Our planet, our health, our priority!

By Éloi Laurent

“Are we able to reimagine a world where economies are focused on health and well-being?” With these words, the WHO issued a call to governments and citizens around the world on World Health Day, 7 April 2022, which marks the 74th anniversary of its founding and the coming into force of its Constitution.

The theme of the WHO anniversary is “our planet, our health”, and it comes only a few weeks after the publication of three important articles that help to grasp the relevance and scope of this theme.

The first two articles demonstrate the progress in our knowledge about the emergence of SARS-CoV-2, the origin of the Covid-19 pandemic. The authors state that, first, it is ”very likely” that the pandemic is the result of a zoonosis (i.e. transmission from animals to humans), as was the case with SARS-CoV-1 in 2002/2003, and that, second, it was at the Wuhan live animal market that this transmission first took place. This is a major breakthrough in a scientific debate that has been fiercely contested for the past two years and where all hypotheses have been seriously considered.

The third article looks at the consequences of the Covid-19 pandemic and measures the magnitude of the health shock it has caused. The authors estimate the excess mortality due to the global pandemic in 191 countries and territories from 1 January 2020 to 31 December 2021. They conclude that there is a discrepancy of one to three between their estimates and the official figures: taking into account errors and mistakes in

the Covid death toll, the number of deaths worldwide over this period was not 5,940,000, but rather 18,200,000 (a global excess mortality on the order of 16%).

For some countries, such as India, the gap is truly considerable: from 489,000 official deaths to an estimated 4,070,000. For France, the gap is still significant: from 122,000 to 155,000, i.e. a difference equivalent to the number of official deaths during the first wave in spring 2020. Yet this global estimate is based on the figure of 17,900 Chinese deaths (almost four times more than officially announced), which is simply impossible to believe.

It is clear therefore that human health is "inextricably linked" to the health of ecosystems and biodiversity, which implies, as the WHO rightly points out, that the health-environment nexus must become the backbone of an economy of well-being calibrated for the 21st century.

This backbone must be based on a "One Health" approach. In November 2020, a panel of high-level experts in this field (with Serge Morand being the only French member) was charged with consolidating and institutionalising this approach under the aegis of the World Organisation for Animal Health (OIE), the Food and Agriculture Organisation of the United Nations (FAO), the United Nations Environment Programme (UNEP) and the WHO. Human health, animal health, plant health and environmental health, these experts tell us, are complementary and interdependent.

The climate challenge similarly highlights the intersection of health and environmental issues. The second installment of the IPCC Sixth Assessment Report, which deals with the impacts, adaptations and vulnerabilities associated with climate change, runs to 3,676 pages and contains no fewer than 4,853 occurrences of the word "health".

Given all this, the WHO might want to update its own

definition of health, which dates from 1948: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. To update this definition, we may wish to define “full health” as “a continuous state of well-being: physical and psychological, individual and social, human and ecological”. The important thing about this definition is to emphasise the holistic nature of the approach, the continuity of health, which links mental health to physiological health, individual health to collective health and human health to planetary health. Full health is therefore health based on interfaces, synergies and solidarities.

If the WHO member states were to adopt this redefinition of health, this would, for example, encourage health issues in France to be studied systematically from an environmental perspective, which is far from being the case today, as can be seen from examining the profusion of reports and proposals on the future of the French health system, and more broadly on health insurance and its financing. The common point in all these is to ignore the ecological issue almost completely. Yet if there is a “Great Social Security System” to be invented, it is social-ecological security.

The Covid-19 pandemic has shown how health is a collective matter that is blurred and distorted by calls for “individual responsibility”, but the collectivity that we must take note of and become partners in goes far beyond the human race alone.

Environmental health policy: A priority for a global health renaissance

by Éloi Laurent, Fabio Battaglia, Alessandro Galli, Giorgia Dalla
Libera Marchiori, Raluca Munteanu

On 21 May, the Italian Presidency of the G20 together with the European Commission will co-host the World Health Summit in Rome. A few days later, the World Health Organisation will hold its annual meeting in Geneva. Both events will obviously focus on the Covid tragedy and on reforms that could prevent similar disasters in the future. “The world needs a new beginning in health policy. And our health renaissance starts in Rome,” said European Commission President Ursula von der Leyen on 6 May. We share this hope and want to see it succeed.

As members of civil society, we have been called upon to contribute to the collective discussion that will lead to the drafting of the “Rome Declaration”. Based on a report we are releasing today as part of the Well-being Economy Alliance (WeALL), we believe that the notion of an environmental health policy should be at the heart of the Rome Declaration and,

beyond that, it should inspire the overhaul of health policy at all levels of government. In essence, we are calling on the delegates at these two crucial summits to recognise the fruitful interdependencies between the environment, health and the economy.

The key principle is to make the link between health and the environment the core of global health and move from a cost-benefit logic to co-benefit policies. Our inability to respond effectively to the twin crises hitting health and the environment stems in large part from our perception of the costs that resolute action would have for the “economy”. But we are the economy, and the economy forms only part of the true source of our prosperity, which is social cooperation. The health-environment transition does of course have an economic cost, but it is clearly lower than the cost of *not* making the transition. The limits of the monetarisation of life are becoming more and more apparent, and every day it is becoming clearer that the supposed trade-offs between health, the environment and the economy are wrong-headed and counter-productive. Conversely, the gains in terms of health, jobs, social cohesion and justice from co-benefit policies are considerable. Health systems are the strategic institutions in this reform, so long as much greater emphasis is placed on prevention, but other areas of the transition are also involved: food

production and consumption, energy systems, social policy (particularly the fight against inequality and social isolation) and educational policy.

