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? 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.

In defense of France's "family quotient"

By Henri Sterdyniak

At the start of 2012, some Socialist Party leaders have renewed the claim that the "family quotient" tax-splitting system is unfair because it does not benefit poor families who do not pay taxes, and benefits rich families more than it does poor families. This reveals some misunderstanding about how the tax and social welfare system works.

Can we replace the family quotient by a flat benefit of 607 euros per child, as suggested by some Socialist leaders, drawing on the work of the Treasury? The only justification for this level of 607 euros is an accounting device, *i.e.* the total current cost of the family quotient uniformly distributed per child. But this cost stems precisely from the existence of the quotient. A tax credit with no guarantee of indexation would see a quick fall in its relative purchasing power, just like the family allowance (*allocation familiale* – AF).

With a credit like this, taking children into account for taxation purposes would lose all sense. As shown in Table 1,

families with children would be overtaxed relative to childless couples with the same income (per consumption unit before tax), and their after-tax income would be lower. The Constitutional Council would undoubtedly censor such a provision.

France is the only country to practice a family quotient system. Each family is assigned a number of tax parts or shares, P, based on its composition; the shares correspond roughly to the family's number of consumption units (CU), as these are defined by the OECD and INSEE; the tax system assumes that each family member has a standard of living equivalent to that of a single earner with revenue R/P; the family is then taxed like P single earners with income R/P.

The degree of redistribution assured by the tax system is determined by the tax schedule, which defines the progressivity of the tax system; it is the same for all categories of households.

The family quotient (QF) is thus a logical and necessary component of a progressive tax system. It does not provide any specific support or benefit to families; it merely guarantees a fair distribution of the tax burden among families of different sizes but with an equivalent standard of living. The QF *does not* constitute an arbitrary support to families, which would increase with income, and which would obviously be unjustifiable.

Let's take an example. The Durand family has two children, and pays 3358 euros less than the Dupont family in income tax (Table 1). Is this a tax benefit of 3358 euros? No, because the Durands are less well off than the Duponts; they have 2000 euros per tax share instead of 3000. On the other hand, the Durands pay as much per share in income tax as the Martins, who have the same standard of living. The Durands therefore do not benefit from any tax advantage.

The family quotient takes into account household size; while doing this is certainly open for debate, one cannot treat a tax system that does not take into account household size as the norm and then conclude that any deviation from this norm constitutes a *benefit*. There is no reason to levy the same income tax on the childless Duponts and the two-child Durands, who, while they have the same level of pay, do not enjoy the same standard of living.

Table 1. Family size and income taxation in euro

		Monthly wages / by tax share	Annual income taxation	Disposable income by consumption unit
Dupont	Couple	6 000/ 3000	8 472	2 526
Martin	Couple	4 000/ 2000	3 409	1 858
Durand	Couple + 2 children	6 000/ 2000	5 114	1858
Durand*	Couple + 2 children	6 000/ 2000	7 258	1798

* with a uniform tax credit.
Source: author calculations.

In addition, capping the family quotient [1] takes into account that the highest portion of income is not used for the consumption of the children.

Society can choose whether to grant social benefits, but it has no right to question the principle of the fairness of family-based taxation: each family should be taxed according to its standard of living. Undermining this principle would be unconstitutional, and contrary to the Declaration of the Rights of Man, which states that “the common taxation … should be apportioned equally among all citizens according to their capacity to pay”. The law guarantees the right of couples to marry, to build families, and to pool their resources. Income tax must be family-based and should assess the ability to pay of families with different compositions. Furthermore, should France’s Constitutional Council be trusted to put a halt to any challenge to the family quotient? [2]

The only criticism of the family quotient system that is socially and intellectually acceptable must therefore focus on its modalities, and not on the basic principle. Do the tax

shares correspond well to consumption units (taking into account the need for simplicity)? Is the level of the cap on the family quotient appropriate? If the legislature feels that it is unable to compare the living standards of families of different sizes, then it should renounce a progressive system of taxation.

Family policy includes a great variety of instruments [3]. Means-tested benefits (RSA, the “complément familial”, housing benefit, ARS) are intended to ensure a satisfactory standard of living to the poorest families. For other families, universal benefits should partially offset the cost of the child. The tax system cannot offer more help to poor families than simply not taxing them. It must be fair to others. It is absurd to blame the family quotient for not benefitting the poorest families: they benefit fully from not being taxed, and means-tested benefits help those who are not taxable.

Table 2 shows the disposable income per consumption unit of a married employed couple according to the number of children, relative to the income per consumption unit of a childless couple. Using the OECD-INSEE CUs, it appears that for low-income levels families with children have roughly the same standard of living as couples without children. By contrast, beyond an earnings level of twice the minimum wage, families with children always have a standard of living much lower than that of childless couples. Shouldn’t we take into account that having three or more children often forces women to limit their work hours or even stop work? It is the middle classes who experience the greatest loss of purchasing power when raising children. Do we need a reform that would reduce their relative position still further?

