

# **REFGOV**

***Reflexive Governance in the Public Interest***

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**Healthcare Expenditure Control**

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## I. Introduction

### A. Healthcare expenditure control and NHS governance

For the last decade healthcare<sup>1</sup> expenditure control has risen on the domestic policy agenda. Since “Juppé’s” (name of the prime minister) reform in 1996, measures have been taken to make up the social security budget deficit, by focusing on the healthcare expenditure. Gradually a new lexicon appeared to describe this policy purpose: “healthcare governance”<sup>2</sup>. From then NHS has been subjected to “good governance” and numerous questions and laws are reassessed and reassigned. Does this amount to a paradigm-to-be?

### B. Questioning governance

What is implied in references to “governance”? Multiple use of this concept makes its meaning obscure. Should such a lexicon which embraces such different areas as policy, multinational company and NGO’s, be taken seriously? From a project of market regulation to questioning public intervention- judged to be too hierarchical - or to renew democratic structures there are various use of the term “governance”. Sometimes it seems purely rhetorical. This only leads to confusion.

The governance’s lexicon, always in extension, is used to describe public intervention and its improvement. It is used among older words such as regulation, deregulation, liberalization... The rhetorical use of “good governance”, in its modern attire, ill-concealed a politic weakening and public regulation decline.

Is this sceptical reasoning acceptable? To answer this question, we must test governance concept use in the policy and juridical discourses. Healthcare expenditure is the best field to accomplish such a test. What’s the meaning of governance in this field? What are the consequences of the public intervention? What does it imply on mankind government?

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1 In the sense of social security’s obligatory system. Thus, all health expenditure is not included. We only focus on reimbursement by the social security obligatory system. Many expenses in the health field are not covered by the latter system. They are evidently not accounted for in the social security deficit, but they remain a blind spot for the control of the healthcare expenditure.

2 The healthcare system is composed of patient and outpatient care on the one hand, and hospital care on the other hand. The use of the term “system” should be treated with care. Firstly the compliance between those two fields remains difficult, despite all the concerns about this question. This compliance do not preexist the healthcare expenditure policies and still remain one of its main challenging question. Secondly, care should be understood as the “panier de soin”, which is social benefit reimbursed by the social security’s obligatory system

Taking seriously the governance concept within the healthcare system invites a focus on healthcare expenditure control policy discourses. How does this new concept reflect on this particular design- controlling healthcare expenditure? Has it changed the form and the role of public intervention? This report aims to disclose conceptions, presupposition, “unthought of” issues on which is built healthcare expenditure control.

This analytical perspective assumes to stress out pre-conception within governance concept. This report aims to describe public intervention goals, not in the sense of describing what is actually done through it, but which conception underlies healthcare governance (how public intervention is conceived and thought out). It addresses a thoughtful political scheme through the policy agenda itself and a sketch of its changing environment. Such descriptions do not prejudge exactness or accuracy of representations at stage.

In doing so, reference to “governance” implies a specific conception of healthcare expenditure. The hypothesis is that healthcare governance is confined to healthcare’s actors’ coordination, which becomes at the same time the mean and the purpose of public intervention. In other words, even though healthcare expenditure control is expressed through objectives, it is actually a governance policy oriented on “how to do” issues. It does not target any more expenses that should be erased or diminished but gives the actors legal means to rationalize their own action, thanks to coordination. This concern needs a new evaluation scheme turn to “efficiency/efficiency”. It is a particular way to measure the realization of a normative program. It is neither an approach turn to “effectiveness/effectivité”, in the sense of conformation to a compulsory model, nor “efficaciousness/efficacité”, meaning evaluation of an achieved goal. “Efficiency” became the sole approach to coordination evaluation and correction. If actors act in an “efficiency/efficiente” way healthcare expenditure would be better controlled. This “efficiency” approach is to adapt means to the ends. Such approach is a common point of reforms accomplished in the two main healthcare fields: “independent medical practitioners” sector and hospitals.

To study healthcare expenditure control as governance policy requires searching for specific coordination’s evaluation and to depict how are elaborate tools to measure the scheme’s “efficiency”.

The report found three different types of “efficiency” measurements which correspond with three French healthcare governance fields: one is global, the social security financing law (LFSS)<sup>3</sup> (§2); one is restricted to “independent medical practitioners sector” sector (§3) and the last one concerned price fixing in the hospitals’ sector (§4).

Through these three studies, this report aims to show various ways to assess healthcare system “efficiency”. It will also describe expectations of the system’s adaptation implied by the “efficiency” approach. In doing so it becomes obvious that healthcare expenditure control is not neutral towards health issues.

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3 Loi de financement de la sécurité sociale

## II. LFSS: Parliament's "efficiency" control on healthcare system

Healthcare expenditure control has social security financing law as a key instrument, but totally new for the French system (A). This instrument is based on a specific evaluation of healthcare system targets "efficiency" of healthcare expenditure (B).

### A. Genesis

The healthcare expenditure control policy started with "Juppé's" 1996 reform. Later reforms were just add-ons and deepening of this reform.

This reform deeply modified healthcare expenditure management and more broadly the whole system. To appreciate such a change we should, in the first place, look at the main character of the French healthcare system. Non-French readers must first of all understand that such reforms are not state control withdrawal, unlike other national experiences to confront the social accountancy deficit. Social protection in France is considered as a public service, which is not State organised. Its financing is based on workers' and employers' contributions and not on taxes or insurance. Furthermore, social welfare management is not given to public authorities or private insurance. It is run by unions and employers' organizations, players of social democracy. It is in such an environment that healthcare expenditure control has been developed. Paradoxically, budget savings are conveyed in more State interventions within healthcare system.

### 1. Premises of healthcare expenditure control

The focus on social welfare expenditure is not new. But it only recently became a policy *per se*, transforming social security and NHS management. For a long time, the primary objective was to extend social welfare benefit to the whole French population. In the first place only workers could benefit from it, as they were contributors. But it came up against divisions of healthcare system and financing which mainly comes from workers' contributions. But this objective recently was achieved thanks to a broader understanding of workers and eligible parties and the creation of the "CMU" program.

It is only in the 90's that the social security budget deficit became a primary political concern. Current policies, focused on social security accounts, rely on two different concerns: the deficit itself and lack of parliamentary control on social welfare management.

#### ***a) Inadequate circumstantial measures against Social security deficit***

Evidently crises, since the 70's, do have consequences on social security finances. Unemployment implies on one hand a lack of contributions and on the other hand benefits expenditure. In order to face those difficulties various reforms have been set up: Veil's plan in 1978,

Barrot's plan in 1979... At least fifteen have been set up since the 90's.

In 1994 a decisive and critical report was produced which announced "Juppe's" reform. It concluded all attempts to stop the deficit increase had failed. It was the first step toward an expenditure control policy.

Concerning hospitals, a mechanism called the "global grant" (overall endowment), set up in 1984, allowed some control of costs. But for the other areas in healthcare it was said regulation was not satisfactory. Concerning outpatient care the use of collective bargaining and statutory fixing of prices were dropped because of their pernicious effects<sup>4</sup>. Until the 90's, only a few mechanisms, such as opposable medical references<sup>5</sup> ("RMO"), appeared to be a medical control of healthcare expenditure. On the whole, controlling the prices and new sources of financing were the main means used to limit the social security deficit<sup>6</sup>. Those two solutions were to be challenged by healthcare expenditure control. The 1994's report proposed a new way to approach the social security's deficit. Now public intervention focuses on the improvement of healthcare coordination's "efficiency".

### ***b)The model of<sup>7</sup>"social paritisme democracy" in question***

The necessity of parliamentary control has been a growing concern. Critics have been levelled against unions' and employers' organisations legitimacy and efficiency managing social security. Originally management given to those organisations was justified by the workers' and employers' contributions financing the social welfare. But such legitimacy has been weakened by extensions to non-workers and financing by taxes. This legitimacy was further questioned as it was seen as granting power to the executive arm. Indeed the government controlled the budget of social security institutions and schemes. Beyond outward appearances, the responsibility of fixing the financial balance has never been on unions' and employers' organisations' leaders<sup>8</sup>. In fact the 1945 laws only gave unions' and employers' organisations responsibility for administrative management of social security institutions.

The executive power pre-eminence comes directly from constitutional principles of the fifth Republic. The state has the responsibility to fix the financial balance, and thanks to constitutional distribution of power it lies with the head of the government. Indeed, by article 34 of the 1958 Constitution, Parliament has only power to fix "fundamental principles of social welfare"<sup>9</sup>. Thus regarding financing social security, parliament does not have the same power as it does in tax issues.

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4 See *Livre blanc sur le système de santé et d'assurance maladie*, La documentation française, 1994

5 "Opposable" should be understood in the legal sense: it can be used against doctors.

6 Ibid

7 « démocratie sociale »

8 See R. Pellet, *Les finances sociales : économie, droit et politique*, LGDJ, 2001, p. 111 et ss.

9 The constitutional court (conseil constitutionnel; DCC n°60-10 Loi du 20 décembre 1960, Rec. p. 39 et DCC n° 84-136 L du 28 février 1984, Rec. p. 111) and the administration supreme court « Council of State » (CE 26 octobre 1990, Union des sociétés d'assurance du secteur privé et a., Rec. p. 293) decided fixing contributions rates belongs to the executive power.

Parliament, unlike tax issues, does not have to be annually consulted about the main social security income. It only has the exclusive power to create new contributions but not to fix its level<sup>10</sup>. Parliament secondary role contrasts with sizeable French social welfare's budget<sup>11</sup>. Social welfare extension, beyond workers' world, and the growing appeal to taxes could only undermine social democracy, which has already been subjected to academic criticisms<sup>12</sup>. So there have been numerous attempts to set up a parliamentary control<sup>13</sup>. Gradually, but not without obstacles<sup>14</sup>, Parliament's inquiry about social budget has been established. However, a true parliamentary control clashes with constitutional rules<sup>15</sup>. Only a constitutional reform could establish a parliamentary control on the social security's budget, this, "Juppé's" reform, has done.