To take simply the example of energy, it is abundantly clear that today's global energy system, based 80% on fossil fuels, makes no sense from the point of view of humanity's well-being, as it is simultaneously destroying current and future health. Air pollution resulting from the use of fossil fuels is playing a grave role in the health vulnerability of Europeans facing Covid-19 (responsible for 17% of deaths according to some estimates); yet reducing air pollution in Europe's cities would bring a key health co-benefit: it would reduce the risk both of co-morbidity in the face of future environmental shocks such as respiratory diseases but also of heatwaves, which are becoming increasingly frequent and intense on the continent. When all the co-benefits are taken into account, first and foremost the reduction of morbidity and mortality linked to air pollution (which, according to recent studies, are much higher than previous estimates, with 100,000 premature deaths in France each year), the switch to renewable energies would lead to savings of around fifteen times the cost of their implementation.

Beyond these areas we have identified, there are many others where health, the environment and the economy are mutually reinforcing. Together they form a foundation on which to erect

policies that
aim for the full health of a living planet. As the Rome Summit and the WHO
Assembly approach, we therefore want to challenge the participants with two
simple questions: What if the best economic policy were a genuine health
policy? What if the best health policy were
a genuine environmental policy? As the countries of Europe know very well,
crises are the cradle of new worldviews, the catalysts of new approaches that
can gain traction. Rome was not built in a day, but the co-benefit approach can
light the way to a renaissance in health.

Social inequality in the face of death*

By Gilles Le Garrec

The problem of inequality in the face of death has become an important topic in French public discourse in recent times, in particular in autumn 2010 during debate about raising the minimum legal retirement age by two years, by gradually shifting it from age 60 to 62. The debate became focused around a politically divisive issue: should the retirement age remain unchanged for low-skilled workers on the grounds that they enter the labour market earlier and / or have more strenuous jobs and live shorter lives?Since the socialist government came to power in 2012, two exemptions have been introduced to allow less-skilled workers to continue to retire

at 60. First was the introduction in summer 2012 of an exception for a “long career”, that is to say, for those who have contributed for a sufficiently long time. This September 2013 it has also been decided to set up a “hardship” account, starting in 2015, which will allow all employees who are exposed to working conditions that reduce their life expectancy to retire earlier. Nevertheless, the issue of inequality in the face of death – a taboo subject? – involves much more than simply the retirement age; before that, there are also the issues of inequality in income, housing, access to employment, education, etc. What follows is a small panorama (statistical) on inequality in the face of death in France, its causes and the difficulty of developing a political solution due to the multidimensional factors involved.

Very old – but not very reliable – statistics

From the late 18th century [1], the development of censuses, which was associated with the rise of statistics, has made it possible to build up data that show the existence of a close link between inequality in the face of death and social inequality more generally. These early studies show that inequality in the face of death is explained primarily by income (Cambois, 1999). However, the import of these studies is limited due to the low reliability of their data and methodology. It is no easy matter to develop reliable indicators on this issue. Once we have the socio-professional categories (SPC) for death statistics and censuses, we can easily calculate mortality rates by comparing the number of deaths for the year (or years) classified by SPC with the size of the population classified in the same way. For example, in France for the period 1907-1908 Huber catalogued on an annual basis the death of 129 business executives aged 25 to 64 out of a total of 10,000, compared with 218 workers. This simple and intuitive method nevertheless gives a distorted view of social inequality in the face of death, due to

incompatibilities between population data and mortality data (Desplanques, 1993). The difficulty of obtaining an accurate representation of inequalities in the face of death becomes especially difficult with this method, as there is a growing trend for career paths to fragment, with alternating periods of activity and unemployment.

The longitudinal method and its lessons

To overcome this problem, France's INSEE has developed a longitudinal method that consists of regularly monitoring a group of individuals who have particular characteristics at a given point in time, and ultimately the date of their death. The permanent population sample thus obtained, which was initialized during the census of 1968, currently includes approximately 900,000 individual histories, ensuring a good representation of the French population (Couet, 2006, for a description of this sample and how it was constructed). This large-scale socio-demographic panel makes it possible to draw a relatively accurate picture of social inequality in the face of death in France. This shows that individual lifetime varies greatly from one socio-professional category to another, especially among men (Table 1). Male executives have a life expectancy (at age 35) that is four to five years above the average for men. Excluding inactive people [2], the most disadvantaged groups are manual workers, followed by white-collar employees, with life expectancies that are, respectively, two years and one year less than the average. Another interesting point is that the overall gain of four years in life expectancy over the period did not reduce inequalities in the face of death. The relatively stable result is that at age 35 the life expectancy of manual workers is six to seven years less (and white-collar employees five to six years less) than that of corporate executives and managers. In addition, at age 35 on average the latter experience 34 years in good health [3], 73% of their life expectancy, against 24 years for manual workers, or 60% of

their life expectancy (Cambois *et al.*, 2008). While among women, the difference in life expectancy between managerial personnel and manual workers was "only" three years at the time of the last census, the differences are comparable with those for men in terms of life expectancy in good health. The conclusion is clear: numerous social inequalities persist in the face of death, including in terms of health. This conclusion holds for every country in Western Europe that has conducted this kind of study, although it should be noted that the level of inequality in France appears to be the greatest by far (Kunst *et al.*, 2000). The ratio of "manual to non-manual mortality" in France was 1.71 for men age 45-59, whereas it is on the order of 1.35 in most other countries (Finland, second behind France in terms of inequality, is 1.53). Leaving aside issues of data comparability, alcohol consumption is, according to Kunst *et al.* (2000), the most important factor behind the specific situation of France. Indeed, the greatest inequalities in mortality in France are due to major differences in mortality due to liver cirrhosis and to cancer of the aerodigestive tract, both of which are associated with excessive alcohol consumption.

