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Recent French health system reform proposals

Nadia Jemiai

Since the 1970s, health care cost containment has been a major objective of the French government. To this end, a series of regulation policies have been pursued but have to date been unsuccessful. Initiatives authorizing the state to fix prices on both prescription drugs and per diem rates for hospitals resulted in the over-prescription of medication and longer stays in hospitals. The increase in co-payments ('*ticket modérateur*') failed to constrain social security expenditure as a growing number of the insured turned to complementary insurance. To compensate for the continual increase in health care expenditure, the rate of social health insurance contributions was sharply raised.

In the 1990s, health policy focused on regulating expenditure negotiations between the state, health insurance funds and providers. However, cost-cutting was constrained by the stakeholders' limited financial responsibilities. In 1996, the '*Plan Juppé*' introduced structural changes mainly affecting: (i) the balance of responsibilities by creating the regional hospital agencies and the regional union of the health insurance funds (ii) the financing system by substituting wage-contributions with tax on income (iii) the planning of health care by giving the parliament a more active role in determining policy directions and expenditure targets; and (iv) medical practice by creating the National Agency for Accreditation and Evaluation of Health Care.[1]

Currently, as health care expenditure reaches almost 10% of GDP, the Minister of Health has proposed new reforms to the French health care system which await parliamentary approval in July. This review mainly summarises the articles found in the June 2004 health care supplement of *Le Monde*.[2]

Health care issues raised

Journalist, Jean-Michel Bezat, denounces a French welfare state that is unable to cope with the current social security crisis. Indeed, by the end of 2004, social health insurance will have accumulated a €32 billion deficit. Bezat questions whether or not it is still possible to reconcile economic competitiveness and social redistribution.

The ageing population, along with those unable to pay health insurance contributions, are reported to create a strain on the solidarity principle and the financial viability of the health care system. Health care expenditure for those over 65 is said to be 2.6 times higher than the average population and 4.5 times higher for those over 85. Projections for 2050 indicate that the ageing population will lead to a 1.5% to 3.2% increase in the total health care expenditure share of GDP. The health system will also have to provide for a growing number of persons considered to be dependant due to a mental illness or a physical disability.

The hecatomb of the August 2003 heat wave is pointed to by journalists as engendering enough collective guilt and political upheaval to push to the forefront projects previously considered unfeasible or too costly. Indeed,

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by the end of August, the Prime Minister recommended the removal of one bank holiday a year so as to finance 'the ageing plan' (*plan vieillesse*). The plan intends to establish an additional branch within the social security system devoted to age-related dependence to complement the four existing branches which deal with illness, work-related accidents, ageing and the family.

Concerns are also raised over the need for tighter control on the number of persons benefiting from state-provided medical aid (*L'aide médicale D'Etat, AME*). The government attempted to pass legislation to reinstate the per diem payment for inpatient care. However, under pressure from humanitarian organisations, the decree was never accepted. The government did commit to reducing the number of AME beneficiaries by drastically reinforcing and controlling eligibility criteria and decision-making. Previously, all non-insured foreigners and those ineligible for Universal Medical Coverage were entitled to receive AME. Since 2003, legislation was imposed specifying that to be eligible beneficiaries must have been residing in France for at least three months.

Currently, approximately 800,000 persons are benefiting from APA financing. This personal independence allowance (*Allocation personalise d'autonomie, APA*), established in January 2002, is means-tested and adjusted in relation to the individual's dependence level, living conditions and needs as assessed by a joint health and social care team. The rapid increase in numbers of beneficiaries has exceeded initial forecasts, putting financial pressure on the French *départements*. APA related expenditures are estimated to be approximately €1.2 billion.

The over-consumption of medical goods and services is also a central concern highlighted by the articles. Doctors are considered to be mainly responsible for this practice. According to *Le Monde*, the fee-for-service system gives doctors the incentive to over-prescribe under the guise of taking all the necessary precautious; and in doing so they choose to ignore the ensuing expenditures from over-prescription which society will eventually have to pay for. The authors explain that pharmaceutical consumption has turned into a cultural phenomena and is no longer only based on medical need. In 2001, the Transparency Committee recommended the removal of 835 drugs from the list of reimbursable drugs as they were found to lack therapeutic value. However, so far, only a few drugs have actually been taken off the list.