## **2. Healthcare expenditure control as healthcare coordination policy**

The 22 February 1996 constitutional reform set up real parliamentary control on the social budget. This constitutional law modified constitution article 34, which frames legislative power. It establishes that "the LFSS fix general requirements for financial equilibrium, and considering the collection forecast, determines expenditure objectives and conditions stated by law". Parliamentary control through the LFSS<sup>16</sup> represents a new normative tool.

In fact, besides redistribution between political and social democracy and redistribution between the legislative and executive powers, the 1996 reform changed radically the nature of government of the "healthcare system". It is oriented to expenditure control and not only fighting back the deficit.

Healthcare expenditure control is based on a new diagnosis of the healthcare budget deficit. Its primary aim is players' coordination, which is under parliamentary control through the creation of the LFSS.

The 1996 reform, setting up the healthcare system, not only allowed parliamentary control, but it combined this control with the social budget deficit issue. Inherently the reform changed

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10 Parliament has exclusive power to "create new contributions, fixing its basis (CE 10 juillet 1966, URSSAF de la Haute-Garonne, Rec. p. 275) and collection principles and to set who's subjected to contribution and its distribution between workers and employers, and to impose contribution solely on the employer's head", See DCC 60-10 L du 20 décembre 1960, Rec. p. 39. The constitutional court also uphold legislator's exclusive power to grant total or partial contributions' exemption, see DCC 70-66 L du 17 décembre 1970 et 97-388 du 20 mars 1997)

11 R. Pellet, *Les finances sociales : économie, droit et politique*, préc

12 Critical approach of unions' and employers' organizations management, see

13 For a description of those attempts see X. Roques, *Le Parlement et le contrôle des finances de la Sécurité sociale*, Dr. Soc. 1996, p. 290

14 Concerning this question

15 See XXX's private bill. The constitutional court decided (n° 87-234 DC du 7 janvier 1988) parliament could not pass a law authorizing its own control on social projected budget. It would have been against constitution's article 34, which limits legislative's intervention in social welfare to defining "fundamental principles".

16 Those laws apply not only to healthcare, but to all social welfare spectrums (family, retirement, maternity and industrial accident). However LFSS's specificity is found only in the healthcare field.

conceptions on coordinating social welfare (undertaking to reimburse medical expenses) and the healthcare system (giving the care).

Until the 1996 reform, public intervention was based on tensions between accountancy control and medical expenditure control<sup>17</sup>. Now control on finances and on NHS is combined. Through this new approach fixing the price of medical interventions is not sufficient. And increasing of financial resources, universally depicted as inevitable, are continuously expostulated as untenable to and unsustainable. In this case the answer to social security deficit could lie in improvements of healthcare efficiency.

Indeed LFSS management's conception is best designed for this field. But the nature of this management is hard to characterize.

NHS "efficiency" improvement needs to cast out budget deficit. Thus controlling expenses has to direct the NHS itself. Since, the 1996 reform has developed in parallel a new concern - governance<sup>18</sup> - and a new area to accommodate this concern – the healthcare system.

Public intervention has been reassigned. It modified Social security budget and NHS management. The link between financing and care, originally autonomous, is the key instrument in healthcare expenditure control. To limit the rise the price of medical intervention is not solely an objective matter. It is also aimed to reduce medical interventions without quality loss. Henceforth financing and NHS intervention would form a new ensemble, the healthcare system.

How can NHS "efficiency" and thus expenditure control be improved? Public intervention then revolves on players' coordination, making them conscious of expenses. The improvement of coordination is channeled through LFSS. In this way the evaluation is oriented to healthcare system "efficiency".

## **B. Creating efficiency assessment for the healthcare system**

### **1. Parliament's assessment on the healthcare system expenditure**

After the constitutional reform, LFSS definition was formulated by law. It enables the legislator to express his view on "general conditions for social security budget equilibrium". The LFSS plans incomes for each social security scheme and fixes expenditure objectives for each of them.

This mechanism has been reinforced through a law enacted on 2<sup>nd</sup> August 2005. The first LFSS allowed parliamentary control, but the extent of this seemed to be limited. It was not always intelligible. And criticisms could be made of their real intentions, despite the constitutional court's

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17 In the first place, those two elements were treated apart, due to social welfare structures, see

18 The term « governance » did not appear straight away, but its purpose was already there in 1996. See healthcare governance report in 2004 which acknowledge "governance" designation.

control<sup>19</sup>. The 2005 reform was brought in to strengthen parliamentary control.

The LFSS' primary objective is to set a true parliamentary control on social security budget balance. Proper parliamentary information enables good legislative control. Before 2005 obstacles came from yearly control. So the LFSS time framework was modified. Now LFSS is divided into four parts<sup>20</sup>, following this chronology: the first concerns the previous year; the second concerns the current year; the third is about income and the budget's general balance for the year to come; the last part concerns the expenditure for the year to come.

Thus Parliament has to *approve* last year social security "accounts"<sup>21</sup>. For the current year the law *rectifies* the income forecast, tables and expenditure objectives. For the year to come, the parliament approves the report on social budget balance joined with the statute. This report depicts the incomes and expenditure for the four years to come<sup>22</sup>. It fixes expenditure forecast especially a national healthcare expenditure objective, hereafter ONDAM<sup>23</sup>.

Social security financing law is a social security instrument panel. It tries to be a real management tool for healthcare expenditure control.

## **2. LFSS as an "efficiency" assessment instrument of healthcare system coordination**

What is the form of such a management? At first sight, one can doubt its mandatory nature. LFSS is composed of various measures. Essentially it fixes a national healthcare expenditure objective, called ONDAM. A maximum expenditure level for healthcare, as a whole, is imposed by law. It is neither an authorisation given for expenses nor an objective to achieve. It has a different purpose: it is a benchmark for the sectors' coordination. LFSS is surprising as its mandatory nature relies not on stipulation but on description.

### ***a) LFSS's "soft law" nature***

#### **(1) No expenditure authorisation,...**

Unlike tax law LFSS does not grant power to authorize expenses. This is a fundamental difference. But on the other hand some similarities appear such as yearly based incomes and expenditure and it has the same form. And LFSS follows the same procedure through parliament as tax laws. Social security financing law can only be proposed by the government. Since the 2005

19 Concerning constitutional intelligible and genuine expectations standards, see

20 See LO 11-3-1 CSS.

21 The law does not refer to "account" but to tables, as it is not a true accountancy, because of different autonomous institutions concerned by it.

22 See LO 111-4, I CSS

23 « objectif national de dépenses pour l'assurance maladie ».

reform it follows very similar steps as tax law: first examination by the national assembly, vote limited by delays, if not conforming the law passes through a delegate legislation procedure... Delays insure coordination between social budget discussions with those for tax law.

Although, social security law has got the same structure as tax law, it has two parts. The first is composed of provisions correcting previous provisions for the current year and provisions for next year, setting the financing balance, accountancy authorization and tables. The second part is composed of objective expenses and ONDAM.

LFSS has to meet the same constitutional, intelligible and genuine expectations standards as tax laws'. But their mandatory nature is different. Tax laws grant power to collect taxes, whereas LFSS has an indicative nature. Parliament can only set forecasts, which may be exceeded. This is due to the autonomous French social protection system. It is not in Parliament's power to authorize the collection of contributions. In fact, Parliament cannot be granted such power, because it would be contrary to Constitution<sup>24</sup>. It would break the connection between one's contributions and one's right to social benefits<sup>25</sup>. Parliament can only set income forecasts. In reality, it would be difficult to set limits on ONDAM's expenditure, as they must cover people's health expenses.

The command and control model does not apply to LFSS. It does not intend to impose conducts<sup>26</sup>. It is not turned to an "effectivité" evaluation, understood as players' conformation to a compulsory model.

## (2) No a teleological program

ONDAM is only indicative and not limitative<sup>27</sup>. Who is bound to legislator's tables' approval, its income's forecast corrections and its financial balance's settings? LFSS is more likely an indicative description of forecasts and declarations than a mandatory tool.

But article LO 111-3 CSS provides that LFSS *determines* ONDAM. This suggests LFSS is an outcome plan, like those statutes mentioned in the constitution whose role is to "set State's objectives in social and economical area". Such an approach would make ONDAM a program-law which is composed of objectives and the means to reach them.

Thus LFSS's mandatory nature would rely on setting expenditure objectives. Primarily it fixes

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24 R. Pellet, op. cit., p. 147

25 Decision n° 93-325, DC du 13 août 1993, Rec., p. 224

26 Of course some provisions are mandatory. However, the nature of the provisions within LFSS is strictly controlled by the constitutional court. This court prohibits what is called "social cavalryman". They are to be linked with social welfare financing. Only measures concerning income, expenditure and social budget accountancy could be put in such laws. And management issues can be added if they have an impact on the financial balance. Moreover, LFSS can take measures to improve Parliament's information and control. Even though some provisions can in some extent be mandatory it is not in LFSS purpose. It is composed of various normative provisions.

27 However LFSS is somehow binding for the legislative power. The constitutional court can oppose Parliament's social security financial balance's settings to later bills. Such a mechanism should be applied to the executive power.

ONDAM. A maximum expenditure level for healthcare, as a whole, is then imposed by law. ONDAM appears to be LFSS's strongest objective. Each of the three healthcare sectors (hospital sector, "independent medical practitioners sector" and health and social care) has its own objective fixed in the law. This mechanism was reinforced in 2005<sup>28</sup>. ONDAM sets the measures to be implemented but there is no sanction if they are not. Therefore doubts can be expressed about its mandatory effect. It is difficult to classify ONDAM by way of a legal analysis. Has it an indirect or postponed mandatory effect? Does it have random effects? Or is it a brand new legal mechanism?