Table. Life expectancy of men and women at age 35, By period and socio-professional category

In years

Socio-professional category	Life expectancy at age 35			Difference with the average			Life expectancy at age 35			Difference with the average		
	1983-1991	1991-1999	2000-2008	1983-1991	1991-1999	2000-2008	1983-1991	1991-1999	2000-2008	1983-1991	1991-1999	2000-2008
	Men						Women					
Executives/managers	43,7	45,8	47,2	+4,5	+5	+4,4	49,7	49,8	51,7	+3,3	+1,8	+2,3
Intermediary profession	41,6	43,0	45,1	+2,4	+2,2	+2,3	48,1	49,5	51,2	+1,7	+1,5	+1,8
White collar employee	38,6	40,1	42,3	-0,6	-0,7	-0,5	47,4	48,7	49,9	+1	+0,7	+0,5
Manual worker	37,3	38,8	40,9	-1,9	-2	-1,9	46,3	47,2	48,7	-0,1	-0,8	-0,7
Inactive, not retired	27,5	28,4	30,4	-12,7	-12,4	-12,4	45,4	47,1	47,0	-1,0	-0,9	-2,4
Total	39,2	40,8	42,8	-	-	-	46,4	48,0	49,4	-	-	-

Source : Blanpain (2011), based on data from the permanent demographic sample, INSEE.

The causes

Several factors have been identified to explain the difference in mortality between socio-professional categories.

First, one can easily imagine that the working conditions of

manual workers are usually physically demanding and debilitating. Moreover, during the 1980s we have seen a transformation in the structure of unskilled jobs. Over this period, the increasing need for businesses to be highly responsive has led to a more widespread use of flexible and precarious forms of employment (short-term contracts; atypical schedules; development of part-time, temporary work, etc.). But the increasingly precarious nature of work, which affects low-skilled jobs above all, is contributing to a serious deterioration in working conditions. Global economic conditions may therefore play a part in explaining disparities in mortality. In any event, working conditions are not improving as quickly for manual workers as for managers. This is certainly the view that was advocated in establishing the "hardship" account that is to be implemented from 2015. So any private sector employee who is exposed to working conditions that reduce life expectancy will accumulate points that will, among other things, enable them to retire early, and potentially before the statutory threshold of 62.

It should also be noted that the most disadvantaged groups cumulate a number of risky behaviours, such as smoking, excessive alcohol consumption, poor diet and a sedentary lifestyle. In contrast, managers and the intermediate professions smoke and drink in moderation. As was already pointed out as a factor in France's poor results in Western Europe (Kunst *et al.*, 2000), these differences in behaviour show up clearly in the mortality rates associated with certain diseases. The risk of death due to a tumour in the aero-digestive tract (larynx, pharynx, lungs, oesophagus, liver) is especially high among manual workers, and is at the heart of a significant portion of the observed differences in mortality. For example, during the 1980s, among men aged 45 to 54, the mortality rate associated with a tumour of the pharynx was 11 times higher for skilled workers and labourers than for teachers and the intellectual professions (Desplanques, 1993).

A lack of access to healthcare for the most disadvantaged groups is another explanation offered for the disparities in mortality, first of all because of costs. Mormiche (1995) thus shows that the consumption of medical products (their quantity but also their nature) is highly dependent on income. Disparities in access to healthcare are particularly marked for care that is expensive or poorly covered (especially dental). Herpin (1992) points out that a reduction in income due to a loss of employment leads to an almost proportional reduction in consumer spending, including on health. The risk of death rises by 60% for unemployed men in the years following a job loss (Mesrine, 1999). A man in poor health is of course more likely to be unemployed, but unemployment, due to the development of financial stress and disorientation and to personal factors, may affect health by creating a physical and emotional distance with respect to obtaining care.

Finally, the social environment and the local context play an important role in the persistence of social inequalities in the face of death, as can be seen in Table 1. The idea that the behaviour of individuals is influenced by their place of residence has been developed in an extensive literature in the fields of both sociology and psychology (Roberts and DelVecchio, 2000). Mechanisms through which children identify with the behaviour of the adults surrounding them highlight a collective type of socialization. However, socio-spatial polarization, which is characterized by the creation of urban areas that cumulate all sorts of social disability, has been steadily increasing since the 1980s in France (Fitoussi *et al.*, 2004). In these neighbourhoods, the high level of concentration of groups characterized by risky behaviours may, through this process of identification, root these behaviours in the core of people's lifestyle. This phenomenon may explain why prevention policies among high-risk populations are ineffective. The financial difficulties that are giving rise to the under-utilization of medical facilities can also wind up leading to social distancing from health issues. The weak

participation of women from disadvantaged strata in public programmes to screen for breast cancer is illustrative of this. Moreover, even in countries where there is effective universal health coverage, the differences in the consumption of healthcare persist.