Finally, the purported state of France's 1,000 public hospitals is also highlighted by the press and the medical profession. Public hospitals are said to be under financial pressure and in great need of structural updating. The management and daily work environment has also been difficult due to:

(i) past quotas placed on the number of medical students entering the nursing and medical professions;

(ii) the introduction in 2002 of a 35 hour week; and

(iii) the increase in the number of medical professionals reaching the age of retirement.

A growing number of inpatients, whether due to an increase in demand or an ageing population, represents a continual problem for a workforce faced with strict work hours, a stagnating number of employees, outdated structures and financial difficulties. It is also argued that social care should be improved to alleviate the number of elderly having to rely on hospitals to receive health care.

Proposed health care reforms

On the 12 May 2004, the Minister of Health announced his proposed plans for health care reforms. Overall, the aim is to recoup an additional €15–16 billion, €10 billion of which would be produced from savings on health care provision. The Minister expressed the alarming need to preserve the health care system from financial failure and from the expansion of private medical insurance which would be detrimental to those less well-off. More specifically the proposed reforms include:

(i) An additional €5 billion generated from new receipts. The €32 billion deficit would be transferred and taken over by the national reimbursement fund for social debt (*Caisse d'amortissement de la dette sociale*). This would result in patients, taxable pensioners, firms and future generations contributing to reimbursing the social debt beyond 2014. Furthermore, social solidarity levies on firms would be raised from 0.13% of revenue to 0.16%, amounting to €780 million. General social contribution rates for taxable pensioners would move from 6.2% to 6.6%. All patients, except for those under 18 or those benefiting from Universal Medical Coverage, would receive €1 less in reimbursement per medical contact consultation. This measure should provide €1 billion to the national health insurance fund. By January 2008, 'Specifications' (*cahiers de charges*) should be defined among the Union of complementary health insurers and the national health insurance funds stating, in particular, the exclusion of the additional €1 per medical contact from complementary health insurance coverage. Firms wishing to benefit from the social and financial advantages received when offering their employees collective complementary health insurance would have to chose to adhere to all the 'specifications'. This policy intends to ensure that patients pay the extra €1 per medical contact as a co-payment or '*ticket modérateur*'.

(ii) Economies of €10 billion on the provision of health care. The government hopes to save at least €3.5 billion with improved containment of health care expenditure and control over sickness benefits. The pharmaceutical industry would have to contribute €2 billion. Generic drugs would be further developed. A revision of the list of reimbursable drugs would continue with the 2001 attempts to remove drugs with insufficient therapeutic value. This revision will be carried out by 12 nominated public health members: 3 each nominated by the Chief of State, the president of the Senate, the National Assembly and the Economic and Social Council. The Minister of Health emphasized that over-

medication resulted in 128,000 hospitalisation admissions and 9,000–10,000 deaths per year. Furthermore, the government intends to create the High Authority on Health (*Haute Autorité en Santé*) which would evaluate medical services and devices and provide recommendations on reimbursement.

(iii) The establishment of electronic medical records and more personalised 'vital cards' to reduce and avoid unnecessary, repetitive and fraudulent use of medical services. Although the Minister of Health admits that both patient and doctor behaviours would have to change, he is optimistic that more coordinated and personalised health care would lead to €7 billion in savings by 2007. Furthermore, patients would receive a reduction in reimbursement if they visit a specialist without a referral from their chosen gatekeeper while specialists would be able to set higher fees; the rules on extra-billing would be set by national conventional agreements between doctors and the health insurance funds.

(iv) The state acting as guarantor while responsibilities for health insurance fund managers increase. A Union of the national health insurance funds would be created with the role of reinforcing the partnership with organisations providing complementary social protection. Managers of the health insurance funds would have to provide the government with a yearly budget and present an initial list of reimbursable services.