These difficulties are reinforced by its objective-based vague nature. Above all, how are health needs taken into account in ONDAM assessments? It is the responsibility of the minister in charge of social security services to draft social security financing law. For the "independent medical practitioners sector" it is UNCAM's role to suggest financial development. But do such mechanisms take into account the healthcare system's needs? It is doubtful as every year financial objectives are exceeded. Then criticisms are addressed to the genuineness of such mechanism. ONDAM's conception appears to be delicate, ignoring its relevance.

It is striking that within LFSS no means are expressly oriented to achieve their goals. This explains the small part taken by real mandatory provisions. On the whole, LFSS is composed of objectives' definition and their assessments for the past year. Except for some minor management measures, LFSS does not contain any other provisions. Hence it cannot be taken as a program-law. Particularly, the means necessary for its implementation are not established in LFSS. They are established elsewhere.

Actually, ONDAM's mandatory nature should not be sought in sanctions taken against expenses' excess but through its implementation's tools. But coordination between those tools and the objective is peculiar. It appears that the tools are not made for the objective's achievement. There is no hierarchical relation, yet implementation presupposes one. Whatever connections between ONDAM and those legal mechanisms, LFSS cannot be taken for an outcome program-law. This connection does not fit an objective/means model, implying a hierarchy. In fact, some healthcare system principles will not allow such model's enforcement. Firstly, social democracy supposes an autonomous management of social security offices forbidding a direct hierarchical command on them<sup>29</sup>. Secondly, a doctor's private practice and the patient's freedom to choose his or her doctor are both constitutional rights. Obviously expenditure control policies have to respect those rights. Those rights are not to be challenged.

LFSS mandatory nature relies on description. Giving an elaborate inventory to players should enable expenditure control.

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28 But it is the government role to fix sub-objectives. Since 2005, those cannot be less than five. For instance in 2007's LFSS seven sub-objectives was fixed for the "independent medical practitioners sector" sector.

29 About the 1996 reform impact on social security schemes management, see

## ***b) LFSS and healthcare system's « efficiency » evaluation***

As ONDAM's realization is not sanctioned LFSS describes how it should be implemented. Such description takes into account healthcare expenditure evaluation towards objectives set into ONDAM. LFSS sets a legitimate scheme of healthcare system combined with financial constraint.

Firstly they are based on an inventory, which can be either retrospective or forward looking. Some provisions set healthcare system evolution, such as forecasting incomes for the current year or the year to come. As these measures cannot be set up in advance with any degree of certainty, they are based on expectations<sup>30</sup>.

This construction shows a hierarchical approach controlling healthcare's expenditure. And ONDAM has the appearance of a compulsory plan. This impression is reinforced since its monitoring in LFSS's appendix. This latter document fixes ONDAM's process and assessment, from the sub-objectives description, analysis of its development regarding public health's needs. It also describes healthcare expenditure at a national level and shows how it has been taken in charge. It can repeat alerts given by independent authorities<sup>31</sup>. In a nutshell this document describes ONDAM's realization. It describes all the measures taken in order to apply the ONDAM.

More than a simple inventory they can be seen as Parliament's yearly policies monitoring within LFSS. Thus it shows a determined public intervention to control healthcare expenditure. Those characteristics can be pinpointed through tables of last year's balance, incomes taken for provision for depreciation or paying off. This assessment approach is reinforced by numerous report put in the appendix. Since 2005 some of them show quality and "efficiency" plans for both income and expenditure for each social welfare sector. Especially in the health system some of them monitor institutions in charge of accounts. For instance reports are produced showing social security improvements (through management's collective bargaining) in ONDAM's enforcement. More research is made to establish some policies' impact, such as contributions' exemption or cuts, on the social security budget. Those reports are to describe new measures taken or to be taken and assess their financial impact, knowing that such exonerations and cuts are to be compensated by the State - as those policies should be neutral for the social welfare budget. All those reports are to describe how ONDAM is implemented. They are built on two key elements: firstly a yearly expenditure objective, divided into sub-objectives for the three sectors, and secondly assessment of those objectives' implementation. Such a procedure gives a semblance of conforming to LFSS's objectives. But is it true? As such provisions are not sanctioned and do not address directly their implementation this means such a statute has a peculiar status. It is through world's representation given in the statute and reports that LFSS aspires to influence the world.

LFSS's "efficacité" relies on players' incitement and sense of responsibility. In this sense the players' must be conscious of financial constraint. Thus healthcare expenditure control implies new

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30 LO 111-3, I, C, 2°, b CSS

31 L'article LO 111-4, III, 7 CSS

players' coordination. This coordination does not only revolve on players' expectations and interests' expression, but it is also means of them taking account of general interest issues such as expenditure control formalized in ONDAM.

What has such "efficiency" approach changed? How come coordination commits players to such a perspective? Such questions focused on giving priority to healthcare's coordination. More precisely how those priming measures prepare and incite players to commit themselves to the "efficiency" approach.

### **III. Healthcare expenditure control implementation and reflexive approach**

Actually LFSS mandatory nature should be sought on making healthcare players' responsible. Nevertheless achieving such a goal does not imply new coordination instruments. It simply reassigns former mechanism to "efficiency" approach. How is such adaptation made up? What have been obstacles to making up players accountable for Social security budget? This report aims to describe how an "efficiency" plan complying with general interest can be possible. "Juppé's" three 1996 statutes set up an institutional mechanism for ONDAM's implementation. They changed social security services' organization. They also modified medical control on expenditure in the "independent medical practitioners sector" sector, and hospital budget's schematics<sup>32</sup>. The 1996 reform did not only create a new management, it identified institutions involved in its implementation too. It required special attention to legal mechanisms' use for expenditure control. Thus LFSS enforcement relies on healthcare players' cooperation. Some mechanisms have been specially created for players' coordination, like "management and objectives bargaining" (COG). Some others existed before LFSS, but have been renewed since then. This suggests a new mandatory direction for those legal mechanisms. Both expenditure control means and players' coordination do not have the same form in the "independent medical practitioners sector" or in the hospital sector. Even though both sectors focus on "governance", that is to say coordination method and legally based decision making, they do have completely different legal instruments and players.

#### **A. "Independent medical practitioners sector"<sup>33</sup> expenditure control**

Healthcare expenditure control relies on an established mechanism: collective bargaining with medical practitioners association<sup>34</sup>. At first it was to determine doctor's fees between medical practitioners association and the social security. Now such collective bargaining aims to make doctors responsible in the sense of making them conscious of financial healthcare issues. Then it turned to numerous reforms such as quantitative expenditure control, to medical practice qualitative management. Often some experiments through collective bargaining are made locally before Parliament takes them up again. Such use of collective bargaining makes its purpose unclear. Maybe

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32 R. Pellet, *Les finances sociales : économie, droit et politique*, op. cit., spéc. p. 148

33 "Secteur des soins de villes"

34 "Syndicat de médecins"

collective bargaining transformation's aims to address successive reforms failures. It was used to remedy those failures. Collective bargaining with medical practitioners association changes provoked by healthcare expenditure control has three characters: implementation, tests and rendering "independent medical practitioners sector" players responsible.

Such a perspective makes those players conscious of both financial and qualitative "efficiency" constraint.

### **1. Expenditure control implemented by collective bargaining**

Collective bargaining with medical practitioners association began in 1928. It first became departmental in 1945, then national in 1971<sup>35</sup>. From the beginning it is seen as an instrument which complies with both doctors' private practice and public services requirements<sup>36</sup>. Thus national state health insurance office reimbursed patients for medical interventions on ground of collective agreement prices ground.

Collective bargaining with doctor's organization sets prices between the social security office and doctors' in private practice<sup>37</sup>. But each doctor is free to adhere to the collective agreement. If he does he has to apply prices set in the agreement.

Used at first to set medical fees, since the 1980's the collective agreement has become a tool for healthcare expenditure control. Gradually it aims to restrict healthcare expenses in the context of economic climate.

In this sector, collective bargaining's purpose became twofold: on the one hand to increase healthcare collective regulation and on the other hand to qualitatively change medical players individual practices. In the latter case organizations have to conceive good practice «good practices» and medical references opposable<sup>38</sup> ("RMO")<sup>39</sup>.

However successive public authorities' reports<sup>40</sup> reveal numerous failures in the use of collective bargaining in expenditure control. Each time it suggests rectifying whether agreements' matters<sup>41</sup> or bargain's conditions.

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35 See Statute n° 71-525, July 3rd 1971, has modified social security code (CSS) L. 257 and 259 up to 266 provisions.

36 Y. SAINT-JOURS, *Traité de sécurité sociale*, LGDJ 1984, p. 224 et s

37 See L. 162-5 CSS

38 "Opposable" should be understood in the legal sense: it can be used against doctors.

39 "Références médicales opposables"

40 See revenue Court yearly report and Claude EVIN's report, January 9th 2002.

41 Its area of application.

The aim pursued is to make doctors aware of their power to authorize social welfare expenses. Therefore Parliament asked them to create their own healthcare expenditure control. At first it was through collective bargaining. Then it turned to a greater individual medical practice management.

### ***a) Collective bargaining turned into a quantitative regulation instrument***

The first instrument used in collective agreement with medical practitioners association is “statistical practitioner’s activity scheme” (T.S.A.P.)<sup>42</sup>, also called “medical profile”. Such schemes are filed by state health insurance office for all practitioners. These “profile” counts all medical treatment done, its nature and its costs. Its “efficacité” should be achieved by sanctioning abnormal doctor behaviour revealed by schemes. Sanctions could be to strike off the register and loss of collective agreement’s advantages. Schemes were encoded and communicated to local medical comity with equal representation of “medical-advisers”, representing health insurance offices and doctors from signatories’ organisations.