What should we conclude?

Social inequality in the face of death is a sensitive issue. At the heart of this problem lie a multitude of more or less overlapping causes. To be effective, policies to combat this type of inequality must grasp them as components of an ensemble, with interactions throughout their economic, social and spatial dimensions. While awaiting the reduction of these larger inequalities, it would seem worthwhile to establish just social policies that take account of this inequality in the face of death. In this regard, setting up a “hardship” account that enables any employee who is exposed to working conditions that reduce their life expectancy to retire earlier is definitely a step in the right direction. Nevertheless, the establishment of criteria is not as easy as it seems. Indeed, it is clear that a good share of social inequality in the face of death can be explained by risky behaviour. Some might reason that such behaviours are an expression of individual freedom and that it is not up to society to compensate for the consequences. Or, it could be argued, to the contrary, that these behaviours are a response to psychosocial stress caused by, among other things, difficult working conditions. From this perspective, the compensation represented by an earlier retirement would seem more equitable. But it is not certain that we can really distinguish these two cases. You can bet that the future definition of the criteria for accumulating points to meet the “hardship” criteria giving entitlement to early retirement will be the subject of lengthy negotiations….

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* I would like to thank Sandrine Levasseur, Hélène Périvier and Evens Salies for their insightful comments.

[1] Pioneering works that could be cited include those by Moheau (1778) and Villermé (1840).

[2] A category that groups individuals who have never worked. For women, this means mainly "housewives".

[3] Good health is defined by the absence of limitations on everyday activities and the absence of incapacity.

Obama 2012: “Yes, we care!”

By Frédéric Gannon (Université du Havre) and Vincent Touzé

On Thursday, 28 June 2012, the United States Supreme Court delivered its verdict. The principle that individuals are obliged to take out health insurance or else face a financial penalty, a central plank in the 2010 reform [1] of the health insurance system (the Affordable Care Act [2]), was held to be constitutional. This reform had been adopted in a difficult political context. It includes a variety of measures intended to significantly reduce the number of Americans without health coverage. Although it will increase federal spending, new revenues and spending cuts will make it possible to reduce the deficit.

From September 2009 to March 2010, there was a lengthy process of drafting and approving the law, with an uncertain outcome due to the lack of a majority in the Senate [3]. Since the law passed by the House of Representatives and signed on 23 March 2010 by President Obama differed from the version passed by the Senate, amendments were introduced in a Reconciliation Act that was passed on March 30th. Opponents of the reform (26 states, numerous citizens and the National Federation of Independent Business) then decided to take the fight to the US Supreme Court. Their hopes rested mainly on the possible unconstitutionality of the law, which centered on the individual’s obligation to take out health insurance, called the “individual mandate”, and on the expansion of the Medicaid public insurance program.

The favourable judgment of the Supreme Court was obtained with a narrow majority: five judges voted for [4] and four against [5]. The political inclinations of the judges did not seem to have worked against the law, since Chief Justice John G. Roberts, an appointee of George W. Bush, gave his approval. The Supreme Court majority considered that the financial

penalty for a failure to take out insurance is a tax [6] and that it had no cause to rule on the merits of such a tax. It passed this responsibility to Congress (the upper and lower houses) which, in this case, has already debated and approved the law. Consequently, this point of law is valid.

According to the Supreme Court, the financial penalty for failing to purchase health insurance could be viewed as an individual obligation to purchase [7], and "the Commerce Clause does not give Congress that power". But from a functional standpoint, this penalty can be regarded as a tax, in which case Congress has discretion to "lay and collect Taxes" (Taxing Clause). Hence the positive verdict of the Supreme Court. However, the Court believes that "the Medicaid expansion violates the Constitution" because the "threatened loss of over 10 percent of a State's overall budget is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion".

The Supreme Court decision represents a major victory for President Barack Obama, who had made a reform to ensure more equal access to the health insurance system one of the spearheads of his 2008 election campaign. His Democratic predecessor in the White House, Bill Clinton, previously had to abandon a similar reform due to fierce opposition from the Republicans and growing divisions among the Democrats. In order to give himself every chance of success, Obama has had to be more strategic in the programming of both the reform and the way it was presented [8]. To do this, he also assembled a team of experienced specialists [9].

The Act represents a real cultural revolution in a country where the health insurance system excludes nearly 50 million people. Besides the individual mandate requiring Americans to purchase health insurance, the ACA's main measures are:

- The creation of "exchanges" for insurance contracts where people can buy health coverage, with a government

subsidy that depends on the level of income;

- Expansion of the Medicaid public health insurance program [10] (public coverage for all households with incomes below 133% of the federal poverty level) and financial penalties on states that choose not to implement this expansion (elimination of all federal funding of the Medicaid program);
- A requirement that employers offer health insurance to their employees (application of financial penalties if the obligation is not met, with exceptions for small businesses);
- New regulations on the private insurance market (obligation to offer coverage to all individuals, with no conditions on their health status).

