Opinion

iMedPub Journals
www.imedpub.com

Health Systems and Policy Research
ISSN 2254-9137

2022
Vol.9 No.7:130

French Administrative Reforms, Democratic Recess, and Social Demotion

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Citation: Daniel Simonet (2022) French Administrative Reforms, Democratic Recess, and Social Demotion. Health Sys Policy Res Vol. 09 No. Issue 07:130.

Abstract

Healthcare has been a quite neglected issue in the French political debate, as the government responded to other more pressing citizens' demands for public housing, urban planning, and employment. The article discusses changes in the French healthcare sector that questioned France's ability to handle public health emergencies. Reforms shook the entire health system and affected its governance and accounting. The financialization of the health system, the verticalization, and the re-concentration of policy decisions led the government to play the role of an incentivizer and the patient that of overseers of reforms. However, outcomes were below expectations on many dimensions. Reforms could not address key health emergencies, including the rise of the medically underserved areas, the shortage of hospital beds, and the already long patients' waiting lists.

Keywords: France; Administrative reforms; New public management; Public sector reform; Diagnostic related groups

Received: 01-July-2022, Manuscript No. Iphspr-22-12812; **Editor assigned:** 04-July-2022, PreQC No. Iphspr-22- 12812; **Reviewed:** 18-July-2022, QC No. Iphspr-22-12812; **Revised:** 21-July-2022, Manuscript No. Iphspr-22-12812 (R); **Published:** 28-July-2022, DOI: 10.36648/2254-9137.22.9.130

Introduction

Outcomes of New Public Management have triggered discussions about whether the French health care system is about to break up. In the 2000s, central health authorities implemented an NPM agenda in search of greater efficiency, performance, and accountability [1]. What was the impact of administrative reforms such as the verticalization and re-concentration of the decision-making process on citizens and the medical profession? What accounting reforms were implemented? What changes affected hospital governance? Practitioners report a higher degree of discontent [2]. The financialization of the health system is on the rise, with the state playing the role of an incentivizer. Did reforms improve citizen's involvement (Christensen & Lægreid, 2011), despite the need for greater budget discipline? In retrospect, despite its potential for improving the quality of public services, citizen participation is not necessarily greater, as power remains firmly concentrated in the hand of administrative elite [3]. Reforms signal the rise of the regulatory state and a return to its Napoleonic traditions that emphasize positivism (Comte, 1855), top-down decision-making, and a concentration of decision-making power within higher health authorities [4].

Hospital Accounting Reforms

French health care reforms targeted first and foremost public hospitals, as these represented 54 % of health expenditures in the 1980s (Le Garrec et al., 2013) [5]. Unlike the NPM-endorsed Anglo-Saxon disaggregation of health services (Talbot, Johnson, 2007), French administrative reforms sought to reassert the central health authorities and the Ministry of Health over public care providers in a bid to end the earlier fragmentation of the health system, as exemplified by the high number of public and non-public regional health organizations with regulatory and monitoring powers [6]. That dispersion created duplications, generated higher costs, opened more opportunities for bribery, and was beyond the central government's control [7].

Hospital compensation mechanisms experienced several reforms to contain rising health care expenditures. In 1983, a lump sum was allocated to local hospitals via direct negotiation with the Ministry of Health [8]. However, the higher bargaining power of care providers prevented the government from achieving the desired savings (Domin, 2013). Hence, the transition to a novel compensation mechanism, known as Activity-based

Payment (T2A), thanks to the development of a Computerised Medical Information Systems Programme (PMSI) between 1982 to 1990 (Domin, 2017) [9]. That lump sum allocated to hospitals eventually disappeared in the early 2000s (Domin, 2017). In the 1990s, France extended the Diagnostic Related Group (DRG) scale, known as Homogenous Groups of Patients (*Groupes Homogenes de Patients*) to all care providers, public or private [10]. Overall, the national DRG scale led to a benchmarking of hospitals against government-set accounting standards (Juven, 2015) calculated on a sample of participating hospitals. There werw major revisions of the DRG categories over the last decade to reflect the diseases' levels of severity [11]. To this day, DRGs remain the primary compensation mechanism for hospitals. Moreover, total health expenditures must stay below a set limit known as the National Health Expenditures Target (*Objectif national de dépenses d'assurance Maladie* / ONDAM), voted in parliament every year. Despite these reforms that met the EEC austerity agenda (McKee, 2012), the level of debt of public hospitals almost trebled between 2003 and 2011 (General Accounting Office, 2013) [12].