In cases of abnormal behaviour, the comity could whether make recommendations or warnings and eventually communicate doctor’s profile in order for health insurance office taking sanction. This comity does not only work on those schemes it also focuses on health expenses evolution and medical consumption. Doing so enables it to national expenditure objectives: developing the comity can put forward an opinion to an economical commission. These commissions’ mission is to facilitate collective agreements with doctors’ organisations implementation in collaboration with local health insurance office and departmental doctors’ organisation. They can also suggest national expenditure objectives to signatories and follow up their achievement. Turning to medical practice individualization these schemes have been put aside in favour of new ones: individual activity and prescription statements.

The third collective agreement with doctors’ organisations signed in 1980 has been a new step in healthcare expenditure control in “independent medical practitioners sector” sector. This agreement provides for signatories fixing yearly expenditure objectives. This objective involves fees and prescriptions complying with the healthcare budget. In case of negative results, partners have to seek solution in better healthcare system use or in fees level. Equilibrium was supposed to result from prices cutback. But the most important innovation was the creation of two sectors: sector 1 for doctors who did not express any peculiar intention and thus were engaged to agreement’s prices and sector 2 for those who still belong to agreement’s system but were not bound to prices. As this system’s “efficacité” relies on doctor’s voluntary adherence it was inevitably weakened. In fact some practitioners (sector 2) could still be in the system without being bound to collective restrictions on expenditure through fees control.

Collective bargaining was reinforced after “Healthcare expenditure evolution bargain control

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42 See 1971 agreement.

protocol” signed October 25th 1991 between ministers and the national state health insurance office. This document sets bargaining between State and health insurance office on a yearly expenditure universal evolution rate regarding medical progress, population needs and demographic changes. It addresses working out an “effective” expenditure regulation instrument and medical intervention encoding. However such provisions have been put into health professionals and health insurance office hands. Collective bargaining with doctor’s organization should take on such responsibility.

Otherwise a “quid pro quo” agreement aims to elaborate incitement for expenditure control. Agreement amendment n°3, signed in April 10th 1992, creates “compensation” between fees increase and respect of year’s expenditure objective level<sup>43</sup>. Incitement was apparently reinforced by strict sanctions. This amendment set a procedure to fix a yearly objective on national and local level. Exceeding the levels was sanctioned by a doctor’s financial contribution when they did not comply with the objectives. Those sanctions could be suspension of health insurance office contributions to doctors’ social contributions in sector 1 or fees restitution in sector 2. But to come into force such a reform needed a legislative intervention. It was the occasion for a new step in expenditure control from a quantitative to a qualitative approach.

### ***b) Quantitative to qualitative objectives***

The January 4<sup>th</sup> 1993 statute grants collective bargaining to doctor’s organization new missions. Different measures are to be addressed by partners such as yearly objectives on fees and on general or specialized practitioners’ prescriptions, quality norms like medical references opposable (“RMO”) settlement to avoid void or dangerous practices, medical knowledge tool’s creation (medical intervention, prescription and disease encoding...). And signatories have to set up sanctions when objectives have not been fulfilled. Such sanctions could still be suspension of health insurance contributions to doctors’ social contributions in sector 1 or fees restitution in sector 2. All those measures were included in October 21th 1993 agreement.

In 1995 “Juppé’s” plan followed this path. The 1993 statute contains the seeds of ONDAM. At the beginning expenditure objective’s evolution were to be fixed yearly by Parliament and then declined for every healthcare’s professions. And each sub-objective should be set up through collective bargaining between those professions’ organizations and the health insurance office. In the case of a bargaining setback the government was entitled to fix this objective. Moreover signatories should set adjustment mechanisms when expenditure exceeded objectives.

Thus signatories have to take into consideration the national objective within the content of the collective agreements. These agreements are an implementing instrument for those national objectives. They should permit medical control on healthcare expenditure.

However this upward scheme did not come into being. From the plan to the reform itself,

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43 In 1992 the expenditure universal objective concerning fees and prescriptions was (+7,05%).

expenditure control was changed to make room for Parliamentary control. Therefore 1996 statutes greatly modified the collective bargaining purpose. Now collective agreements have to have regard for LFSS's principles. Those statutes were a starting point for a collective bargaining crisis. Numerous failures appeared like unsuccessful sanctions against expenditure excesses. This crisis ended up splitting the doctors' agreement in two: one for generalist practitioners and one for specialized practitioners both signed in March 12<sup>th</sup> 1997. Each convention implemented the 1996 statutes on a yearly basis amendment. This defines recommendations, professional's references and sanctions. They also set local adaptation mechanisms to the projected expenditure objective and "sanctions" if they are not honored.

The 1996 statutes grant collective bargaining standardization power on individual practice. It aims to give financial and qualitative healthcare system "efficacité". Signatories have to work out good practice «good practices» and medical references opposable ("RMO"). So they fix a normalized definition of responsible medical practice. But those "individualized" actions results are rather mitigated.

## **2. Collective bargaining with independent medical practitioners associations put to test: Failure of responsiveness of expenditure**

### ***a) Quantitative mechanism inefficiency***

The use of collective bargaining in price regulation and for quantitative objective definition has been questioned. While quantitative objectives in collective agreements become widespread great differences appeared in their settings and mandatory nature. Only the laboratory analysis agreement, signed in 1994, fixed mandatory objectives, but its adjustment mechanism has never been used<sup>44</sup>. In other sectors objectives varied from profession to another and only had an indicative quality.

Those failures pushed the 1996 statutes to adapt collective bargaining for expenditure control requirements. Collective agreements were rendering doctors responsible for fixing fees and prescriptions opposable objective. Collective bargaining was given two missions, yearly based: to fix fees and prescriptions opposable objective and to establish individualized doctors paying back when they exceeded objectives limits.

But such mechanism implying sanctioning doctors individually for collective excess encountered legal obstacles. Firstly, the Council of State<sup>45</sup> in a July 3rd 1998 decision invalidated the 1997 specialized doctor's agreement, as some doctors were not subjected to pay back measures<sup>46</sup>. Then the constitutional court in December 1998 invalidated one LFSS provision settling a collective

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44 Revenue court report, Les politiques conventionnelles entre les professionnels de santé et l'assurance maladie, September 2000.

45 French administrative supreme court.

46 Considering their practice localization.

regulation instrument. The court found that Parliament couldn't make all registering doctors responsible, through general contribution, regardless of their individual behavior towards fees and prescriptions<sup>47</sup>. This decision forbids a collective responsibility based on doctors solidarity. Finally, the Council of State invalidated partially a November 1998 generalist doctor's agreement as individualization pay back criteria was not precise enough. Signatories just set "all doctors were subjected to contribution accordingly to law"<sup>48</sup>.

Individual sanctions are not easy to establish. It has to comply with disciplinary law and the European Convention on Human Rights (right to a fair trial, defender's rights, impartial tribunal, sentence necessity and the proportionality principle). Health insurance office intervention encounters legal obstacles as they detain both investigatory and judgment powers. Furthermore investigation power is barely organized authorizing judges to nullify health insurance office's decision on this sole ground<sup>49</sup>. Such nullified decisions have been numerous and forbids in the end to sanction doctors. Such legal obstacles coming from European Community and constitutional law has been pinpointed several times in public authorities' reports<sup>50</sup>. For example the Evin's report: "this exceptional overall legal constraint is harder to comply with as it falls within bargaining's scope, characterized by conflicts and antagonist interest"<sup>51</sup>.

In fact, there has never been doctor's collective commitment to the new tools. Often the most representative organization refused to sign collective agreements. Generally only minority organizations agreed to sign such agreements<sup>52</sup>. Thus Council of State invalidated both 1997 agreements and March 28th 1997 order approval as the solely specialized doctor's organization signatory was not representative<sup>53</sup>. The extension of collective bargaining to strict quantitative expenditure control failed causing deep disruption in collective relations. Collective agreement legal uncertainty led to a collective agreement system reform.

Hence LFSS 2000 reform<sup>54</sup> aims to elaborate mandatory quantitative objective for all medical professions. Regulation is no longer focused on pay back but on price readjustment and intervention valuation. Partners are also subject to a tight schedule. If no agreement is signed health insurance office can unilaterally take the necessary measures. Hence each expenditure excess entails a price fall proposal to the medical professional causing the excess. Signatories were to meet at least twice a year to examine expenditure level and fees evolution. And bargaining should start again whenever expenditure evolution was not compatible with ONDAM. However the government refused to follow the health insurance office suggestion to limit nurses' income surcharge for Sunday and night work.

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47 Conseil constitutionnel, Décision n°98-404 DC du 18 décembre 1998, Loi de financement de la sécurité sociale pour 1999 (1999 LFSS).

48 CE 14 avril 1999, SML et autres, Rec. p. 139.

49 CE 26 juin 1998 et CE 3 juillet 1998.

50 See Setember 2000 revenue court and Claude EVIN's reports.

51 EVIN's report, p. 13

52 CE 26 juin 1998, Confédération des syndicats médicaux et autres, Rec. p. 253

53 CE 26 juin 1998, Confédération des syndicats médicaux et autres, Rec. p. 253

54 See statute n° 99-1140 du 29 décembre 1999 de financement de la sécurité sociale pour 2000 (2000 LFSS).

Government encouraged setting up measures through collective bargaining.

Despite this reform collective bargaining did not gain the place expected. Health insurance offices did not find in the medical professions' organizations viable negotiators ready to commit themselves in Parliament's purpose. Revenue Court's 2000 report stated regulation through collective bargaining had not "proved its worth".