Beginning in 2014, millions of uninsured American households should benefit from the expansion of Medicaid, which the Supreme Court has now ruled unconstitutional – this raises numerous questions [11]. How many States will be tempted not to expand Medicaid? What are the consequences for the poor households [12] who were to benefit from this expansion? Will they have the means to afford subsidized private insurance [13]? Will they be penalized financially if they do not buy insurance? Will they be encouraged to migrate to States that have adopted the expansion [14]? It is reasonable to expect that few States [15] will boycott the expansion of Medicaid, as the ACA offers them other strong incentives (federal assumption of 100% of the additional cost from 2014 to 2016, then 95% after 2017, and 90% after 2020; loss of some federal funds if no expansion). However, adjustments in the law will likely be useful if policymakers want to avoid excluding those who are too poor to afford subsidized private insurance.

The law will come into force gradually, with the various measures to apply from 2014. According to the latest report by the Congressional Budget Office (2012), annual government expenditure (expansion of Medicaid and private insurance

subsidies) should rise by about $265 billion per year [16] by 2022 (the estimated total cost between 2012 and 2022 is $1,762 billion), and the number of uninsured should fall by about 33 million [17]. The reform also provides for an increase in tax revenue (higher compulsory levies and new taxes) and a reduction in federal spending (primarily substitutions between the expanded Medicaid program and the old program). This will result in amply offsetting the cost of the reform. In a previous report in March 2011, the CBO estimated that the total reduction in the deficit over the period 2012-2021 will come to $210 billion. In the name of hallowed liberties, however, there is still strong opposition to the individual mandate [18], but over time it can be hoped that this mandatory principle will come to be viewed first and foremost as a basic right that protects all citizens.

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[1] For an overview of the health insurance system and the reform, see Christine Rifflart and Vincent Touzé, "La réforme du système d'assurance santé américain", *Lettre de l'OFCE, n°321*, 21 June 2010. Also see the Wikipedia article on this subject.

[2] This legislation reconciles the two laws, the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act*.

[3] "Health Care Reform: Recent Developments", *The New York Times, June 29*, 2012.

[4] Stephen Breyer, Elena Kagan, Ruth Bader Ginsburg, and Sonia Sotomayor, along with Chief Judge John G. Roberts.

[5] Clarence Thomas, Anthony Kennedy, Antonin Scalia and Samuel Alito.

[6] Floyd Norris, "Justices Allow the Term 'Tax' to Embrace 'Penalty'", *The New York Times, June 28*, 2012.

[7] The legal position of the Obama administration has been to argue that the portion of the obligation to purchase insurance tantamount to a tax is the penalty paid by those who do not meet this requirement. This penalty has a regulatory function: it is designed based on the logic of an incentive, and not from the perspective of new tax revenue. Judge Jeffrey Sutton explained that if the government had clearly specified that the obligation to buy insurance was a tax, it would have been easier to justify in terms of its constitutionality. Most tax allowances or tax rebates are positive incentives (tax breaks on the acquisition of cleaner vehicles, for example). The health insurance requirement acts instead as a negative incentive by imposing a penalty / fine on those who decide not to buy insurance. Faced with these alternatives, they will choose in all rationality – according to a Pigouvian perspective – the option that they consider the most profitable or the least costly.

[8] Ezra Klein, "Barack Obama, Bill Clinton and Health-Care Reform", *The Washington Post, July 26*, 2009.

[9] Robert Pear, "Obama Health Team Turns to Carrying Out Law", *The New York Times, April 18*, 2010.

[10] Medicaid is a public health insurance program for the poorest households (about 35 million beneficiaries). The numerous criteria (income, age, degree of invalidity, state of health, etc.) lead to excluding a non-negligible portion of society's poorest. Hence more than 20 million people living below the federal poverty level do not have access to Medicaid. On the other hand, Medicare, the other public health insurance program, which is only for those aged 65 and over, broadly covers this age group.

[11] Urban Institute-Health Policy Center, "Supreme Court Decision on the Affordable Care Act: What it Means for Medicaid", *Policy Briefs, June 28*, 2012.

[12] Genevieve M. Kenney, Lisa Dubay, Stephen Zuckerman and Michael Huntress, "Making the Medicaid Expansion an ACA Option: How Many Low-Income Americans Could Remain Uninsured?", *Policy Briefs, Urban Institute – Health Policy Center, June 29*, 2012.

[13] In the absence of an expansion of *Medicaid*, their health insurance spending will be capped at 2% of their income.

[14] This notion of voting with their feet was put forward in an article by Charles M. Tiebout (1956): "A Pure Theory of Local Expenditures", *The Journal of Political Economy*, 1956, vol. 64/5, pp. 416-424.

[15] Brett Norman, "Lew: 'Vast majority' of states will expand Medicaid", *Politico, 1st July 2012*.

[16] In 2022, 136 billion dollars will finance public health insurance for 17 million poor people (expansion of Medicaid) and 127 billion dollars will go to subsidies for the purchase of private insurance by 18 million people.

[17] In 2022, the 27 million uninsured remaining will consist of illegal immigrants (ineligible for public and private insurance programs) and those eligible for Medicaid who do not want to take out insurance as well as those ineligible for Medicaid who also do not want insurance.

[18] Susan Stamper Brown, "Time To Clean Up The Obamacare Mess", *The Western Center for Journalism, June 26, 2012*.

Is our health system in danger? Reorienting the reform of health management (4/4)

By Gérard Cornilleau

Health is one of the key concerns of the French. Yet it has not been a major topic of political debate, probably due to the highly technical nature of the problems involved in the financing and management of the health care system. An OFCE note presents four issues that we believe are crucial in the current context of a general economic crisis: the last major concern about the health system is hospital financing. This underwent severe change in 2005 with the launch of the T2A system, which reintroduced a direct financial relationship between the activity of the hospitals and their financial resources. It has reinforced the importance and power of the "managers", which could give the impression that hospitals were henceforth to be regarded as undertakings subject to the dictates of profitability.

