Health insurance, efficiency and equity: French debates

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The French health care system is based on social insurance. It shares many features with Belgium's health care system. Like Belgium, France has universal compulsory insurance with broad coverage, financed through income-related contributions and taxes. At the same time, the market for care is very liberal in both countries. In France, there is almost no rationing in care provision; patients can choose (and freely change) their GPs with no limitations. Despite a gate keeping system set up in 2004, direct access to specialists is not very restricted, because the corresponding penalty is rather small. Doctors are predominantly remunerated through fee-for-service, with the exception of physicians working in public hospitals, and those providing care services in schools or firms. A large proportion of hospital stays occurs in private-for-profit hospitals: one third of total stays and more than half of surgical stays.

On the whole, the French health care system combines strong socialization of financing with loose regulation of efficiency in care delivery. Hence the French health care system can be characterized as hybrid, just like the Belgian system described by Schokkaert and Van de Voorde. Furthermore, the French health insurance system offers a good example of a mixture of public and private health insurance (Barigozzi, 2003; Blomqvist and Johansson, 1997). Of course, the national health insurance (named *Sécurité sociale*) acts as a single payer and provides the bulk of the coverage, but a large number of private health insurers supply complementary health insurance that covers a much smaller, but nonetheless sizeable proportion of health expenditures.

1. Overview of the French health care system

The French health care system is rather costly: according to OECD data for 2008, the proportion of GDP devoted to health expenditures amounts to 11.2%, which places France in second place for health expenditures among OECD countries, behind the USA (16.0%) and slightly ahead of Belgium (which is at the third place with 11.1%). Levels of annual health expenditures per capita are quite similar in France and Belgium. For the year 2008, they are equal respectively to €3,677 and €3,696 (PPP). For the same year 2008, 76.8% of French health expenditures are covered by national health insurance and 13.7% by private complementary health insurance. The remaining 9.5% comes from out-of-pocket payments. This proportion of out-of-pocket payments is one of the lowest among OECD countries.

Given its cost, the performance of the French health care system is fairly good, without being outstanding. In France, life expectancy at birth is one of the highest in Europe. France ranks second worldwide, behind Japan, for life expectancy at birth of women (84.4 years in 2007). But for men France falls back to 13th place (77.5 years in 2007).[1] The French performance is rather poor as regards avoidable deaths (before 65) and conditions connected to risky behaviors (tobacco, and alcohol). Moreover, income-related health inequalities are sizeable in France. Many commentators

[1] In Belgium, the corresponding figures are, for the year 2007, 82.6 years (women) and 77.1 years (men).

incriminate fee-for-service payments and the extensive freedom of French GPs as concerns their localization. These features provide little incentive for preventive care and lead to a very uneven spatial distribution of GPs, who are relatively rare in low income areas. Consequently, not enough screening exams are performed in response to the needs.

This mitigated assessment contrasts strongly with the first place given to France in a worldwide ranking of health care systems carried out by the World Health Organization (2000). This ranking suffers from numerous methodological shortcomings and a sensible economist can hardly believe the results.[2] It has nonetheless had political consequences in France, where parties in favor of the status quo brandish the first place of France in this ranking to reject any attempt at reorganization.

The preamble to French Constitution states that the Nation guarantees health protection for all. Consequently, the French health insurance system ensures solidarity between the healthy and the sick in order to make care affordable for any citizen. The HCAAM[3] (2011), an advisory council in charge of following developments in the French health insurance system and making policy recommendations, has recently stated that the general philosophy of the French system is to espouse the following principle: "From each according to his capacities, to each according to his needs".[4] According to the HCAAM, this means that (i) the cost of insurance should be related to individuals' level of income and independent of their health; (ii) the benefits should depend on the need for care only, irrespective of the individual's wealth. These principles are close to those put forward by Schokkaert and Van de Voorde for Belgium. It should be stressed that there is a strong consensus of opinion in France on universal solidarity as concerns access to care. For instance, all attempts at introducing deductibles have been met by general protest and rejected. Everybody wants to defend free access to care, without being conscious that non-negligible inequalities already affect the costs of care that some persons have to pay out of pocket (see section 3). Moreover, there is a categorical rejection of any decision that could introduce rationing in care delivery. This climate of public opinion, adroitly maintained by doctors, is a major obstacle for a government that tries to improve efficiency in care delivery.

In France as in Belgium (and in any health care system in developed countries), the main issues are efficiency and equity in care delivery. As concerns equity, there is a general agreement on the principles and the French system performs rather well. Efficiency is much more problematic. The search for efficiency in the context of a public opinion that is rather hostile to the idea has led to decisions that do not really promote efficiency and actually might threaten equity in care delivery.

In France, as in Belgium and elsewhere, the long-run challenge is to accommodate expected increases in health care expenditures. As shown in Dormont *et al.* (2006) and Dormont (2009), the main driver of this increase is the diffusion of medical innovations that improve longevity and quality of life. Of course, it is crucial to improve efficiency in care delivery. But for a given (and hopefully optimal) level of efficiency, there is no point in limiting health expenditure growth if this increase contributes to a gain in social welfare (Hall and Jones, 2007). Depending on the assumption adopted for the pace of technological progress, we can expect French health expenditures to come to somewhere between 14% and 21% by 2050 (Dormont *et al.*, 2010).