### ***b) Limits to qualitative regulations***

Signatories add to doctor's collective agreement content qualitative provisions focused on medical practice. «good practices» and RMO were originally developed through collective agreement under the 1993's statute. Later those instruments were extended to all medical professions. Since the 1996 statutes they belong to collective bargaining power. However collective partners should based those references and code on ANAES<sup>55</sup> documents. Such definition has not been easy: firstly collective partners did not really bargain on such instruments and whenever they have done so legal obstacles remained to impose such provision on practitioners. The Council of State in a 1999 decision invalidated sanctions to settle in accordance with RMO. For some medical professions RMO have never been agreed. For some others even HAS<sup>56</sup> preliminary work has not started yet. Finally in some medical fields lack of scientific evaluation simply forbids the formulation of a good practice «good practices».

In 2000, the State Audit Office proposed to change the collective bargaining role. It suggested strictly dividing the area of application between executive power norms and collective bargaining. Furthermore it suggested collective bargaining should focus only on matters to which medical professionals can individually commit. Thus it would aim at precise, operational and controllable matters. The revenue Court's document<sup>57</sup> also suggests better bargaining preparation with, for instance, preliminary tests and health insurance office legal advice reinforcement. Finally it insists on mid and long term study on price rises, medical interventions increase and their structural effect on expenditure.

In the end national agreements have been insufficient to modify individual practice and moreover to coordinate all medical professions. Doctor's agreements encountered other professions hostility affected by power redistribution. Such hostility came from nurses and also appeared between general and specialized doctors. For instance such difficulties appeared in "referent doctor" and "nurse medical intervention" reforms. It appears collective bargaining is not suited to structural changes. In reality, collective bargaining did not settle faster a regulation system, as it was expected in 1996. Actually as most medical professions did not have void collective agreement it contributed to increased tensions among the players, creating less favourable conditions for regulatory implementation.

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55 Which became now HAS.

56 « Haute Autorité de santé »

57 « Rapport de la Cour des comptes

March 6<sup>th</sup> 2002 statute intended to restart actions towards medical professionals' behaviour. In order to promote dynamic collective bargaining it created new tools to individually commit doctors in expenditure control. Some of them - such as "good practice contract", "good care agreement", or "public health contract"- are oriented to transform care practice. They are negotiated with individual medical professionals who received lump sum payments. In doing so professionals are guaranteed to be paid for extra work like public health actions or working in an emergency department. Then a positive dialogue is set, as there is no longer any sanction against unusual or abusive behaviour. Government believed then most medical professionals would take this positive step. But such system supposed to gradually eliminate non-fixed fees sector in order to make such tools appealing<sup>58</sup>. But it never happened.

The 2005 statement on "good care agreement" (ACBUS)<sup>59</sup> appeared in a mitigated form. The evaluation of qualitative control provisions' evaluation is rather difficult. Often it is not possible to connect successes with ACBUS. For instance, since 1999 an experimented antibiotic therapy campaign has been pilot in Burgundy on a sore throat speed diagnosis test (TDR). Such a test allows the differentiation between bacterial and viral sore throats and reduced redundant antibiotic prescriptions by half. In 2002 national health insurance office launched a plan aimed at the proper use of antibiotics to maintain its efficient potency. On April 2002 a first agreement has been signed with generalist doctors organisations on TDR use- which was freely hand out. The National health insurance office has declared spectacular results with a 16% antibiotics prescription decrease within two years.

But some other campaigns such as "healthy diet" which relied solely on communication have not achieved the same success, according to the Revenue Court's 2005 report<sup>60</sup>.

This latter report gave a mitigating statement on ACBUS. On March 30<sup>th</sup> 2005, on 14 ACBUS only 11 have been implemented. One only achieved success: the one about sore throats. Revenue Court stated it was not only ACBUS which should be credited with this success. In order to prove ACBUS relevance and usefulness they should be applied to higher financial and healthy matters. And quantified objectives and operational procedure should be included on each time<sup>61</sup>.

Individual contracts are aimed at doctors' training, good practice implementation, coordination, prevention or continuous service. It gives doctors a yearly lump sum payment. But the Revenue Court's report stated such contracts had limited effect on doctors' behaviour. Indeed few doctors agreed to be subjected to such a contract. Generally most measures taken pursued former practices. And only justified prices rise<sup>62</sup>. The Court's conclusion is clear: "actions taken to change doctors' behaviour relying on income rate failed". No objectives have been achieved due to such

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58 See EVIN's report, p. 20.

59 « accords de bon usage des soins »

60 See revenue Court's September 2005 report on financing social welfare, p. 185.

61 See p. 214

62 See p. 216.

contracts. Giving compensation or money did not succeed in transforming doctors' behaviour on reducing their activity. Neither had it been successful in linking medical caring to income rate.

On the whole no objectives have been achieved. Neither medical professional's behaviour nor healthcare expenditure evolution control have been achieved<sup>63</sup>. In August 13<sup>th</sup> 2004 a statute intended to restore collective dialogue and correcting collective bargaining details of implementation was passed. It was modified in 2006.

### **3. Collective bargaining adaptation**

Reforms changed collective agreement both in detail of implementation and content. Negotiation mechanisms have been adapted to match two different logics: doctors' organisation legitimacy to commit the whole profession and bargaining "efficacité". But both are not easily reconciled.

Medical collective agreement signing up rules are defined in the social security code. Medical collective bargaining was first addressed in a July 3<sup>rd</sup> 1971. The first important reform occurred in 1975 to set up negotiation and validity conditions. Agreements are negotiated between medical professionals' organisations and the health insurance office. After signature they are approved by the minister concerned.

Before bargaining an investigation is made to establish which organizations can claim to be representative. Then a sole representative organization among others can sign the agreement. Social security code provisions concerning collective bargaining are brief, but they have been enriched by jurisprudence. A 1990 statute admitted dividing medical convention between generalist and specialized doctors. In order to avoid non-agreement a 1996 statute authorized a "minimal settlement" taken under social security minister in charge's responsibility. This latter document fixes fee level and pay back conditions when medical expenditure objectives are exceeded. Only two years later due to bargaining difficulties and various agreements invalidation "minimal settlements" were taken. Such mechanisms satisfied no one. They are intended to bypass lack of agreement. They permit setting up minimal relation standards between doctors and the health insurance office. The aim was to circumvent deadlock situations and to encourage partners to resume negotiations. Therefore "minimal settlement" provisions are often more flexible on expenditure control than collective agreement.

The March 6<sup>th</sup> 2002 statute aims to deeply transform the collective bargaining system in order to adapt to new purposes. Now only in the case of non-applicable agreement, the health insurance office recovers unilateral power to fix expenditure objectives and fees. The same mechanism applies to twice-a-year checking of medical expenditure. Before the health insurance office had a unilateral power in those checks.

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63 See p. 217.

The modification then turned its attention to collective agreement's conclusion conditions. The last system flow was identified as commitment failure. More precisely it was due to lack of adherence to such agreement, especially when mandatory provisions have been challenged before judges and succeeded. Such invalidations withdraw collective agreements of all practical significance. It jeopardized the whole coordination system from minister to health insurance office and to doctors. A clarification of the system was necessary.

It is in the August 13<sup>th</sup> 2004 healthcare's reform based on new governance coordinating health insurance scheme and complementary health insurance scheme that collective bargaining conditions have been renewed. The reform focused then rather on the actors than the bargaining conditions. It gives on one hand greater autonomy to the health insurance office in order to permits real bargaining. On the other hand it reinforces the medical professions legitimacy to ensure a more "effective" agreement implementation.

Beforehand collective bargaining was led by the head of the health insurance office board composed of employers and workers representatives. Since 2004 reform it is conducted by national health insurance office union's (UNCAM)<sup>64</sup> general director. From then the health insurance office board can only express directions before negotiations and make observations on agreements. Thus bargaining capacity is reinforced. The partners' identification is clearer: the health insurance office is in charge of financial management - and being State's cog in the machine - bargaining with medical professionals organizations. However undertakings and workers representatives, i.e. contributors' representatives, lost influence in favour of the health insurance head of board appointed by executive power. But bargaining procedure is legitimised as medical professions organisations having more than 50% vote in last URML elections can oppose agreement application. Thus Parliament implements a majority-opposition system.

To ensure greater collective bargaining legitimacy Parliament changed provisions regarding negotiation breakdown. Beforehand a minimal settlement was decided by the State in such cases. Now such settlement must be decided between an UNCAM arbitrator and at least one of medical professional's organisations. If this procedure does not come to fruition - or in case of majority opposition - arbitrator should be appointed by "healthcare prospect high committee"<sup>65</sup>.

But the "efficacité" approach often jeopardizes the system. For instance as 2006 URML elections gave majority to opponents to 2005 doctor's collective agreement, Parliament modified once more opposition right conditions in order to consolidate the collective agreement's application.

The 2007 LFSS imposed a new condition to exercise opposition rights. Organisations must be recognised representative before negotiation started to be entitled to oppose agreement application. Such a condition allows putting aside organisations with significant votes in their favour if they have not been recognised representative prior to negotiation. Such recognition is subject to

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64 « Union nationale des Caisses d'assurance maladie »

65 See CSS article L. 162-14-2.

social security minister service's investigation. This condition has been validated by constitutional court as those agreements aim to make medical professionals respect relevant and quality care criteria and price restraint<sup>66</sup>.

#### **IV. Hospitals expenditure control**

How is hospitals expenditure controlled? Difficulties here lie in hospital public organization. Hospitals are health caring public legal entities with administrative and financial autonomy. But some tasks - like diagnosis and patient caring and monitoring - can be assumed by private legal entity<sup>67</sup>. Some other tasks, like university teaching<sup>68</sup>, belong only to hospitals. This report focus on hospital sector as LFSS has no connection to private legal entity budget, except for healthcare price. LFSS sets up healthcare public establishment's budget such as hospitals. Since the 1950's three mechanisms have been successively set to forecast hospitals' budgets and their financial needs. All three have been mobilised to render hospitals' players more responsive to healthcare expenditure control. First one concerns a peculiar medical coordination: activity based price (1). It radically renews hospital's budget forecasting and its governance. However its implementation implies hospital's and care practice's transformations (2).