The proposed reforms for the health care system focus on increasing funding and controlling expenditure rather than on implementing the needed structural changes. The measures suggested to increase funding benefit those with a higher income as the more progressive tax on income has already been reduced by 10% while the general social contribution tax would be raised. Also, no solutions are recommended for the ailing public hospitals. Doctors are once again overlooked as economic agents and instead are considered as virtuous professionals who would change their practice of over-supplying services and prescription drugs to embrace the new establishment of electronic medical records, and giving patients more controlled, attentive and personalised care. It is difficult to imagine such results without plans to modify the current fee-for-service system or to restrain the degree of choice for both providers and patients. The loose form of gatekeeping suggested, combined with a greater opportunity for specialists to set fees, would increase the risk of supply-induced demand as specialists would favour care for patients without a referral for which they can increase their consultation fees. Patients, on the other hand, would be penalised for going directly to a specialist by receiving a lower rate of reimbursement. Reluctant to challenge the medical profession's practices or to compromise patient and provider choice, it is unclear how the proposed reforms would improve the financing of the French health care system.

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Dental health care policy in the UK

Ray Robinson

The dental health care sector in the UK is undergoing major reform. But in a recently published report, *The Economics of Dental Care*,[1] my colleagues and I have argued that the reforms do not go far enough. In particular, they fail to take sufficient account of the changing pattern of dental health needs and demands among the population, of a traditional payment system that is ill-suited to these changing needs and of a fast growing private sector. This article summarises some of the analysis and recommendations from the report.

Changing dental needs and demand

Standards of oral health in the UK have improved dramatically over the last thirty years. People are keeping their natural teeth longer and are less prone to dental disease. In 1968, 37% of adults in England and Wales had no natural teeth. By the time of the 1998 UK Adult Dental Health Survey, this proportion had fallen to only 13%. Among the dentate population (i.e. those with some natural teeth), the average number of sound and untreated teeth has increased from 13 in 1978 to 15.7 in 1998.

For many people, dental health needs are now fully met and they have moved on to express what is more accurately called dental demand in the form of cosmetic treatments such as tooth whitening, veneering and gum contouring.

Within this picture of overall improvement, however, there are still some causes for concern. Over half of all children between 6 and 10 years have some known form of dental decay. Dental health inequalities persist between different socio-economic classes. Increasing numbers of elderly people with special dental health needs are placing new demands on the dental service.

Organization and finance of NHS dental care

The dental care sector is a labour-intensive industry with a low degree of market concentration. The sector is dominated by small scale activity with around 24,000 general dental practitioners working as independent contractors to the National Health Service (NHS) in around 11,000 practices across the UK. These dentists traditionally been have paid through a fee-for-service system. This operates with a list of items (currently comprising over 300 separate treatments), with individual items priced in a way designed to yield a target income.

This payment system has been the subject of frequent criticism. From the dentist's point of view it has been described as a 'treadmill' necessitating high volumes of work in order to secure target income, and insufficient time to offer high-quality treatments. From the patient's point of view, it has been claimed that supplier-induced demand has led to excessive and unnecessary treatment. The Audit Commission drew attention to evidence of unnecessary orthodontic work, excessive fillings and the fitting of crowns and similar work that was more cosmetic than a dental health care need.[2] In addition, the fee-for-service system is poorly geared to the current need for preventive rather than restorative treatment.

Patients have experienced major growth in user charges in relation to NHS dental care. This is striking because, within the NHS generally, little use has been made of user charges - only about 2% of total NHS income is derived from user charges. In the dental sector, however, charges were first introduced in 1951 and, since 1971, have become quite substantial. Currently patients are required to pay 80% of the costs of examinations and treatments up to a maximum of £372 for one course of treatment. Exemptions for children under 18 years of age and certain other groups, for example, people receiving income support, means that not everyone pays. In total, patient charges meet about 30% of total costs.

The expanding private sector

The private market in dental care has expanded rapidly over the last 10 years (see Table). In 1990/91 it accounted for 15% of total expenditure. By 2000/01, this share had increased to 45%. The overwhelming majority of private dental treatment is paid directly by the patient on a fee-for-service basis to dentists in mixed practice who treat both NHS and private patients.

The way that the rapidly growing private dental sector operates has recently been the subject of criticism in an Office of Fair Trading (OFT) report.[3] The Office raised concerns about lack of consumer information in relation to price and the quality of private services and the consequent difficulty for consumers to make informed choices.