The reality is more complex, as the T2A system is aimed less at making hospitals "profitable" than at rationalizing the way expenditure is distributed among the hospitals by establishing a link between their revenue and their activity, as measured by the number of patients cared for weighted by the average cost of treating each patient. Paradoxically, the risk of this type of financing is that it could lead to a rise in spending by encouraging the multiplication of treatments and actions. In fact, the HCAAM report for 2011 (*op. cit.*) notes that the 2.8% growth in hospital fee-for-service expenditures in 2010 can be broken down into a 1.7% increase attributable to an increase in the number of stays and a 1.1% increase

attributable to a “structural effect” linked to a shift in activity towards better reimbursed treatments [1].

This development is worrying, and it could lead to a rise in hospital costs for no reason other than budget needs. The convergence of costs at private clinics and at government and non-profit hospitals is no guarantee against this tendency, as the incentives are not different for private clinics. Here we are reaching the limits of management by competition, even in a notional form, as its flaws are too numerous for it to be the only means of regulation and management.

Public hospitals also receive lump-sum allocations to carry out the general interest and training missions assigned to them. This lump-sum envelope represented approximately 14% of their actual budget in 2010 [2]. It provides funding for teaching and research in the hospitals, participation in public health actions, and the management of specific populations such as patients in difficult situations. Unlike reimbursements related to the application of the fee schedule, the amounts of the corresponding budgets are restrictive and easy to change.

Consequently, budget adjustments are often based on setting aside a portion of these allocations and revising the amounts allocated based on changes in total hospital expenditure. In 2010, for instance, the overrun of the spending target set for the hospitals that year, estimated at 567 million euros, resulted in a 343 million euro reduction in the budget allocated to the general interest mission, or an adjustment of about -4.2% from the original budget (HCAAM, 2011).

The regulation of hospital expenditure has tended to focus on the smallest budget share, which is also the easiest for the central authorities to control. While it is possible to revise the reimbursement rates of the T2A fee schedule, this takes time to affect the budget and the targets are harder to hit. The system for managing hospital budgets is thus imperfect,

and it runs the dual risk of uncontrolled slippage on expenditures governed by the T2A system and a drying up of the budget envelopes used to finance expenditures that do not give rise to any billing. There is no magic bullet for this problem: returning to the previous system of a total budget to finance total expenditure would obviously not be satisfactory when the T2A system has made improvements in the link between hospital activity and financing; nor is it acceptable to keep putting the burden of any budget adjustments solely on the budget envelopes of the general interest and investment missions, especially in a period of austerity. The general trend is to minimize the scope of the lump-sum funding envelope (Jégou, 2011) and to maximize the scope of fee-for-service charging.

Pricing is not, however, always perfectly suited to the management of chronic complex conditions. One could therefore ask whether, conversely, the establishment of a mixed rate system of reimbursement, including a component that is fixed and proportional, would not be more effective, while facilitating the overall regulation of the system as a whole by means of a larger lump-sum envelope. The fixed part could for example be determined on the basis of the population covered (as was the case in the old system of an overall budget). This development would also have the advantage of reducing the obsessive managerial spirit that seems to have contributed significantly to the deterioration of the working atmosphere in the hospitals.

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[1] The patients treated by the hospital are classified into a *Groupe Homogène de Malade* (GHM, a diagnosis-related group) based on the diagnosis. For each stay of a given patient, the hospital is paid on the basis of a fee set in the *Groupe Homogène de Séjours* (GHS, a stay-related group), which refers

to the patient's GHM and to the treatment that they receive. In theory this system can associate an "objective" price with the patient treated. In practice, the classification into a GHM and GHS is very complex, particularly when multiple pathologies are involved, and the classification process can be manipulated. As a result, it is impossible to determine precisely whether the shift towards more expensive GHS classifications reflects a worsening of cases, the manipulation of the classifications, or the selection of patients who are "more profitable".

[2] The credits, called "MIGAC" (for general interest missions and aid to contracting), came to 7.8 billion euros in 2010 out of total hospital expenditure in the "MCO" field (Medicine, Surgery, Obstetrics, Dentistry) of 52.7 billion; see HCAAM, 2011.

Is our health system in danger? Reforming the reimbursement of care (3/4)

By Gérard Cornilleau

Health is one of the key concerns of the French. Yet it has not been a major topic of political debate, probably due to the highly technical nature of the problems involved in the financing and management of the health care system. An OFCE note presents four issues that we believe are crucial in the

current context of a general economic crisis: the third issue, presented here, concerns the reimbursement of health care, in particular long-term care, and the rise in physician surcharges.

