned previously, were blocked by lifetime appointments to the position of *chef de service.* We have already seen how the statutes were modified in order to deal with this situation; but it should be pointed out that, instead of replacing services with departments, it would have been possible to limit the *chef de service*'s term of office.

Two other conceptions underlie departmentalization. One comes from the unions representing the paramedical personnel, the major

ones of which are on the left. Demanding an active voice for the personnel in the activities of the units where they work, these unions have called for the creation of an elected council with managerial powers over which an elected coordinator would preside. For the left in general, the "boss" (*chef de service*) symbolizes an autocratic, archaic power. The second conception is held by those hospital managers who support global budgeting. They see departmentalization as a means of having doctors face each other to discuss their medical objectives and of establishing bilateral relations with department heads. Traditionally, managerial methods have been based upon doctors avoiding each other. Departmentalization could thus lead to pooling resources, equipment, and facilities. In managerial terms, a department could countervail the excessive differentiation that has resulted from medical specialization. The hospital would no longer be an association of expert but autonomous entrepreneurs, for there would be negotiations leading up to an overall strategy.

Various observers have repeated the criticisms that patients have made about the impersonal nature of hospital care. A report by two doctors at the request of the minister of health in May 1981, after presidential elections, recommended "global care" for the patient, who should no longer run from one service to another but should see various specialists meeting at his bedside (Gallois and Taïb 1981).

Though not exhaustive, the foregoing comments do show that departmentalization aroused diverse, not necessarily compatible, expectations and, consequently, led to the adoption of differing measures. In brief, two conceptions of the department are at odds. Most hospital doctors hold a minimal conception. Although they agree about giving more medical responsibilities to young doctors and realize the importance of improving coordination and of managing resources in common, they insist upon having the top hand in any reorganization. They support their point of view with arguments about local contingencies. Most of them are against doing away with either the services or the *chef de service*, and they oppose filling positions of responsibility through elections. The maximal conception figured in the first draft of the reform document in late 1982 and in preliminary reports. Accordingly, services should be abolished, departments set up, and elections held that would involve all categories of the personnel. The arguments underlying this conception imply that the department should heal all

the ailments afflicting the services—overspecialization, a "fragmented" doctor-patient relationship, the waste of resources, the lack of openings for young doctors, and so forth.

From the start, the departmentalization reform has been more controversial than global budgeting. It is intrinsically more difficult to make this reform operative so that it can apply to all public hospitals. Defining a managerial procedure such as the global budget is much easier than proposing a reorganization with many finalities. Which rationale should be followed in order to departmentalize hospitals (de Pouvourville and Cabridain 1982)? Since any single service can fit within several informal networks of cooperation and coordination, which network should be used to form the department? Should the personnel from one service participate in the meetings of another service during which cases are presented and decisions made about treatments? Should already existing "channels of care" be formalized? If the aim is to manage resources in common, is it necessary to create departments? Could existing units not sign agreements? The division into services is grounded in reality not only through the "institution" of the *chef de service* but also through the definition of disciplines in medicine and through the layout of establishments that isolate territories from each other. Departmentalization is not an operation that can be readily enforced through uniform, general rules and regulations, even though procedures having to do with management and the distribution of roles can be and have been laid down. For this reason, regulations have mainly stipulated how elections are to be held, how councils and electoral colleges are to be formed, and how responsibilities are to be assigned. These one-sided texts have been used to focus debate on the political aspects of this reform, namely, the abolition of the position of *chef de service,* the election of the department head, and the composition of electoral colleges.

Hence, this reform has become one of the major issues in which the medical profession opposes the Socialist government. Several texts have been published that have gradually veered away from the maximal conception. For instance, the department head is not to be elected by representatives from all categories of the personnel but only by doctors. Notwithstanding concessions from the government, many doctors have blocked implementation of the texts published in late 1984. A new text was published in December 1985, but owing to

the approach of parliamentary elections, which the left is not sure to win, doctors have adopted a wait-and-see attitude.

