



Unit 1: What can health economics teach us ?



4. Why is health care spending increasing in France?

- ➔ Since 1995, health care spending in France has grown from 9% of GDP to 11%. In the US, this increase was even bigger as, over the same period, we moved from 13% of GDP to 17%. What do we mean by health care spending? France measures this with the CSBM or consumption of health care and medical goods. This is just a part of what we just spoke about i.e. current health spending on an international level. The CSBM covers all spending related to medical care, be it outpatient, inpatient, or patient transportation. Inpatient care accounts for about half of this spending. However, managing and maintaining the health care system is, as we will see, part of overall current health spending. Current health spending includes the CSBM which I just mentioned and other costs required to run the health care system such as financing medical research dealing with contributions from health care professionals or other management expenses. Current health spending does not include investment or gross fixed capital formation. The indicator we choose is important as current health spending is compared internationally while France tends to prefer to look at the CSBM, which covers the most typical costs: doctors, hospitals and drugs. Current health spending increases a little over 2% per year which is more than GDP, which increases less than 2% per year. What does health care spending in France cover? So we have significant public spending. This brings up two issues. Is the spending sustainable? We will look at this shortly. We will also try to understand why this spending is increasing. We can cite the aging population or technological progress or even increasing demand from patients. Health care spending in France is mainly financed by social security. The law for the financing of social security is voted in Parliament each year. This financing of social security is often in deficit. This year's objective is to reduce the deficit as much as possible as deficits are financed by borrowing, i.e. by future generations. France even established the ONDAM or national objective for social security costs in 1996, but this objective is not mandatory. It simply shows general trends in social security costs without being strictly applied. The CSBM corresponds to about €3,000 per person per year i.e. about 9% of GDP and just under 13% total household consumption spending. 75% of the overall CSBM is financed through social security. This increases to over 90% for hospitals and transportation but is just 65% for outpatient care and less for other medical goods e.g. optical or orthotic devices. Private insurance corresponds to 13%. These are mutual funds and accident or life insurance. What remains for households is around 8% i.e. what they must cover themselves with no help from insurers. This part can vary greatly from 2% for hospital fees to 17% for drugs. The remaining 1.4% of costs are covered by the State and supplementary universal health coverage. In 2017, the French National Health Accounts showed the CSBM divided into several areas: less than half, or 46%, for hospitals then 26% for outpatient care independent practices, pharmacies medical spas and laboratories. Patient transportation was only 2% drugs were 17% and other medical goods were 8%. Since 2008, drug expenses have fallen compared to other areas. Does more health care spending lead to better access to care? The French health care system allows doctors to work where they want at the price they want choosing their own patients. Doctors are therefore paid per consultation which makes some people think that these costs are naturally inflationary. By comparison, doctors in the UK are paid per capita which means the number of patients, not consultations. This system also includes compulsory gatekeeping where patients have to go through a GP to be able to see a specialist.





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- The French system is therefore quite different from the neighboring UK system but, by studying how it works, we can see that the French system is inflationary but also affords better access to care than the UK system. The UK system, however, has a better handle on costs but in exchange has longer wait times and limited access to care. Why is health care spending going up? Now let's look at the many factors determining spending. Demographics and the aging population can increase health care costs. Technological progress and health insurance coverage can vary across countries. But on a macroeconomic level the main factor is quality of life. This largely determines health care spending levels across countries, more so than demographics. We see the same thing on a microeconomic level. Quality of life and personal diseases can affect health spending but income remains the main factor. Does health care spending improve health and life expectancy? Does health care spending work to improve health and life expectancy? In France, life expectancy progressed from about 25 years in the 18th century to more than 80 years today. Is this increase due to health care spending? It turns out that increased life expectancy was initially for other reasons: better hygiene a reduction in infant mortality and advances in nutrition and living conditions. Health spending, too, had an impact e.g. through the smallpox vaccine or antibiotics. This led to a continuous, yet late improvement. Although improved life expectancy initially benefited younger people due to reduced infant mortality it now benefits more older people through reductions in heart disease. Today, health care spending has a bigger impact. According to David Cutler, health care spending could be the reason behind increased life expectancy through better nutrition, public health care and hygiene. Cutler estimates that around 40% of the increase in longevity in the US over the last century is due to technological advances in medicine. What are the main factors for increased health care spending? Economists aim to determine the main factors behind increased health care spending. We often take the aging population. Elderly people do consume more, so if they increase in number this will increase health care spending by default. However, other factors could also be at play. This was the aim of the article I will briefly discuss which I wrote with Brigitte Dormont and Michel Grignon on health care spending in France in the 1990s. Our observation was simple. First, we saw a demographic increase in elderly people accompanied by an increase in spending at a given age which we can see on this graph. We see that health care spending varies over time according to age. This is to be expected as elderly people consume more. We can also see a shift in this pattern of spending between 1992 and 2000. What was the real impact of this change in spending trends? To answer this, we used a simple econometric method to model people's behavior depending on age or illness. We then tried to simulate what would have happened had they lived at a different time. For example, how much would the people observed in 1992 have had to pay in 2000? The answer surprised us. We observed that the effects of the behavioral changes based on age or illness were three times greater than those due to demographic changes resulting from aging. We also saw that behavioral changes and maybe technological progress are the main factors for increased spending. We see the same thing on a macroeconomic level as there is a direct correlation between spending levels and quality of life, rather than demographics. Should we spend more on health? Although the French system maintains the idea of horizontal equity i.e. the same needs receive the same treatment regardless of the patient's income this goal is only partially achieved.





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- The goal of coverage is achieved as almost the entire population is covered. There is even a redistribution effect because of this as the least healthy people tend to be the least well-off and therefore benefit from the financial redistribution which is an important aspect of the health care system. But in terms of health care
- consumption spending is unevenly distributed. Health care consumption for GPs is often concentrated among poorer patients while consumption for specialists is generally concentrated among the rich. In terms of health and the effects of health care spending there are still clear inequalities between different socioeconomic groups i.e. the life expectancy gap between 35-year-old blue/white-collar workers which has stayed at six years from 1976 to 2013. Death rates from heart attacks fell by 47% for high-level managers between 1982 and 1990 but by only 14% for workers or lower level employees. Progress in terms of health has therefore been uneven. We saw that health care spending has different determining factors and has been increasing for several years. Is this increase sustainable or even desirable? We are currently attempting to get a handle on health care costs. However, if we do spend so much, it is possibly by choice? Then we might wonder if there is an ideal level of health care spending. Some economists particularly Hall and Jones asked this question, taking our societies into account which are affluent societies. They wanted to know if it was possible or desirable to continue increasing health care spending for one simple reason: given that our societies already have wide access to consumer goods what can this extra growth in developed countries offer us? A third car? More travel? Maybe, if we already have enough consumer goods the rest of our wealth can go to our health and longer life expectancy so we can make the most of our goods and our lives. But the question of the ideal level of health care spending remains open. It is not the job of economists to decide this – we simply provide the tools.

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