Reform of dental health care

The NHS dental sector is currently being reformed as part of the NHS plan. The intention is to bring dentistry within a more managed structure. Primary Care Trusts will commission services from general dental practitioners through local contracts drawn up according to national frameworks. While these reforms offer some scope for improved service coverage and quality, they do not really address the fundamental question of the changing public-private mix in dental care nor do they address the perverse incentives of the payments system.

VALUE OF GENERAL DENTAL PRACTICE IN THE UK (£MILLION)

	PUBLIC SECTOR GDS	PRIVATE SECTOR GDS	TOTAL MARKET GENERAL DENTAL PRACTICE	
	Total	Total	Spending by patients	Total
1990/91	1,174	206	635	1,381
1991/92	1,456	274	761	1,730
1992/93	1,497	316	788	1,813
1993/94	1,403	340	784	1,744
1994/95	1,466	388	850	1,855
1995/96	1,482	423	883	1,905
1996/97	1,503	533	993	2,036
1997/98	1,538	775	1,244	2,313
1998/99	1,637	990	1,497	2,637
1999/00	1,686	1,197	1,718	2,883
2000/01	1,761	1,440	1,987	3,201

Source: Robinson R, Patel D, Pennycate R, 2004[1]

The dental health of the population has improved dramatically over recent years. A rapidly growing proportion of the population is now financing dental care privately. For many people it is now a life-style, consumer-good. This is a trend observable in many other European countries where dental care is largely outside the publicly funded bundle of health care services. Moreover, on a theoretical level, some economists have questioned whether dental care has the special characteristics of health care generally that make public finance necessary on efficiency grounds.[4] These considerations give rise to the question: why cannot dental care be left to the private market? Do we really need government involvement any more?

There is a strong case for arguing that there are many areas of dental care that can quite legitimately be left to a private market where individual patients are free to buy services of their choosing from independent practitioners, and where prices are set through the normal interaction of demand and supply. At the same time though, there is an important role for government in improving the efficiency of the sector and in making sure that equity objectives are not neglected.

As long as the NHS enters contractual arrangements with independent dental practitioners, there will be a case for it using its monopsony power to negotiate prices. However, the current fee scale has not been fully examined since 1998 and clearly needs review both in terms of the level of fees and its unnecessary complexity. Moreover, with the growth of private practice, many dentists are now charging two sets of prices – NHS prices and higher private prices. This has clear incentive effects in terms of the mix of NHS and private work. Private work is both more remunerative and offers dentists more time to practice their clinical skills. Government needs to recognize these competing demands in setting NHS fee levels, particularly as, in contrast to medical practice, large scale exit from NHS work is already a reality in the dental sector.

As far as patient charges are concerned, approximately 70% of NHS patients are currently liable to charges and pay 80% of the cost of treatment up to a maximum of £372. The government therefore provides a price subsidy equal to about 20% of their bill. This arrangement is clearly arbitrary – a leftover from a forty year period in which patient charges for dental care have risen steadily. There is no particular logic in an 80% charge. As such, there is a case to move towards a system of full-cost charging for the non-exempt population with more closely targeted subsidies for a wider set of exempt groups. (In passing, it is relevant to note that as long as NHS prices are below private sector charges, the non-exempt group will still be receiving an element of price subsidy).

Driffield and West[5] have estimated that the withdrawal of the 20% subsidy would save about £153.7 million per year in public money, if consultation rates remain unchanged. However, as 70% of adult claims are for treatments costing less than £25, for most people, little financial hardship is likely to ensue. Additional public sector savings would accrue through reductions in administrative costs associated with processing subsidy claims and if consultation rates fell through, for example, less frequent check-ups, scaling and polishing.

Future exemptions could be closely linked to the aim of ensuring access to care for deprived and vulnerable groups, and those with special needs. For example, large numbers of elderly people have special dental needs – in relation to decay and gum disease – but receive no financial assistance. In contrast to prescription charges, there is no general exemption for adults over 60 years of age, and 82% of this age group receive no assistance with the costs of dental care. Cost deters many elderly people from receiving necessary care and, as a consequence, their general health suffers as well as dental health.