The reimbursement of care by the French Social Security system currently varies with the severity of the illness: long-term care, which corresponds to more serious conditions, is fully reimbursed, whereas the reimbursement of routine care is tending to diminish due to a variety of non-reimbursed fixed fees and their tendency to rise. In addition to this structural upwards trend there is a rise in non-reimbursed doctor surcharges, which is reducing the share of expenditure financed by Social Security. As a result, the share of routine care covered by health insurance is limited to 56.2%, while the rate of reimbursement for patients with long-term illnesses ("ALD" illnesses in French) is 84.8% for primary care [1]. This situation has a number of negative consequences: it can lead people to forego certain routine care, with negative implications for the prevention of more serious conditions; and it increases the cost of supplementary "mutual" insurance that paradoxically is taxed to help compulsory insurance on the grounds of the high public coverage for long-term illness. Finally, it puts the focus on the definition of the scope of long-term illness, which is complicated since in order to draw up the list of conditions giving entitlement to full reimbursement it is necessary to consider both the measurement of the "degree" of severity and the cost of treatment. The issue of multiple conditions and their simultaneous coverage by health insurance under both routine care and long-term illness is a bureaucratic nightmare that generates uncertainty and expenditure on relatively ineffective management and controls.

This is why some suggest replacing the ALD system by setting up a health shield that would provide for full reimbursement of all spending above a fixed annual threshold. Beyond a

certain threshold of average out-of-pocket expenses (*e.g.* corresponding to the current "co-payment" level) after reimbursement by compulsory health insurance, which was about 500 euros per year in 2008[2]), Social Security would assume full coverage. A system like this would provide automatic coverage of the bulk of expenses associated with serious diseases without going through the ALD classification.

One could consider modulating the threshold of out-of-pocket expenses based on income (Briet and Fragonard, 2007) or the reimbursement rate, or both. This possibility is typically invoked to limit the rise in reimbursed expenses. This raises the usual problem of the support of better-off strata for social insurance when it would be in their interest to support the pooling of health risks through private insurance with fees proportional to the risk rather than based on income.

The establishment of a health shield system also raises the issue of the role of supplementary insurance. Historically mutual insurance funds "completed" public coverage by providing complete or nearly complete coverage of anything in the basket of care not reimbursed by basic health insurance (dental prostheses, eyeglass frames, sophisticated optical care, private hospital rooms, etc.). Today these funds function increasingly as "supplementary" insurance that complements public insurance for the reimbursement of health expenses on the whole (coverage of the patient co-payment, partial refund of doctor surcharges). The transition to a health shield system would limit their scope of reimbursement to expenses below the fixed threshold. It is often assumed that if mutual insurance were to abandon its current role of blind co-payment of care expenditures, it could play an active role in promoting prevention, for example, by offering differential premiums based on the behaviour of the insured [3]. But where would their interests lie if the shield came to limit their coverage beyond the threshold not covered by public insurance? Even in the case of maintaining a

substantial “co-payment” beyond the threshold because of doctor surcharges, for example, they would undoubtedly remain relatively passive, and there would not be much change from the situation today, which isolates them from the bulk of coverage for serious and expensive diseases.

A system in which public insurance alone provides support for a clearly defined basket of care is surely better: this would require that the health shield increases with income, with the poorest households receiving full coverage from the first euro. If affluent households decide to self-insure for expenses below the threshold (which is likely if the latter is less than 1000 euros per year), the mutual insurance funds might withdraw almost entirely from coverage of reimbursements of routine care expenses. On the other hand, they could concentrate on the coverage of expenditures outside the field of public health insurance, which in practice would mean dental prostheses and corrective optics. They could intervene more actively than now in these fields to structure health care delivery and supplies. Their role as principal payer in these fields would justify delegating them the responsibility of dealing with the professions involved. However, this solution implies that a system of public coverage would be needed to give the poorest strata access to care not covered by the public insurance system (in a form close to France’s current CMU universal coverage system, which should however be extended and made more progressive). There is thus no simple solution to the question of the relationship between public insurance and supplementary private insurance.

The merger of the two systems should also be considered, which in practice means the absorption of the private by the public. This would have the advantage of simplifying the system as a whole, but would leave partially unresolved the question of defining the basket of care covered. It is quite likely that supplementary insurance would relocate to the margins of the system to support incidental expenses not covered by the

public system because they are deemed nonessential. The reimbursement of health costs should certainly remain mixed, but it is urgent to reconsider the boundaries between private and public, otherwise the trend towards declining public coverage will gain strength at the expense of streamlining the system and of equity in the coverage of health expenditures.

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[1] In 2008. This is a level of coverage that excludes optical. Taking optical into account, the rate of coverage by health insurance falls to 51.3% (Haut Conseil pour l'Avenir de l'Assurance Maladie [High Council for the Future of Health Insurance], December 2011).

[2] HCAAM, 2011 (*ibid*).

[3] It is not easy to take into account the behaviour of the insured. Beyond the use of preventive examinations, which can be measured relatively easily, other preventive behaviours are difficult to verify. Another risk inherent in private insurance is that insurers "skim" the population: to attract "good" clients, coverage is provided of expenditures that are typical of lower-risk populations (for example, the use of "alternative" medicines), while using detailed medical questionnaires to reject expenditures for greater risks.

Is our health system in danger? Dealing with the shortage of doctors (2/4)

By Gérard Cornilleau

Health is one of the key concerns of the French. Yet it has not been a major topic of political debate, probably due to the highly technical nature of the problems involved in the financing and management of the health care system. An OFCE note presents four issues that we believe are crucial in the current context of a general economic crisis: the second issue, presented here, concerns access to care, which could become more complicated due to a temporary reduction in the number of doctors.