##### **A. Hospital's expenditure "efficiency" statement genesis**

Hospital's budget is given by state and the health insurance office. Hospital activity "efficiency" improvement relies on budget assessment. Numerous financial calculation methods followed one another each of them attempting to improve on previous former ones. Since hospitals are regarded as a caring place three different periods appears which correspond to different calculation method of a hospital's budget. First period lasted from 1944 to 1983 when the "daily price" system was in place (a). Second period lasted from 1983 to 2004 and correspond to "overall grant" (overall endowment) (b). Since then "activity based price" system has been widespread (c).

##### **1. "Daily price" system**

During 20th century hospitals became open not only to the destitute but to the whole population. This combined with medical progress and inflation led to hospital s' great deficit. Since 1944 in an effort to contain this phenomenon two budget forecasting have been tried out successively. The first one was "daily price" system based on the cost of average spells in hospital. Even though there were around twelve prices categories (one per department), the calculation method is rather simple:

Daily price= forecasted hospital's expenditure / number of forecasted spells per day

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66 See Decision n° 2006-544, 14 décembre 2006, Loi de financement de la sécurité sociale pour 2007

67 See Public health code, article L.6111-1.

68 See article L.6112-1 on hospitals public service missions.

This method averages out all spells in hospital costs. Accountably it is likely every spell's day of any patient costs the same amount. But of course each patient needs different NHS, examination or intervention depending on his or her problem. For instance surgical intervention would imply more accountable operations than in-patient days afterwards. In typical a spell in hospital costs should decline as the stay and in progressed last days hopefully there would only be housing and meals costs. As social protection is based on solidarity there is no point in taking one's NHS consumption into account. This calculation method was just to index the hospital budget to its activity. Only yearly total forecasting mattered. But as deficit rose various critics were addressed to such system. Some pinpointed its inflationary effects. Actually the longer the spell in hospitals the better it was for its budget forecasting, especially considering last days of the stay generally cost less money. Others said it was then impossible to compare hospitals and private entity activities, as the former were in charge of specific tasks like university teaching. Comparison was even more difficult as hospitals took in charge greatest pathology - the most expensive. When two elements are conceptualized to be different and complementary comparing them is not relevant. It is precisely questioning this structural difference that led politics to elaborate new accountancy tools in order to permit comparison. Work started in 1982. One year later a statute<sup>69</sup> ended the "daily price" system to put «overall grant» system in place.

## 2. "Overall grant" system

To curb the inflationist effect, the January 19<sup>th</sup> 1983 statute established a hierarchical and regional budget distribution system. This system was based on hospital's yearly healthcare overall reimbursement corrected by "key rates". Thus overall grant<sup>70</sup> (DGF)'s was calculated:

$$\text{DGF year "n"} = (\text{DGF year "n-1"}) * \text{"key rates"}$$

The idea was to empower public authorities to adapt budget to real activity level through "key rates" fixation. Simultaneously the first computing experiments were made to describe and precisely evaluate a hospital activity – named "medical information plan" (PMSI). This mechanism was said to be counter-inflationary and avoided former customs searching for numerous and longer spells. But it succeeded only for a while. Two reasons explain its failure in long term. Firstly there was no sanction when the forecast budget was exceeded. Actually habits were budget automatic revaluation during accounting year. Secondly there were tremendous financial allocation inequalities between hospitals. Some were over-granted regarding their activity level while others were under-granted. As key budget forecasting information is previous year budget these inequalities were just carried on year to year.

The gap between evolution of medical needs and hospitals' budget has been brought to the fore by PMSI. Nevertheless this «overall grant» approach lasted for 20 years<sup>71</sup>. It was the first step

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69 Statute n° 83-25 du 19 janvier 1983

70 In the sense of overall endowment

71 Since October 3rd 1985 decree authorizing computing exit documents in both hospitals and private healthcare entity.

towards “activity based price”.

### **3. « Tarification à l’Activité » (T2A), or casemix-based hospital financing system genesis**

The actual hospital budget calculation came from successive developments of a description of a hospital’s activity. Gradually key concepts have been forged. Once a description tool has been successfully completed Parliament just had to refer it to price scale. Only this second step is named after “activity based rate” system.

Since 1983 public authorities carried out some experiments to create an accountancy system for hospitals similar to the American model named “Diagnosis related groups” (DRG), based on Robert Fetter’s work. It gave birth to PMSI. Its purpose is to encode all pathology and medical acts into nomenclatures.

In 1986 the first French version of American DRG was published by decree<sup>72</sup>. It is named “GHM’s classification, version zero”. Since 1990 it has been rolled out to the whole hospital sector, including private entities. Right then it was to classify activities within “sick person homogenous group” (GHM). It allows description of all activities carried out within hospital sector. Since 1993 all GHM are weighting in an “activity overall index” in order to evaluate each establishment’s productivity. Each GHM is expressed in ISA’s points, which correspond to average spell in hospital costs. GHM are compared to a “referential-GHM” fixed at 100 ISA points. It allows comparison of all establishment productivity. It could even evaluate each hospital department’s productivity. Actually the establishment’s running costs and its ISA points’ collection ratio gives the establishment’s ISA point value on a given period. Afterwards it is possible to say where the ISA point is less expensive and therefore tell which establishment is more productive. A comparison of regions’ is also possible. This index stopped being taken into account for budget forecasting in 2004, when “activity based price” was put in place. In fact under the new system each GHM is directly expressed in Euros. Despite ISA obsolescence, its creation reveals hospitals successive reform spirit: to measure each establishment’s productivity, its budget “efficiency”.

In 1994 the expert’s department of national health reference index (PERNNS) was created, which in turn became the hospital information technical agency (ATIH) in 2000. It proposed the actualized GHM index version to public authorities. Up to that point PMSI has not been achieved and there was no unified hospital’s activities description. It did not take into account professionals technical acts’ added value. Therefore it did not describe all activities within hospital. Moreover there were great income differences between medical specialties and no objective explanation (based on technical specification, risks or time taken). And two price indexes existed, one for “independent medical practitioners sector and the other one for hospitals, adding to healthcare financing system confusion. In this context the medical acts common index (CCAM) pursued three

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<sup>72</sup> circulaire n° 160 du 5 août 1986 relative à la diffusion de la classification des groupes homogènes de malades (GHM) (Non parue au Journal officiel)

purposes: measuring medical professions productivity, diminishing doctors' income differences and harmonizing medical acts description in "independent medical practitioners sector" and in hospitals. CCAM resulted from collaboration with social security minister services and national health insurance office and PERNNS and "scholarly societies". In 2003 CCAM was integrated into PMSI, which became widespread due to a December 31st 2003 decree. Since then a complete description is applied to every hospital activity. In order to create a hospital medically approach in fixing price it was necessary to set a price for each stay category. This was done through the "activity based price" system in 2004.

## **B. "casemix-based hospital financing system" implementation**

"Activity based price" (T2A) is the current hospital budget calculation method. It is the main mechanism for expenditure control in hospital sector. It aims to describe precisely each medical establishment's activity in order that the health insurance office finances only "effective" healthcare consumption. Its methodology lies on observation of over-granted or under-granted establishments' existence<sup>73</sup>. This reform has been seen as hospital governance reform focusing on some coordination key elements. But its implementation is rather hesitant in carrying out geographical limited experiments<sup>74</sup> and gradual application to hospital budget's parts<sup>75</sup>. This process focused on hospital player's coordination.

Besides providing hospitals activities descriptions it gives professionals tools for their own practice observation. It is an indispensable condition for a better coordinated system as players have to constantly adapt to new rules. In a nutshell T2A coordination action is on two levels: gradual and experimental implementation and giving hospital players' deep understanding of their practice.

After achieving PMSI, procedures to index hospital budget to such information had to be created. It was one of the main purposes of the 2004 statute. Now, each spell in hospital is classified in one of 700 categories nomenclature named "homogenous care group" (GHS)<sup>76</sup>. One GHS can gather several "sick persons homogenous group" (GHM). GHS definition is based on an experiment carried out in 50 French hospitals. It gathers GHM on the basis of medical criteria and average cost. It is a flexible tool which can be adapted to specific pathology or other issues, such as patients 70 years old and over. This allows higher price to cover elderly, pregnant women or infant patients. Thus total stay in hospital costs permits to cover average costs of one establishment. It would be this overall average cost constituting healthcare undertaking and therefore hospital budget. Of course other factors are taken into account, like economic inflation or specific general interest tasks carried out by hospitals. But on the whole this system aims at patient medical and individual expenditure accountancy.

Hence T2A establishes a common accountancy language for all hospitals based on pathology

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73 See revenue Court and Social and economical committee reports.

74 Like in Languedoc-Roussillon (June 23rd 1994 Decree).

75 Art.33 statute n°2003-1199 du 18 décembre 2003 (JO du 19 décembre) de financement de la sécurité sociale pour 2004

76 "Groupe Homogènes de Séjours"

and medical acts costs. Such a system requires information on players' detailed activities. Doctors have to fill in a document – “standard exit document” – giving pieces of information on patient and his or her stay in hospital. There are pieces of information on patient identity and NHS. Afterwards they are anonymously encoded. Then all these pieces of information are handed to the national health insurance office and minister. It enables the comparison of establishments and to adapt decision making to healthcare activity's development. Such procedures have to comply with patients' personal data law<sup>77</sup> increasing implementation complexity.