On the subject of paying NHS dentists, there is a need to shift from a primarily curative service towards one based on a greater element of prevention. This sug-

gests a move from fee-for-service towards capitation. This would break the link between income and throughput. This proposal is hardly new. Oliver[6] argued that this policy could be adopted through the allocation of needs-based capitated budgets to general dental practitioners and points out that this is similar to the approach being adopted in relation to primary medical care services. Sheiham and Batchelor[7] adopt a similar line of argument, but suggest a mixed payment system – a capitation element to cover high volume items, such as examinations and simple restorations, and a fee-for-service payment system for low volume, high cost items.

A mixed payment system involving capitation and fee-for-service is likely to be the way forward. Capitation has a number of advantages but the growth of private practice – paid on a fee-for-service basis – cannot be ignored. The NHS must be in a position to offer some comparable incentives.

The rapid growth of the private sector has posed special problems of market adjustment. As mentioned already, the OFT has examined the sector and argued that its rapid growth from a small market, over a short space of time, has meant that consumer needs are not well met. More effective regulation is required in terms of, inter alia, price transparency and freedom of market entry.

Private patients should be informed about services that are available through the NHS and those that are available privately; have access to prominent displays of indicative prices for the range of relevant services; and receive itemised costings in written treatments plans.

On restrictions of trade, the OFT recommended that certain professions complementary to dentistry (for example, dental hygienists and dental therapists) should be able to provide services directly to consumers rather than simply through general dental practices as at present. The UK presently has a smaller proportion of dental hygienists and dental therapists, per dentist, compared with many other European countries.[5] Liberalization could lead to changes in skill mix, more consumer choice and wider access.

Better consumer information and reductions in barriers to entry should improve market efficiency. Effective regulation will, however, require appropriate mechanisms to be put in place in order to monitor market behaviour and address failings when they occur. At a time when the new Commission for Health Care Audit and Inspection is about to get underway – with a remit to cover both public and private sectors – there is a case for investigating the scope for either it, or a comparable body, carrying out a similar function in relation to the dental sector.

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Generic substitution savings in Finland

In November 2003, Kela, the Social Insurance Institution of Finland, reported that generic substitution and drug price reductions brought about through price competition, generated €39.7 million in savings in the first six months since generic substitution was introduced on 1 April 2003.[1] The patients' share of these savings was €17.5 million and €22.2 million was saved in drug reimbursement payments by the social health insurance system. This saving represented approximately 5% of the total cost of all reimbursed medicines.

One year on since the introduction of the new law on generic substitution, such savings have continued. In the period between October 2003 and March 2004, Kela reports further combined savings of approximately €48.6 million.

Whilst the total cost of reimbursed medicines fluctuated slightly throughout the first year of generic substitution, the total savings made by patients and social insurance has grown incrementally from €17.7 million in the first quarter (April–June 2003) to €24.8 million in January–March 2004 (see Table).

Under the Finnish generic substitution procedure the prescribed medicinal product is substituted in a pharmacy by the cheapest, or close to the cheapest, generic alternative. Both the prescribing physician and the purchasing individual can over-ride the substitution and under the Health Insurance Act, the reimbursement payment is based on the price of the dispensed product. Moreover, the list of substitutable medicinal products is provided by the National Agency for Medicines (www.nam.fi). Only products

that contain the same active substance in the same amount and pharmaceutical form, and which are biologically equivalent, may be substitutable.[2]

The first six months of the new scheme's operation have provided valuable information on the uptake of generic substitution amongst both physicians and patients. Although physicians may forbid the exchange of a prescribed product on medical or therapeutic grounds, between April and September 2003, only 0.4% of substitutable prescriptions were not allowed by physicians. Purchasing patients declined the substitution in nearly 11% of such prescriptions. In all, during the initial six month period approximately 14% of all eligible prescriptions generated substitution. These substitutable products accounted for 45% of all reimbursed prescriptions and 35% of the total cost of all reimbursed medicines. It should be borne in mind that this figure takes into account prescriptions that did not generate a substitution because the physician had already prescribed the cheapest, or closest to cheapest generic alternative. This trend has been sustained throughout the first year, with 12.6% of total prescriptions generating a substitution and consequent savings. Moreover, over this period 73.9% of all prescriptions were already for the cheapest (or closest cheapest) generic alternative.