Governance Reforms and its Repercussions on the Medical Profession

The 2009 HPST law implemented a new hospital governance that replaced the board of directors with a supervisory board and the executive board with a managing board, with both having reduced power (art L. 6141-1 of Public Health Law) [13]. Rather than granting greater autonomy to local welfare institutions (Lægreid Per and Mattei Paola, 2013), the 2009 HPST law re-concentrated and re-centralized health policy decisions within the Regional Health Agencies (RHA) and hospital managers at the expense of the hospital board of directors [14]. The Ministry of Health now appoints the managers of the Regional Health Agencies and the hospital directors (they used to be elected by hospital physicians rather than appointed) who were given substantial incentives (they can be fired if they do not meet targets defined by the central government) and extended power to achieve objectives defined by the Regional Health Agencies (Mas et al., 2011) [15]. These macro-level initiatives were designed to reassert the center to ensure greater sustainability of the welfare state (Lægreid and Mattei, 2013), achieve desired performance targets (Guigner, 2013), and provide integrated care, as in foreign exemplars (Wright & Turner, 2021) [16]. They ended the 'negotiated order' (Degeling & Maxwell, 2004) that traditionally presided over the medical profession and triggered a verticalization of the chain of command from the Ministry of Health to the hospital director at the expense of the operating core (e.g., physicians and nurses) [17].

That 'de-professionalization' of the medical profession had multiple repercussions: the transfer of power to an administrative elite at the expense of physicians' autonomy in decision-making, a lesser need for specialized knowledge (Jones, 2020), greater job insecurity for the medical profession, all of which weakened the sense of belonging (Demailly & De La Broise, 2009) [18]. This was aggravated by the mercenarization of the medical profession in some specialties (e.g., anesthesia). In response, the 2014 Health Project (Tourraine, 2014), which required the contribution of over 200 regional forums (Tourraine, 2014), sought to encourage greater participation from the medical profession by reinstating physicians in hospital governance [19]. Nonetheless, the alienation of the medical profession could only worsen: working conditions for medical staff deteriorated. A rising number of medical students suffered from burnout (Faivre et al., 2018). While none of these were anticipated, the blame was put on hospitals rather than on a chronic shortage of resources (Juven et al., 2019). Hospitals were accused of being unable to reform on their own and patients of going to the ED for non-urgent care

Financialization and Corporatization of Care Providers

The financialization of health care is on the rise (Hunter & Murray, 2019). Hospitals are incentivized to set ambitious long-term targets for their activities. As a result, they allow too much for future demand, inflate their profit targets, and, like corporations, tend to overestimate their future capacity and size (Turner & Wright, 2021). Due to a shortage of resources, hospitals are also compelled to borrow extensively and to hire short-term staff [20]. Inspired by the EU-led marketization agenda (Deters & Falkner, 2020), hospitals adopted other NPM management recipes such as project management, management by objectives, a quantification of outputs or 'governing by numbers' (Bezes, 2020), greater flexibility in human resources, a new status for hospitals (i.e., hospitals are no longer public administration, but public health entities under government contracts), and a greater standardization of health services (Domin, 2016) via the issuance of medical guidelines [21]. While these shall lead to a 'profitable hospital', they also threaten the provision of health services. The least profitable medical units such as emergency services in city centers and maternity hospitals in rural areas face closure.

The Government as an Incentivizer

The state has acquired a new role, that of an 'incentive manipulator. As suggested by NPM, there is now a greater incentivization of care providers via penalties and premiums. Public hospitals must comply with government-defined patient volume targets or face penalties. Payments to hospitals do not just reflect the actual costs of health services (Belorgey, 2018) but also incentivize them to opt for cheaper treatments. For example, ambulatory care benefits from a higher compensation rate than hospital care. In addition, hospitals must repay the excess treatment costs of a disease if these are higher than the DRG set fee. Moreover, care providers must comply with a National Health Expenditures Target (Objectif National des Dépenses d'Assurance-Maladie, ONDAM), voted every year in parliament. Coupled with a greater autonomy in decision making (Domin, 2016), government incentives prompt care providers to increase their efficiency, compete for patients and select the least expensive to treat (the 'profitable patient'). Hospitals are also incited to induce demand or increase the number of consultations to secure an income (Belorgey, 2018). Inducements have had important repercussions in care delivery. There is now

a greater division of medical procedures into smaller ones, just like a factory (Velut, 2020). However, this Fordist approach does not view the patient or his/her ailment as a whole, which may jeopardize the treatment of chronic or long-term diseases such as diabete or mucoviscidosis that requires a more global approach. It also led to the dehumanization of patients (Ogien, 2000), shorter consultation times, and a risk of patient readmissions, as seen in other systems that pursue similar Managed Care reforms. These failings prompted Juven et al. (2019) to reassert that the hospital cannot be run like a corporation.