The coming decline in the number of physicians, even if it is limited and temporary, runs the risk of developing medical deserts. Incentives exist to steer health professionals towards areas with a low medical density, but these are woefully inadequate, and the issue of more direct intervention is now on the agenda.[1] It will be difficult to avoid calling into question the complete freedom of doctors to install wherever they wish, which could result in a requirement for new physicians to go first to priority areas. But this would place a heavy burden on younger doctors, and inevitably involve some recompense. Would this mean accepting further increases in pay? To what extent? Should we allow further increases in physician surcharges ("dépassements d'honoraires")? The need for comprehensive negotiations with the profession is becoming clear: the past weakness of the *numerus clausus* restrictions on supply will lead for a while to some rationing in the supply of physicians; this reinforces the profession's market power at the very time when it is becoming necessary to call old compromises into question.

Ideally, it would be desirable to negotiate an increase in the income of doctors in training against a reduction in surcharges and constraints on their locations (possibly compensated by specific premiums). But this won't work for generations who have just completed their studies. So the only way forward clearly involves a strong upgrade in prices for medical acts (or fixed fees if, as would be desirable, doctors' incomes were calculated less on acts and increasingly on the size of their patient base [2]) as a counterpart for their acceptance of constraints on location (compensated) and a reduction in surcharges. These changes would constitute an additional burden on the health insurance system, which could be justified at least partially by the development of good practices. On the other hand, the increase in the individual remuneration of doctors will, for a few years, be partially offset by a reduction in their numbers.

The constraints of queuing should also encourage a better distribution of activity between physicians and a certain number of health technicians who can assist and even replace them in some situations (as is beginning to be the case in corrective optics). All these changes – the end of absolute freedom of installation, stricter regulation of surcharges, the sharing of medical activity with health technicians, the development of group work – are possible but would involve a major overhaul of the old compromise between the state and doctors. The main difficulty here is socio-political. To overcome it, we must also accept financial compensation for physicians, which will be difficult in a context of general rationing.

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[1] The HPST Act (Hospitals-Patients-Health-Regions) in July 2009 introduced a "public service commitment contract" that offers second-year medical students and interns an additional income of €200 per month for a commitment to move to a priority area for a period at least equal to the duration of

the receipt of the aid, with a minimum of 2 years. 400 contracts were offered in 2010-2011 (200 to students and 200 to interns), but only 148 were signed (103 students and 45 interns). This very limited figure is clearly insufficient in view of the forthcoming problems with doctors locating to areas in difficulty.

[2] Since 2010, Health Insurance has established a "Contract for Improving Individual Practice" ("CAPI"), which provides a lump sum of up to €7,000 per year for physicians who agree to follow certain rules on care and prevention. This scheme introduces a form of pay for performance that is distinct from pay for medical acts, which is in addition to the very limited pay related to the management of patients with a long-term illness ("ALD") by the treating physicians (€40 per year and per patient).

Is our health system in danger? The financing of health insurance and the crisis (1/4)

By Gérard Cornilleau

Health is one of the key concerns of the French. Yet it has not been a major topic of political debate, probably due to

the highly technical nature of the problems involved in the financing and management of the health care system. An OFCE note presents four issues that we believe are crucial in the current context of a general economic crisis: the first concerns the financing of health insurance, which is being undermined by a lowering of revenue due to the crisis; the second relates to access to care, which could become more complicated due to a temporary reduction in the number of doctors; the third involves the poor management of changes in the way reimbursement is divided between social security and complementary health insurance organisations in the context of a rise in non-reimbursed expenses (in particular higher surcharges by doctors); and finally, the fourth problem concerns hospital management, which has experienced major disruptions by the introduction of charges on this activity.

The financing of health insurance: A new source to explore

The crisis has further intensified the difficulty of financing health insurance, which is feeding concern about the sustainability of the health system and about public responsibility for healthcare costs. However, an analysis of the main trends in spending and financing shows that in the event of a return to a "normal" macroeconomic situation, the financial difficulties should be contained and only a limited structural effort would be needed to achieve a balanced situation; the initial deficit is relatively small (about 0.6 GDP of the total deficit, which is divided roughly into two equal halves of 0.3 point for the structural deficit and 0.3 point for the cyclical deficit), and there are only moderate prospects for a further rise in spending (with an increase in the expenditure / GDP ratio of around 0.1 percent of GDP a year). An increase in the CSG wealth tax and realistic efforts to control spending (of around 1 to 2 billion euros per year relative to the spontaneous trend) should be sufficient to ensure the financial sustainability of the system.

If the macroeconomic climate remains very bad for a long time,

the health insurance deficit could increase, in which case the issue of cutting expenditure could be posed more acutely. There would then be two options: either to accept a new increase in the deficit, as only a radical change in European policy would solve the issue of funding; or to put off a return to growth, which would mean adjusting the financial configuration of health insurance. Three variables could be used to adjust the accounts: to shift spending downwards; to raise taxes; or to lower reimbursements. In the bleak scenario of a halt in growth, it is likely that governments would seek to make use of these three variables. It is difficult to envisage a downward trend in spending at a time when needs will be increasing due to population growth and aging, and the spontaneous trend is already moderate. It would be possible to increase charges, but this would compete with tax increases to finance other government spending. As for lowering reimbursement rates, it would be difficult to do this uniformly when coverage of expenditure on primary care physicians is already very low.

The only path that has not yet been taken is means-testing reimbursement, which would lead to a large increase in the financial co-payments of the wealthiest households. This would undoubtedly reduce the deficit, but it would weaken the system, as public care would become increasingly expensive for the wealthier strata, which would lead them to support moves towards a private insurance system that excluded any redistribution between rich and poor.