The government's aim, when it introduced generic substitution, was to promote cost effective drug therapies and to promote competition between pharmaceutical companies through the substitution of cheaper alternatives. To track the progress and impact of generic substitution Kela maintains a Prescription Register which is updated monthly with data on substitutions and the savings made. These updates are available from www.kela.fi/research

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GENERIC SUBSTITUTION IN FINLAND, APRIL 2003 – MARCH 2004

	April–June 2003	July–September 2003	October–December 2003	January–March 2004	April 2003–March 2004
All reimbursed medicines					
Number of prescriptions (million)	7.0	6.6	7.2	6.8	27.5
Total cost (€million)*	344.4	336.3	377.1	350.7	1,408.
Cost to social insurance – reimbursements (€million)	204.6	202.2	224.6	210.8	842.5
Savings generated through substitution only (€million)					
For patients	3.0	2.8	3.3	3.7	12.7
For drug reimbursement payments	3.5	3.5	4.3	4.8	16.0
Total	6.5	6.2	7.6	8.5	28.8
Savings generated through substitution and drug price reductions (€million)					
For patients	7.8	9.7	10.6	11.1	39.2
For drug reimbursement payments	9.9	12.3	13.2	13.6	49.1
Total	17.7	22.0	23.8	24.8	88.3

* Medicine sales through pharmacies which generated reimbursement payments

Source: Kela www.kela.fi/research

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NEWS

Denmark: drug prices

Commercial drug prices are continuing to decline in Denmark, as the nation's pharmaceutical industry upholds a strict price agreement entered into with the Ministry of Health.

According to the Danish Medicines Agency's latest half-year price report, drug prices showed "a declining tendency" throughout the second half of 2003. The general price index, calculated on daily defined dosages (DDD), fell 1% from July to December 2003. For state-subsidized prescription medicines, the decline in DDD topped 1.5%.

"Essentially, the price report shows that prices are continuing to decline as a result of intensive competition in the drug market. And that's due not least of all to the fact that many medicines are facing patent expiration," said Jan Hylleberg, information director of the Danish Medicines Agency. Patent expiration on individual drugs typically leads to the introduction of cheaper, generic versions on the market, and these generic varieties can lead to massive price drops of 60–70%.

Since 1995 (price index 100), drug prices in total have fallen about 20%. For state-subsidized prescription medications, the drop since 1995 has been even greater, with prices falling 25%. A standing price agreement between the Danish drug industry and the Ministry of Health has kept prices on the domestic market at or under the EU's average price. The agreement was extended last year, and will remain in place to July 2005.

Interior Minister, Lars Loekke Rasmusen, is required to report every six months on drug price developments to Parliament's Health Committee. In a written statement to the committee, the minister stated that "the national drug industry association's member companies have upheld their price guarantee." As part of its price survey, the Danish Medicines Agency analysed 2,332 packaged drugs, and concluded that 1,680 of these labels (72%) had posted price drops of up to 10%. 403 other drug labels (17%) saw price declines of up to 20%. Despite falling drug prices, public sector expenditures for prescription drug subsidies have continued to skyrocket, due to rising drug consumption as a result of demographic developments, and the introduction of new drugs on the market. The Danish health care sector's drug costs rose in 2003 to DKK 4.9 billion, up 5.7% from the previous year.

The Netherlands: medical heroin

Municipal authorities are to be allowed to increase the number of places for treatment with 'medical heroin' from the current 300 to 1,000. These places will be spread over 15 treatment units in eleven regions. The government took this decision in response to a proposal by health minister Hans Hoogervorst, justice minister Piet Hein Donner and minister for government reform Thom de Graaf. Medical treatment with heroin does not involve the free distribution of drugs.

Sweden: rare diseases database

The Swedish government has commissioned the Swedish National Board of Health and Welfare to develop a knowledge database on rare diseases. The concept of 'rare diseases' is defined as: "Disorders or injuries resulting in extensive handicaps and affecting no more than 100 individuals in one million inhabitants". The ambition of the database is to provide up-to-date information on rare diseases and on the support and services these groups of people require. To date, 182 rare diseases have been described (in Swedish), and additional diagnoses are being drawn up. The descriptions are published as internet documents in full text, printed documents in full text and pamphlets with summaries. The full texts of the internet documents are being translated into English to enable people in Sweden and elsewhere who do not read Swedish to access the information from this database. The diagnoses that have been translated are searchable at www.sos.se/smkh/indexe.htm.

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