Table 2. Living standard of a family according to the number of children and employment status relatively to a couple without children

In euro per month by CU in 2009

Adult 1	MI	MW	MW	MW	2 MW	3 MW	4 MW
Adult 2	Inactive	Inactive	½ MW	MW	1 MW	2 MW	4 MW
1 child	99.9	99.4	89.9	85.0	84.9	85.5	85.2
2 children	102.6	97.5	87.1	79.9	77.1	76.2	75.7
3 children	105.8	98.4	93.6	84.0	75.7	70.6	70.5

MI: minimum income; MW: minimum wage.
Source: author's calculations.

The standard of living of the family falls as the number of children rises. Having children is thus never a tax shelter, even at high income levels. So if a reform of family policy is needed, it would involve increasing the level of child benefit for all, and not the questioning of the family quotient system.

Overall, redistribution is greater for families than for couples without children: the ratio of disposable income between a couple who earns 10 times the minimum wage and a couple who earns the minimum wage is 6.2 if they have no children; 4.8 if they have two children; and 4.4 if they have three. The existence of the family quotient does not reduce the progressivity of the tax and social welfare system for large families (Table 3).

Table 3. Income distribution is more equal between families

	10*minimum wage/ minimum income	10*minimum wage/ 1*minimum wage
0 child	9.2	6.2
1 child	7.8	5.3
2 children	6.8	4.8
3 children	6.0	4.4
4 children	5.7	4.2

Source: author's calculations.

Consider a family with two children in which the man earns the minimum wage and the wife doesn't work. Every month the family receives 174 euros in family benefits (AF + ARS), 309 euros for the RSA and 361 euros in housing benefit. Their disposable income is 1916 euros on a pre-tax income of 1107 euros; even taking into account VAT, their net tax rate is negative

(-44%). Without children, the family would have only 83 euros for the PPE and 172 euros in housing benefit. Each child thus "brings in" 295 euros. Income is 912 euros per CU, compared with 885 euros per month if there were no children. Family policy thus bears the full cost of the children, and the parents suffer no loss of purchasing power due to the presence of the children.

Now consider a large wealthy family with two children where the man earns 6 times the minimum wage and the woman 4 times. Every month this family receives 126 euros in family benefits and pays 1732 euros in income tax. Their disposable income is 7396 euros on a pre-tax income of 10,851 euros; taking into account VAT, their tax rate is a positive 44%. The French system therefore obliges wealthy families to contribute, while financing poor families. Without children, the wealthy family would pay 389 euros more tax per month. Its income per CU is 4402 euros per month, compared with 5819 euros if there were no children. The parents suffer a 24.4% loss in their living standard due to the presence of the children.

Finally, note that this wealthy family receives 126 euros per month for the AF, benefits from a 389 euro reduction in income tax, and pays 737 euros per month in family contributions. Unlike the poor family, it would benefit from the complete elimination of the family policy.

It would certainly be desirable to increase the living standards of the poorest families: the poverty rate for children under age 18 remains high, at 17.7% in 2009, versus 13.5% for the population as a whole. But this effort should be financed by all taxpayers, and not specifically by families.

No political party is proposing strong measures for families: a major upgrade in family benefits, especially the "complément familial" or the "child" component of the RSA; the allocation of the "child" component of the RSA to the children of the unemployed; or the indexation of family benefits and the RSA

on wages, and not on prices.

Worse, in 2011, the government, which now poses as a defender of family policy, decided not to index family benefits on inflation, with a consequent 1% loss of purchasing power, while the purchasing power of retirees was maintained. Children do not vote …

I find it difficult to believe that large families, and even families with two children, especially middle-class families with children, those where the parents (especially the mothers) juggle their schedules in order to look after their children while still working, are profiting unfairly from the current system. Is it really necessary to propose a reform that increases the tax burden on families, especially large families?

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[1] The advantage provided by the family quotient is currently capped at 2585 euros per half a tax share. This level is justified. A child represents on average 0.35 CU (0.3 in the range 0 to 15 year old, and 0.5 above). This ceiling corresponds to a zero-rating of 35% of median income. See H. Sterdyniak: “Faut-il remettre en cause la politique familiale française?” *[Should French family policy be called into question?], Revue de l’OFCE*, no. 16, January 2011.

[2] As it has already intervened to require that the Prime pour l’emploi benefit takes into account family composition.

[3] See Sterdyniak (2011), *op.cit.*

“Social VAT”: Is it anti-social?

by Jacques Le Cacheux

The prospect of a “social” value added tax, which was raised anew by the President of France on December 31 during his New Year speech, is once again provoking controversy. While the French employers association, the MEDEF, has included this measure in a series of proposed tax changes designed to restore France’s competitiveness, the Left is mostly opposed. It views the “social VAT” as an oxymoron, an antisocial measure that is designed to cut the purchasing power of consumers and hits the poorest among them disproportionately and unfairly. But what exactly are we talking about? And from the viewpoint of taxes on consumption, what is the situation in France relative to its main European partners?