Change or Continuity?: The Continuation of Changes

When the left came to power in 1981, it announced new reforms and marked existing proposals with its language and arguments. As expected, the new government not only tackled health expenditures but also attempted to modify the health-care system permanently through structural reforms, in particular decentralization and departmentalization. In the health field however, decentralization has not taken place; on the contrary, the tendency to centralize decision-making has become stronger. The future of departmentalization is still unclear. If the left continues governing after elections in March 1986, the medical profession will have to adopt a deliberate attitude of civil disobedience in order to prevent implementation, since the texts have already been published. The government has a major weapon—the budget—to use against reluctant hospitals.

The reforms that the Socialist government has passed and begun applying are extensions of actions undertaken by preceding governments. Regardless of who is in power, the budgetary belt has been gradually tightening around public hospitals. Apparently and paradoxically, private hospitals have, in the short run, benefited by recruiting both doctors, who have no future in the public sector, and patients, who fear lest budgetary restrictions lower the quality of health care in public hospitals.

Rewriting history by conjecturing about what would have happened had the right stayed in power is venturesome, as is predicting the future. If the Socialists are returned to office, they might fully be able to carry out structural reforms. But, although the relationship between the medical profession and the government has changed, the latter's actions fit within the trend toward reinforcing public control over the producers of health care.

Translated from the French by Noal Mellott, Paris.

Postscript (April 21, 1986)

On March 16, 1986, the French Socialist party lost the majority at the Assemblée Nationale, and a new government was formed under the leadership of Jacques Chirac as prime minister. This government is supported in Parliament by a coalition of the two major parties of the French right. No major change in health policy has yet occurred. Nevertheless, there are a few indications of what may happen.

First, let us recall that presidential elections are due in May 1988. To win these elections against President Mitterand, the government has to achieve significant action in two years' time, in particular, in the areas of economic growth, employment, and inflation. Actually, the government is betting on fiscal cut-offs on one side, and on budgetary restrictions on the other side, to stimulate economic growth and improve employment. If this should succeed, the Social Security fund should improve its balance through increased revenues from payroll taxes. Nevertheless, in the short term, it is probable that the government will maintain the pressure on expenses, and the public health administration will not be spared in budgetary cut-offs. A second consequence of this two-year election race is that the government may be inclined to postpone or modify the main reforms undertaken by the Socialists in order to keep the support of physicians, be they hospital-based or not. Thus, one way to manage both unpopular short-term resource restriction and the quest for support would be to take actions that have high symbolic value, but no short-term financial consequences.

If this is the case, the first step taken appears to be in the wrong direction. The first cabinet included a huge ministry for social affairs, with responsibility for the public health administration. It took ten days before Jacques Chirac appointed Dr. Michele Barzach, a woman gynecologist in private practice, as delegate minister for health under the authority of Philippe Seguin, Minister for Social Affairs. The appointment of a private practitioner is an innovation; it is probable that Dr. Barzach will pay more attention to private practice and physician revenues than her predecessors, who focused more on hospital-based medicine.

As for the reforms discussed in this article, one can only rely on public information given during the election campaign; at present,

it seems that the new government is taking time before making decisions. The major propositions made during the campaign confirm the assumption of a preference for symbolic actions. For instance, it was suggested that hospital departments should be created on a voluntary basis, and should no longer be an obligation. Private practice in public hospitals should be restored. To the contrary, global budgeting is not questioned, and French DRGs will probably be used to improve resource allocation and redistribution, through the comparison of hospital performances.

To broaden the scope of this article, one must also mention that the national Social Security system was equally under criticism from the right-wing parties, who suggested that part of the coverage for sickness be turned over to private insurers. However, these ideas are not presently being debated.

We shall probably have to wait two more years, and see the first results of the government's economic policy, before we can clearly perceive major new orientations in terms of health policy.

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