In conclusion T2A needs hospital players' enrolment in the evaluation process. How players' commitment has been foreseen?

### **C. « Casemix-based hospital financing system » necessary conditions**

T2A implementation had repercussions on the hospitals themselves. Such an evaluation tool needs to reorganize evaluated object's environment. The two main reorganizations concerned the medical act itself (1) and the hospitals' structure (2).

#### **1. Medical act assessment**

PMSI did not give a neutral description of hospitals activities. It modified how such activities were perceived in order to comply with healthcare expenditure control “efficiency”. It adapted medical acts' assessment to the main 2004 reform objective.

Already in 1985 the reforms' long term objective was to put in place a qualitative hospital budget management. Which was to evaluate social interest taken on by hospitals, i.e. patient's care<sup>78</sup>. So appeared establishments' productivity assessments. The Objective was to improve health care “efficiency” with regard to budget granted by the national health insurance office. It was therefore not only hospitals' activities description. The second step was taken in a January 1<sup>st</sup> 2005 statute. Hospitals budget are financed on a activity measurement basis. At this stage activity description became a key account element. But reading first texts on PMSI it was not obvious it would permit “activity based price” from then on. Such a tool could have been used not in an accountancy perspective but more likely in a sociological or epidemiological approach. It could have been used in decision making without being key element in price fixing. But looking back it seems PMSI has always been planned from a budget fixing perspective. But in 1983 the lack of hospital's activity nomenclature's prevented activity based price being put in place immediately. It has taken twenty years for hospital sector to experiment and establish a medically approach accountancy – something suggested in 1971 by public authorities<sup>79</sup>.

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<sup>77</sup> See national liberties and computing Commission decision (n°95-035, March 21th 1995)

<sup>78</sup> See Decree n° 119 October 4th 1995

<sup>79</sup> See VIth Plan « Health » Commission report, Documentation française, 2 tomes, 1971

One main reform character was to set a common language. First this implies a common approach to reality and same hospitals events' interpretation through complementary and commensurable concepts. Such approach needs procedures for language development in order to match reality transformations. It has to be able to take new pathology discoveries and medical technical progress into consideration. But this approach postulates that one sole vision can be defined in medical field. It is in fact against scientific progress' working for the last 50 years: science progress due to to theoretical confrontation among scientists.

This common language needs medical discussion to be ensured within legal procedures in order to describe medical practices. Actually to recognise a new pathology needs medical professionals' consensus. This is particularly true for psychiatry but also in other medical fields. For instance diseases designated as "flu" are too various to set a scientific definition. Furthermore "headache" covers too many phenomenon and symptoms. Reviewing procedures are necessary. As every medical knowledge can be questioned. However medical activity description does not seem to take this methodological caution into account<sup>80</sup>. Thanks to this system medical professionals have to come from medical diagnosis to this nomenclature. In doing so they "translate" medical language into legal and accountancy categories. It reveals the nature of legal and accountancy nomenclature. Because of the lack of reviewing procedure such "translation" is methodologically invalid. How does this common language definition address such difficulties?

In fact hospital sector's common language is composed of two "sub-languages" encompassed in a third. It is the latter which is translated into accountancy and budgeting language. Those four different languages have different description purposes. The first two are to named pathology and medical acts – respectively through International Statistical Classification of Diseases and Related Health Problems (CIM)<sup>81</sup> and Medical Acts Common Index (CCAM)<sup>82</sup>. The latter two languages are to describe stays in hospitals and their costs – through GHM and GHS classifications. Each of those four languages is elaborated through specific procedure even if they are interrelated. What are those procedures and how do they take into consideration the evolution of hospital activity?

In the first place T2A is built on International Statistical Classification of Diseases and Related Health Problems (CIM) which encoded pathology identified by the medical community. It depends on common and shared medical knowledge, what Kuhn calls "normal science". "Normal science" is a medical theoretical agreement strong enough to be the starting point for other works. As such knowledge is to evolve and this classification needs to be updated. The 10<sup>th</sup> CIM (CIM-10) revision applicable at the present time is repeated in the French system. This revision was done in 1990 within the World Health Organization (WHO). This revision legal value resulted from the international convention creating WHO in 1948<sup>83</sup>. Hence CIM is rather unilateral for French medical sector as

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80 For instance GHM 10th adress such categories : « J09 Flu provoked by identified avian influenzavirus », « J10.0 flu with pneumopathology, other identified influenzavirus » et « J11.0 flu with pneumopathology, unidentified virus ».

81 "Classification internationale des maladies"

82 "Classification Commune des Actes Médicaux"

83 World Health Organization's convention has been adopted in 1946 in New York and ratified July 22<sup>nd</sup> 1946 (Actes off. Org. mond. Santé, 2, 100)

French system only legally ratifies WHO's work. In fact international law – applicable to WHO - only recognizes to States and international organizations power to create law. WHO's legal pathology identification simplicity contrast with complex scientific methodology. It is striking it does not set reviewing procedure nor adaptation to the local epidemiological environment.

CCAM is a nomenclature elaborated by medical professionals themselves. Medical acts are encoded due to a technical approach (anatomical area, action, techniques used) and organized into a hierarchy regarding their added value (lapse of time, level of difficulties and risk taking). The aim is to describe medical professionals' activity in order to translate it into financial criteria. This nomenclature has been created under both state and national health insurance office responsibility. It mobilized 500 experts within "scholarly societies". They were cautious to consult experts from all medical fields<sup>84</sup>. However experts' appointments have not been transparent. So there is no guarantee about nominations' appointment and no legal means to ensure medical debate in the field concerned. It is unclear whether the French State and national health insurance office took experts' advice for granted or if they have to establish methodological disagreement. In the latter case how has it been settled? Have they been surpassed? Responses to such questions remain in obscurity. For someone working outside the healthcare system only one thing can be observed: public authorities and experts are working hand in hand.

The third language level is GHM. They are used for hospital budget needs' medical evaluation. In this perspective stays in hospitals are classified thanks to their medical similarity. Each stay in hospital corresponds to a price. This monetary conversion corresponds to GHS classification. Even if those two classifications are interrelated they are elaborated through different methodologies. In fact to classify stays on medical and financial criteria is not the same as organizing each category referring to average costs. Despite methodological differences both classifications are done by the same body – the hospital intelligence technical agency (ATIH). This body created in 2000<sup>85</sup>, is a French State authority under the social security minister's responsibility. In other words, despite experts' consultation, ATIH's hospital activities' description is nothing other than State regulation.

T2A reform was presented as making hospitals real players reviewing their own activity. Description tools combined with financial responsibility was supposed to give establishments a means to transform their own structure. T2A's "efficiency" approach requires hospital to have means to constantly adapt to its medical and accountancy environment. Hospitals should have been equipped with "harms" enabling them to act in accordance with their accountancy "vision". This problem has been addressed through hospital sector reorganization with medical activity hub and "accrediting procedures" enabling hospitals to change their own caring quality and safety procedures.

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84 CNAMTS, nomenclature department, mars 2002, p.1.

85 Décret no 2000-1282 du 26 décembre 2000 portant création de l'Agence technique de l'information sur l'hospitalisation et modifiant le code de la santé publique

## **D. Hospitals new identity**

T2A reform entailed players' adaptation. This adaptation is established on two legal mechanisms: formalization by contract (a) and self-evaluation by certification procedure (b). Those mechanisms are due to place hospital players in a reflexive procedure.

### **1. Hospital reorganization due to formalization by contract**

There are two types of formalization by contract in hospital reorganization. The first one is concluded between hospitals and hospitalization regional agency (ARH). It is named "means and objectives contract". It allows hospitals to be part of hospitalization reorganization on the regional level (1). The second mechanism is an "inner" tool based on creation of new entities – the "area of activity" mechanism (2).

#### ***a) The "means and objectives contract" mechanism***

National expenditure objectives' translation on hospital level is rather a complex process. The first step is a five-year plan established on a regional level. This plan is named "health regional scheme" (S.R.O.S). The aim is to "create healthcare complementary adaptation measures and hospitals cooperation. It establishes objectives on quality, accessibility and healthcare organization « efficiency »"<sup>86</sup>. This plan implementation depends on hospitals involvement through the "means and objectives contract". These contracts can be concluded for a five years maximum period – the S.R.O.S. period length - between the hospital and the ARH. The main aims are to establish "hospital strategy"<sup>87</sup> and quantitative objectives in medical and accountancy fields<sup>88</sup>. This mechanism gives autonomy to hospitals and makes them accountable for expenses. This mechanism is in a way to enlist hospitals in expenditure control. The sanctions, if hospitals do not respect their "means and objectives contracts", are to ensure such enlistment<sup>89</sup>.

However formalization by contract is not the solely legal mechanism at work in hospitals reorganization. At least two other legal phenomena are to make hospitals autonomous and accountable for their budget. At first, more deliberative procedures are developed. Secondly, there is an increase of administrative norms to translate national objectives at local level. For instance state authorities elaborate regulation within the S.R.O.S. This scheme is established through consultations

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86 See article L6121-1 al.2 du Code de la santé publique

87 See Art. L.6114-2 du Code de la Santé Publique

88 Art. L.6114-2 et L.6114-3 du Code de la Santé Publique

89 Sanctions are a fine, a contract suspension or cancellation by ARH (see Art. L.6114-1 du Code de la Santé Publique). If the hospital budget is unbalanced it can be put under public services authority (L.6143-3, L.6143-3, D.6143-39 et D6143-40 du Code de la santé publique).

of three entities composed of local and national authorities' representatives<sup>90</sup>. Despite these norms hierarchical nature the procedure is oriented to local players' involvement in national objectives implementation.

In hospitals reorganizations appears some paradox. In fact, the state seems to bring under control hospitals health care scheme but in the same time seeks for establishments' autonomy and it welcomes deliberative procedure. Such a paradox matches with the concept of governance.