The proposal to establish a social VAT represents, in fact, a combination of two measures: raising the VAT rate and allocating the additional revenue obtained to finance social welfare, while lowering – in principle by the same amount – social contributions. The way that these two operations are conducted can differ greatly: the rise in VAT could involve the standard rate (currently 19.6%), the reduced rate (currently 5.5%, but recently increased to 7% for a range of products and services), the creation of an intermediate rate, a switch to the standard rate of certain products or services currently at the reduced rate, etc., while the reduction in social contributions could cover employer contributions or employee contributions, be uniform or targeted on low wages, etc. Many policy choices are available, with distributional impacts that are not identical.

France now has one of the lowest rates of implicit taxation on consumption in the European Union (Eurostat). Its standard VAT

rate was reduced to 19.6% in 2000 after having been raised to 20.6% in 1995 to help ensure compliance with the Maastricht criteria, as the recession of 1993 had pushed the budget deficit significantly higher. This rate is now slightly lower than the rate applied by most of our partners, particularly as the deterioration of public finances has recently prompted several European countries to raise their standard rate of VAT. The reduced rate, at 5.5%, was, until the increase decided in December 2011 on certain products and services, the lowest in the EU.

What can we expect from a social VAT? Let's consider in turn the effects on competitiveness and then on purchasing power, while distinguishing the two aspects of the operation. A VAT hike has a positive impact on the competitiveness of French business, because it increases the price of imports without burdening exports, which are subject to the VAT of the destination country. In this respect, a VAT increase is equivalent to a devaluation. In so far as most of France's trade is conducted with our European partners within the European single market, this could be deemed a non-cooperative policy. Fine, but if all our partners were to use this type of "internal euro zone devaluation" – recall that in 2007 Germany increased its standard VAT rate from 16% to 19% – and we didn't, this would actually amount to a real appreciation of the "French euro". It would undoubtedly be better to aim for improved fiscal coordination in Europe, and to work for more uniform rates. But current circumstances are hardly favourable for that, and the threat of a VAT increase may be one way to encourage our main partner to show more cooperation on this issue.

Allocating the revenue raised to reduce social contributions will, in turn, have an additional positive impact on competitiveness only if it leads to a real reduction in the cost of labour to firms located in France. This would be the case if the reduction targeted employer contributions, but not

if it were on employee contributions.

Can we expect a positive effect on employment? Yes, at a minimum thanks to the impact on competitiveness, but this would be small, unless we were to imagine a massive increase in VAT rates. The effect of lowering labour charges is less clear, because the employers' social contributions are already zero or low on low wages, which, according to the available studies, is precisely the category of employees for which demand is sensitive to cost.

Isn't the decline in the purchasing power of French households likely to reduce domestic consumption and cancel out these potential gains? In part perhaps, but it's far from certain. Indeed, the rise in VAT is unlikely to be fully and immediately reflected in selling prices: in the case of Germany in 2007, the price increase was relatively small and spread over time –meaning that the margins of producers and distributors absorbed part of the increase, thus reducing the positive impact on business somewhat. In France, empirical work on the increase in 1995 shows that it too was not fully and immediately reflected in prices; and, although one cannot expect symmetrical results, it's worth recalling that the cut in VAT in the restaurant business was not passed on much in prices.

Would the rise in VAT be "antisocial" because it winds up hitting the poorest households disproportionately? No! Don't forget that the minimum income, the minimum wage (SMIC) and pensions are indexed to the consumer price index. So unless these indexes were somehow frozen – which the government has just done for some benefits – the purchasing power of low-income households would not be affected, and only employees earning above the minimum wage, together with earnings on savings, would suffer a decline in purchasing power, if consumer prices were to reflect the rise in VAT. It should also be noted that, if there is a positive impact on employment, some unemployed workers would find jobs and total

payroll would increase, meaning that the depressive impact on consumption often cited by opponents of this measure would only be minor, or even non-existent.

In short, “social VAT” should be neither put on a pedestal nor dragged through the dirt. As with any tax reform, we should certainly not expect a panacea against unemployment, or even a massive shift in our external accounts, even though it should help to improve our external price-competitiveness. But rebalancing our tax burden to focus more on consumption and less on the cost of labour is a worthy goal. In the context of globalization, taxing consumption is a good way to provide resources for the public purse, and VAT, a French innovation that has been adopted by almost every country, is a convenient way of doing this and of applying, without explicitly saying so, a form of protectionism through the de-taxation of exports. VAT is not, on the other hand, a good instrument for redistribution, since the use of a reduced rate on consumer products ultimately benefits the better-off as much or more than it does the poor. Most of our European partners have understood this, as they either do not have a reduced rate (as in Denmark) or have one that is substantially higher than ours (often 10% or 12%). It would be desirable to make the French tax system fairer, but this requires the use of instruments that have the greatest and best-targeted potential for redistribution: direct taxes – income tax, CSG-type wealth taxes, property tax – or social transfers, or even certain government expenditures (education, health). What is missing in the proposed “social VAT” is making it part of a comprehensive fiscal reform that restores consistency and justice to the system of taxes and social contributions as a whole.