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Competition policy for health care provision in France

Philippe Choné

CREST (Centre de Recherche en Economie et Statistique), 15 boulevard Gabriel Péri, 92245 Malakoff, France

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ABSTRACT

There are more than two thousand hospitals in France, about equally divided between government-owned and privately-owned hospitals. Activity-based payment, which has been generalized in 2008 for acute care hospitals, has raised competition issues as DRG tariffs differ according to ownership status. Furthermore, the payment rule has been criticized for preventing the realization of potential hospital synergies, and as a result a recent reform has mandated close cooperation between public hospitals. The physician market is dual, with most GPs being subject to fee regulation and many self-employed, private-practice, specialist doctors being allowed to set their prices freely. Government regulation and centralized negotiations have traditionally been preferred to market mechanisms in this industry.

1. Introduction

Health care expenditures represent about 11% percent of GDP in France. They are funded by baseline public insurers ("*Sécurité sociale*", 76.5%), supplementary insurers (13.5%), and households (8.5%). Tariffs paid to providers are set by governmental agencies or negotiated by the *Sécurité sociale* at the national level. Some providers, however, have the discretion to charge extra-billings under certain circumstances. For any medical service, baseline insurance covers a percent of the administered price and supplementary insurance covers part or all of the rest depending on the applicable policy.

In 2012, 95% of the population is covered by supplementary health insurance, among which 54% is covered on an individual basis, 35% on a collective basis (through the employer of a household member), and 7% by the state-funded supplementary insurance designed for low-income households. Starting in January 2016, all undertakings whatever their size have the legal obligation to offer their employees a supplementary insurance scheme. Some economists have complained that this provision unduly strengthens the link between health insurance and the labour market. For instance, Geoffard [1] fears that employed individuals with low health risk move away from individual contracts to firm-level contracts, which may destabilize the economy of individual contracts.

In France, patients freely choose their health providers. The nature of competitive interactions between providers is therefore closely linked to the functioning of the insurance market. As patients incur low out-of-pocket expenses for hospital services, financial considerations are probably not the main driver of hospital choice and therefore competitive interactions between hospitals are likely to operate mostly in non-price-dimensions. Out-of-pocket expenditures are significantly higher for non-hospital based services. For instance, physician extra-billings are poorly covered by supplementary insurers, which leaves scope for both price and quality physician competition.

From an institutional point of view, the French health care system is characterized by a high degree of complexity, with multiple layers of regulation. Self-employed doctors, who account for 60% of all doctors in France,

E-mail address: chone@ensae.fr

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negotiate contractual arrangements with the main public insurer at the national level, while hospitals are regulated by governmental agencies both nationally and regionally. The complex regulatory framework makes coordination between hospital-based and non-hospital based services difficult. More generally, the multiplicity of payers and regulators (sometimes for the same healthcare services) is criticized by economists (e.g., Dormont et al. [2] for impeding demand-side and supply-side regulation.

A common theme in what follows is that France has a long tradition of centralized planning, which is not easy to reconcile with decentralized competition policies. After providing industry background, we turn to competition policies in Section 3. We place a great deal of emphasis on the tension between competition and cooperation in the hospital industry. Physician competition is more briefly examined. Recent developments about selective contracting are briefly discussed in concluding remarks.

2. Institutional set-up

2.1. Hospital services

2.1.1. Hospital choice

In France, hospital choice by patients (and their family doctors) is and has always been free. The choice may include a financial dimension, for instance in case of extra-billings not fully covered by supplementary insurers. Yet in general there are no or little out-of-pocket expenses. According to National Health Accounts, out-of-pocket expenses for hospital services have remained low and stable at the aggregate level over a long period, representing about 3% of total hospital expenditures. About 91% of all hospital expenditures are covered by baseline insurance (*Sécurité sociale*) and 5.5% are covered by supplementary insurers. Financial considerations, therefore, are not the primary driver of hospital choice. The attractiveness of a hospital depends on the "quality" perceived by patients and by refereeing family doctors. The yearly rankings published by newsmagazines (*Le point, L'Express*) may contribute to hospital reputation. Word of mouth is probably important, too. Connections of family doctors into the hospital world may be important as well. Perceived quality certainly incorporates a high number of dimensions.

To facilitate hospital choice, the *Haute Autorité de Santé*, an independent scientific institution dedicated to the improvement of healthcare quality, has set up the website http://www.scopesante.fr/ that provides information about more than 4000 hospitals. Information consists of 230 indicators about hospital activity (number of stays, average length of stay, C-section rate, number of deliveries, etc.) and 231 indicators about care quality. As regards the latter, only *process indicators* are published. Those indicators concern many dimensions: patient safety, hospital-acquired conditions, patient information, catering services, etc. Some indicators are specific to a medical procedure (acute myocardial infarction, haemodialysis, etc.). The Authority does not publish outcome indicators for a number of reasons, among which the difficulty of controlling for case-mix variations and the fear of triggering strategic response by hospitals (e.g., underreporting of negative outcomes and patient selection). According to public health researchers, individual patient data (describing severity and comorbidities) are not precise enough to compute reliable *risk-adjusted* mortality rates.

The first version of the site has been online since 28 November 2013. At that time, the site was accessed mainly by professional users (hospital staff) as it was the only website that allowed a hospital to compare itself with others. In time, members of the public started to visit the site. In 2015, the site received about 340,000 visitors, of which about 50% were members of the public. Unfortunately there is no evidence yet that people are basing their choice on the information made available to them. The most recent version, online since May 2016, provides simpler composite indicators, making less information available upfront to the website visitors.

2.1.2. Market structure

The industry has historically been divided into two "sectors" defined by ownership and legal status: the "public sector" is made of government-owned and other non-profit hospitals while the private sector is made of for-profit, private clinics. The private sector is well developed in France: out of the 2660 French hospitals, 1030 belong to the private sector. For instance, as regards surgical services, the private sector accounts for about 60% of all hospital admissions.

2.1.3. Activity-based payment

Both sectors have moved to fixed-price activity-based payment, whereby each patient stay is assigned to a diagnosis-related group (DRG) and paid a fixed price accordingly. The change was completed as early as 2005 in the private sector, and financial incentives have not dramatically evolved thereafter in that sector.

The major regulatory reform in recent times has concerned the public sector. The shift from global budgeting to an activity-based, fixed-price payment has been gradual over the years 2005 to 2008. Up to 2004, the revenue of each public hospital was determined administratively on a historical basis and as a result, was only loosely connected to its real activity. In contrast, from 2008 on, each extra patient admission was explicitly associated with additional revenue. This reform dramatically changed the incentives of public hospital to attract patients.

2.1.4. Regulation

The regulation of the hospital market is mostly implemented by governmental bodies, at both the national and regional levels, with baseline and supplementary insurers playing little role. The national regulator is *Direction Geíneírale de l'Offre en Santeí* (DGOS), an administrative body within the Ministry of Health. Regional health agencies are administrative bodies in charge of implementing health policy in each French region. The head of each agency is appointed by the government. These institutions have been created in 2010. These national and regional agencies shape the health supply landscape by providing hospitals with authorizations (or not) to practice a service.

DRG prices are set nationally by the DGOS after a complex technical and political process. A technical agency,