Hospitals involvement in national objectives implementation needs new tools to adapt their structure to their new responsibility. It is the purpose of the "area of activity" mechanism.

### ***b) The "area of activity" mechanism: an "inner" contractual tool***

The May 2<sup>nd</sup> 2005 reform required hospitals to reorganize through the "area of activity" mechanism. This mechanism allows the head of hospital to divide the hospital in units of management. This should adapt hospital's work to medical and economic context. The government asserted this mechanism was "to give players the means to reorganize themselves"<sup>91</sup>.

This mechanism grants hospital a large autonomy to reorganize. Bargaining between the head of the hospital and the new management units are now taking place to respect hospital's commitments, such as "means and objectives contract". The "area of activity" mechanism allows hospital to establish its own units and in the same time to take over its new autonomy through contractual bargaining with these units.

Therefore, hospitals are not only subjected to national objectives. They are also taking part in the declination of such objectives in direction to the medical staff. This mechanism aims at making medical staff conscious of national objectives. This explains the establishment of a self-evaluation for medical staff. Such an evaluation is certainly the more reflexive mechanism in healthcare governance. This self-evaluation needs first to work on a quality and a safety health care.

## **E. Hospital self-evaluation by certification procedure**

The certification procedure is part of the "means and objectives contract" conclude with ARH<sup>92</sup>. Such a procedure is to grant an external – to the hospital and regulating body – evaluation. This evaluation aims at health care quality and patients' safety<sup>93</sup>. This procedure is under the high healthcare authority (HAS) responsibility. It appoints medical expertise group composed of three to

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90 See article R6121-2 du Code de la santé publique. These three entities are "healthcare conference", "healthcare regional committee" and "social regional committee".

91 Report to the President of the French Republic on the May 2<sup>nd</sup> 2005 statute, n° 2005-406, JORF n°102 du 3 mai 2005, text n°14, NOR: SANX0500028P.

92 See Article L6113-4 du Code de la santé publique.

93 See the first accreditation book, 1999.

six healthcare professionals – whether in medical or management field and coming from the public or the private sector. Such a group should be composed of at least one manager, one doctor and one nurse. This group is to evaluate compliance with the “certification book” provisions, provided by HAS.

The procedure has different steps. The first one is self-evaluation. This is to ensure the hospital takes the certification book provisions into account. The second step is the medical expertise group visit – from 6 to 30 days depending on hospital’s size. The medical expertise group draft a report communicated to the HAS. Then the HAS draft itself a report composed of assessments on the hospital, recommendations and the final decision of certification.

Depending on HAS assessments a new delay is established to grant the next certification (up to 5 years). If certification is not granted a new visit is scheduled within 18 month – it could focus only on HAS reservations.

## **v. Conclusion**

This project was to describe healthcare expenditure control developments. The overall coherence of successive reforms is not self-evident.

In order to explain political objectives at work we had to take the governance’s references seriously. As governance became the objective and the purpose of healthcare reforms it should be taken as a key point of the French system.

Therefore we have to address healthcare expenditure control whole scope. On the national level, expenditure control was under Parliament’s responsibility. Through LFSS Parliament fixes the ONDAM. The ONDAM is a tool to evaluate expenditure evolution. But for the healthcare sectors two different mechanisms have been used by to control expenditure. In the “independent medical practitioners sector” doctor’s private practice impose to use collective bargaining as an expenditure control mechanism. In the hospital sector public services issues led to a particular mechanism: T2A. It should allow more accurate price assessment.

In both sectors evaluation process does not stick to the market model. Those mechanisms focused on healthcare players’ involvement in expenditure control. The purpose of these reforms was players taking part in expenditure control. And Parliamentary thought it would play its role.

In this perspective the governance concept is heuristic. It permits to describe the new approach at work in the expenditure control. Such an approach questions hierarchical public intervention. The ONDAM is not mandatory; neither is its translation in both sectors. National level and sectors relation is not deterministic. Neither collective bargaining nor T2A are mechanical translation into sub-objectives. In other words these mechanisms do not set expenditure maxima. They do not fix a priori expenditure level.

These mechanisms are to give players a share of responsibility in expenditure control. Collective bargaining and T2A aim at getting better players activity “efficiency”. In this perspective the ONDAM is a key instrument and should not be reduced to a symbolical indicator. The ONDAM is the base for healthcare assessment.

But reforms overall failure reveals presuppositions at work. What are the conditions for such a public intervention’s implementation? What are the presuppositions within the governance concept?

The healthcare expenditure control permits to address such questions. The project to make players taking part in expenditure control is not only based on coordination. Both to invite players taking healthcare expenditure issues into account and to assess healthcare activity “efficiency” are not enough to have players taking part in the control. In order for players to take part in the control process requires to adapt the healthcare system. From this angle successive reforms have been done to go deeper into adaptation. Thus, such system adaptations disclose conditions for players to take part of the control. There are different adaptation measures for healthcare system implementation.

First of all, players taking part in control needed a medical activity description. Collective bargaining and T2A are used for such a description. In doing so, a dialectical relation is set between evaluation criterion and the object of such an evaluation. Then expenditure control policy led to a new medical activity description. It means that an “efficiency” approach is not neutral. It has implication on activity description. It is a governance paradoxical effect: getting a better coordination implies to redefine NHS. One should be vigilant toward healthcare expenditure control neutral appearance. The “efficiency” approach is not without consequences on care’s definition.

Secondly, the healthcare expenditure control modified coordination mechanisms. In the “independent medical practitioners sector” sector, collective agreement have been adapted to set new obligations. But to grant new power to bargaining organizations is not enough. The healthcare expenditure control modified bargaining rules. A link is made between a coordination system implementation and the working out process. But bargaining rules adaptation has sometimes been ambiguous. Some provisions granted greater autonomy to bargaining organizations. Some others only aimed at bargaining “efficacité”, which rely on a hierarchical logic – contrary to players’ autonomy. But the latter reforms focusing on securing collective agreement signature may fail to make doctors taking part in expenditure control.

And yet players’ playing their part within the system is a precondition to a governance policy.

But the “effective” players’ role in the system is not sufficiently taken into consideration. The collective bargaining failure into expenditure control shows difficulties to make players play their part. And an “efficiency” coordination relies on players taking part in the system. And without players involvement the coordination system may not be implemented. Such concern is greater when the goal is to make doctors taking their share of responsibility in expenditure control.

The healthcare expenditure control implementation needs to address three preconditions:

- **Implication:** One precondition is players taking part in the system. How to make them take such a share of responsibility? In fact the main issue is the players willing to commit themselves. It seems that in the “independent medical practitioners sector” sector failed to address such an issue. It appears that law provisions assume that players will be willing to take part in expenditure control. In fact legal studies often assume players commitment depends on sanctions. Such an approach is consistent with defining law as a rule of conduct. But other typical mechanisms could be used for instance incitement to or rewarding have been used by in the “independent medical practitioners sector” sector. But it has not been sufficient for players playing their part. To do so heighten doctors’ awareness of expenditure issues should be the first step. It is a prerequisite to players taking expenditure control issues into account in all their actions. It is necessary for the system’s “efficiency”. Players’ commitment implies they internalize expenditure control issues. In order to achieve that it is necessary to create conditions for players to commit themselves.
- **Empowerment:** Secondly, making players committing to such a policy implies to empower them. The system should grant them the means to take on their share of responsibility. The governance approach within the coordination system emphasizes the need for players’ empowerment. Such a need exist also in the T2A implementation. In order to have an activity-based evaluation requires hospitals to reorganize. The “area of activity” is the prerequisite of such an evaluation. Without hospitals reorganization T2A would not achieve an “effective” improvement in hospital management.
- **Identity:** Thirdly, it is not for sure that players’ involvement and empowerment is sufficient to get them commit themselves. In fact the new coordination system needs to transform the player itself. The player is then subjected to a new assignment and a new identity to fit its new mission. Therefore we can say there is an existential link between the law and the identity of those subjected to it. The players’ enrolment lies in players’ identity adaptation. For instance in the hospital sector it could be the case for certification procedure. Hospital self-evaluation aims at implementing a reflexive mechanism in hospital running. Therefore self-evaluation is a mechanism to adjust hospital structure to expenditure control issues.

In this perspective, a governance policy implies to focus on players identity. It needs a reflexive mechanism in players’ identity redefinition.

In a nutshell successive reforms failed to address the link between the norms and the players’ identity redefinition. Despite the fact it is a key issue in a governance policy.

Such an issue also shows limits to a governance policy. Addressing directly players' identity implies to institutionalize players in the coordination system. Therefore it is no more compatible with a hierarchical model. Otherwise it would only be a making use of players. The governance policy implies to elaborate a dialectical system between norms and the players. In other words to redefine actors identity is only worthy when it is done in accordance to norms reassignment.

But the French healthcare expenditure control does not seem to have been elaborate in accordance to such concerns. For instance collective bargaining reforms first aim is to reduce expenses. Healthcare players have to abide by this objective. Most of the times, in the hospital sector NHS or certification provisions are not elaborated through a reflexive procedure.

In fact the healthcare expenditure control seems to be trapped in a hierarchical model. This model corrupts political diagnosis, which is the ground for the governance policy. The healthcare control objectives are not subjected to a true reflexive procedure. Focusing on players' commitment needs to challenge this hierarchical approach. Healthcare expenditure objectives should be elaborate with all healthcare players. For instance LFSS is too much like an expenses control mechanism. The ONDAM which appears at first as a reflexive mechanism could constitute in fact an obstacle to a truly regulation. The ONDAM should also take into account healthcare system adaptation. To do so public intervention should be freed from a Malthusian accountancy "efficiency" point of view.

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