Discussion

The Patient as a Reform Overseer?

There has been a controversial debate raised by the scholarship on how French health reforms affected the balance between political and professional control (Pierru, 2012, 2009) and the role of patients' and users' oversight (Bordet, 2012; Benamouzig, Besançon, 2007). According to Giordano and Tommasino (2011), citizen engagement can positively influence the provision of local public services such as education, civil justice, and healthcare. The paradigm of an open government requires increased transparency in public processes. Public information shall be available online to the citizenry. The impact of openness to the public depends on citizens' democratic ability, opportunities for participation, and empowerment. Citizens and non-governmental organizations must be encouraged to interact, contribute and evaluate health services through innovative platform-based forms of involvement. The 2014 Health Act intended to reconcile the NPM managerial agenda with citizen engagement and to implement a direct representation and participation of citizens via a patient committee in every public hospital and to improve coordination and efficiency of local public services (Giordano, Tommasino, 2011) thanks to the creation of Hospital Territorial Communities. As for citizen participation, many NPM governance mechanisms (e.g., balanced scorecards, league tables for hospitals, patient satisfaction survey) have the potential to enhance democratic accountability in health care (Mattei 2009), embrace a higher degree of patient's representativeness and inclusiveness (Pierre, 2009) in hospital governance and instill a greater deliberation on policy direction (Overeem, 2011) and consultation. However, outcomes were below expectations. In practice, public reporting is unlikely to have a limited impact on the quality of care. While citizens' perception of local public services is positively influenced by performance management (Andrews & Van de Walle, 2013), there is limited evidence of patient use of public reporting in ways that can effectively improve the quality of health services.

Advocating NPM-modelled patient choice in French policymaking will require a new definition of the concept of sovereignty for the principal (e.g., patients). To begin with, the patient is not a consumer, as no one chooses to be sick, which sets health care apart from other marketplaces. The lack of choice of a secondary care provider (e.g. hospitals) in French health care is a legacy that highlights path-dependency in reforms (Duit, 2016). Compared with Anglo-Saxon countries that emphasize perfect competition and the selection of a care provider, choice was never a core feature of the French health system. Unlike NPM-modelled reforms that view users as consumers and emphasize patient choice (e.g., the US managed care), the latter has not materialized in France due to a lack of care providers, except in the capital city and on the French riviera. The primary care physician plays the role of a gatekeeper for specialty care to which patients do not have direct access, unless they opt for a more expensive private care provider. Moreover, there are too few performance indicators for patients and physicians to compare and select an appropriate care provider. Accounting indicators such as health care costs and patient volume were at the expense of quality indicators (e.g., patient medical outcomes) and access (e.g., waiting lists, affordability, and availability of sophisticated medical equipment such as MRI in regions). Quality indicators do not exist in France, except for nosocomial infections. Thus, it is vain to expect the public to act as an overseer of health services or to discipline a market-driven health system. Was it realistic to talk about patient choice in the first place? A patient is first and foremost an anxious person who can be influenced easily, even manipulated. Patients seek a competent health care professional who can be trusted. Therefore, physicians take the oath not to abuse patient trust (Grimaldi, 2013). When treatment choices and preferences are available, the public does not make rational decisions. Instead, it relies on subjective factors such as a practitioner's reputation, word-of-mouth, recommendations by friends or medical professionals, and proximity to their home rather than hospital league tables. Even doctors remain relatively indifferent to the ranking of hospitals. Overall, French health authorities emphasized government regulations and centralized negotiations to avoid the worst: marketization.

Verticalization and Re-Concentration of Policy Making

The strengthening of Ministry-level bureaucrats intends to restore core public values (O'Flynn, 2007) such as neutrality, territorial equity, and uniformity that receded under earlier decentralization policies (Montricher, 1995), as evidenced by the rise of geographic disparities.The vertical alignment of regional health agencies on centrally-defined policies will, in theory, preserve institutional continuity and other key administrative features contained in the path dependency theory (Martin, 2010; Pierson, 2000). These include the French tradition of centralization (vs. the juxtaposition of health systems, as observed in the British National Health System); national coherence (vs. territorial dispersion); central control (vs. Anglo-Saxon commissioning and contracting of health services by local health authorities). The steering of the regional health policies by the Ministry of Health also suggests greater demand for spatial planning, despite neo-liberal times (Waterhout et al., 2013). Hence, a reinstatement of Skowronek's (1982) and Wilson (1973) earlier work on the state-building capacity, on convergence and unification of regions; on the quest for impartiality; on neutral expertise rather than political party strategies. Nonethless, the outcomes of Regional Health Agencies (RHAs) were below expectations. Their weak

management capacities became apparent during the covid pandemic. Critical shortcomings included a shortage of Personal Protective Equipment (PPE) and tests, a lack of beds in Intensive Care Units (ICU), an inaccurate assessment of the magnitude of the epidemic (Shuyi, 2020)… In addition, the RHAs proved too bureaucratic, lacked coordination and logistical capabilities, and focused on control rather than service delivery. While the RHAs were not initially designed to manage emergencies, their failings in that area led policy-makers to suggest further decentralization from regions to counties (or "*departement*") to improve services delivery (Camões, 2020) and to propose a return to the principle of unity of command, as opposed to having two decision-makers: the Prefect, who has traditionally been the government arm of policy implementation since Napoleon, and the Regional Health Agencies (Escudié, 2020).

Reforms point to a hybridization of New Public Management (Pyun, 2014). There is an alignment of the neo-Weberian model that emphasizes rationality, specific statutes, reliability, precision, and expertise with a 'new' contract-based market model (Biland, 2012) structured around pay-for-performance contracts between Regional Health Agencies and care providers, as well as policy instruments such as DRGs, management by objectives, performance targets… Care providers are monitored through various metrics (e.g., hospital length of stay, caps on expenditures with a penalty for exceeding the latter, patient volume targets…). As in Di Giulio's earlier's work (2015), elements of the positive and the regulatory state are increasingly interrelated with reforms aiming at 'governing at a distance' (Rose, Miller, 2010) i.e. from an administrative dashboard rather than at privatizing and deregulating, as originally feared (Majone, 1997).

However, efforts to improve the transparency of the health system and contain costs remain largely theoretical. Accountability, be it horizontal or vertical, is not necessarily greater. New governance mechanisms are needed to preclude gaming strategies (Gao et al., 2021) such as the upcoding of a disease to a DRG that benefits from a higher compensation rate (Milcent, 2021), to prevent patient selection (Domin, 2017), and the use of NPM as a reputation-protecting tool by the political class and top-level bureaucrats. Outsourcing of healthpolicy decisions to consulting firms creates opportunities for politicians to blame private organizations in times of crisis (Greasley, 2020). When activities are delegated to private operators, the negative repercussions in terms of reputation loss for the government are often temporary, as exemplified by the blame game between Anglo-Saxon consulting firms and the French government regarding delays in vaccine delivery during the covid-epidemic. As for cost containement policies that drove reforms initially, savings were below expectations due to NPM's higher bureaucratic costs. 33.7 % of French hospital employees are administrative staff against 23 % in Italy, Germany, and Spain. Despite reforms, France is the country that spends the most on health (11.3% of its GDP) in Europe, followed by Germany (11.25%), Sweden (11%), Austria (10.4%), Belgium (10.3%), Denmark, and the Netherlands (10.1%). That shift of expenditures towards the technostructure was at the expense of hospital capacity, as exemplified by the suppression of public hospital beds **(69,000 between 2003 and 2017), though needs are higher due to population aging and rising technological progress**.

Conclusion

The government struggles to balance the economic agenda of the NPM reforms, its quest for performance and accountability with the need for greater democratic participation, and citizens' demands for a more generous health system that would end economic and democratic disparities. Regulations and guidelines are likely to build up at the expense of health care providers' autonomy and social accountability, that is, accountability to citizens, patients, and societal actors (Brummel, 2021). These limitations highlight the need for a "fuller commitment to the development of policy capacity, with all that it entails in terms of leadership and social responsibility" Furthermore, the need to balance social equity with efficiency of public services has led to reiterated calls for a collective post-NPM agenda that would emphasize public participation and inclusion.

Acknowledgement

None.

Conflict of Interest

None.

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