How can we cope with such an increase in health expenditures? Four options are conceivable, three of which are close to the ones considered for Belgium by Schokkaert and Van de Voorde: (i) doing

[2] The ranking is based on the estimation of the relation between health (measured by life expectancy) and health expenditures, while controlling for the level of education (which also influences health). The estimation was performed on data from 191 countries as different as France, USA, Guinea Bissau, the Maldives, Zimbabwe, etc. and assumed that the coefficient describing the influence of education on health is the same, whatever the country's development level. Given this method, the first place attained by France is due to a lower number of years of education in France than in countries of northern Europe, for comparable level of health expenditures. Therefore, the French performance in life expectancy appears to be particularly good. The apparent efficiency of French health care system thus derives from relatively low investment in education (Grignon, 2008).

3 *Haut Conseil pour l'avenir de l'assurance maladie*.

[4] It is rather surprising to find this Marxist phrase in an administrative report. However, in the HCAAM report, it concerns only one part of consumption, namely health care. Therefore, it does not have the same meaning at all as the principle that Marx laid out in 1875 as a guide to the construction of communist society, where it concern all individual consumption.

nothing, which implies an extension of the coverage provided by the private complementary health insurance; (ii) extending the role of national health insurance; (iii) accept an increasing role of complementary insurers, while introducing regulated competition to prevent risk selection, guarantee affordability of complementary insurance and provide incentives for contracting with care providers to pursue efficiency in care delivery. The fourth option under debate in France is called "*bouclier sanitaire*". It consists of putting a cap on annual total individual copayments, while introducing deductibles to finance the resulting additional reimbursements. This option comes down to modifying the distribution of copayments between individuals.

In what follows, I describe the architecture of the French health insurance system, and then consider the equity and efficiency of the French health care system. Then I present the four options that could permit to deal with the future increase in health expenditures. To conclude, I examine how the French experience might possibly be useful to Belgians in rethinking their own system.

2. Architecture of the French health insurance system

From the beginning, national health insurance did not provide a full coverage of health care costs. Copayments were set up in order to limit expenditures. However, these copayments have progressively been covered by complementary health insurance, leading *de facto* to a mixed insurance system: coverage is provided by the compulsory national health insurance and private optional complementary insurance. Currently, the involvement of complementary health insurers is not negligible: in 2008, they covered 13.7% of total health expenditures and 20.7% of ambulatory care. A specificity of France is that complementary health insurers play the roles of both complementary and supplementary health insurance (Colombo and Tapay, 2004). They are complementary in that they participate in the coverage of basic health care services, i.e. the care services to which access is guaranteed to all by the Constitution. They are supplementary in that they cover the costs of other care services, such as comfort in hospital, alternative medicine, extra charges for consultations. The fact that optional insurance reimburses a significant proportion of basic care is specific to France. In many other countries, optional insurance covers only goods and services that are not considered essential to health.

The coverage provided by national health insurance is fairly generous and amazingly steady over time. The proportion of health care expenditures covered by national health insurance was equal to 76.8% in 2008. It was equal to 76.5% in 1970, forty years ago. Given that health expenditures increase more rapidly than GDP, this stability of coverage requires a continuous increase in the rate of income-related contributions and taxes devoted to financing national health insurance. In 1970, contributions equal to 3.8% of GDP were enough to cover 76.5% of health expenditures. For comparable coverage in 2008, a much higher contribution rate, equal to 6.7% of GDP, was required. Given the increase in health expenditures that is expected in the future, maintaining this coverage will not be possible without an increase in the contribution rate.

Yet in France, as in many countries, there is growing political pressure in favor of a limitation in taxes and social contributions. Consequently, for the last several years, the actual rule applied was to avoid raising the contribution rate for health insurance, leading to sizeable deficits for the national health insurance.[5] Each year, a drama is played out whose scenario is always the same: the government raises the alarm when publishing the extent of the deficit, named "*le trou de la Sécu*".[6] It is said that the deficit is catastrophic and that measures must be taken immediately. For many years, the decisions taken consist of increasing copayments, which comes down to implementing a gradual retreat of national health insurance in favor of larger coverage by complementary health insurers. There has

[5] Anyway, this has entailed in practice an increase in the tax rate to reimburse the resulting debt.
[6] That is, the "hole" of the *Sécurité Sociale*.

been a slight but continuous erosion of the coverage rate by national health insurance, from 78.5% in 2004 to 76.8% in 2008 (-1.7 percentage points), in favor of OOP payments (+ 1.2 percentage points, from 8.3% to 9.5%) and coverage by complementary health insurers (+ 0.5 percentage point)[7].

The magnitude of copayments has led to the creation of safety nets to protect the poor and the sick. In 2000, free complementary coverage was instituted for people with low incomes. This shows the recognition by the government of the role of complementary insurance in guaranteeing access to care. About 7 % of the French population benefit from this plan. In addition, people affected by a chronic disease may enjoy 100 % coverage for all care services connected to this disease. To be eligible for this plan, people have to be affected by a condition reported in the official list of "*Affections de longue durée (ALD)*". In practice, this plan has contributed to the creation of two populations with very different coverage rates: on average, ALD patients are reimbursed 90% of the cost of medical care whereas non-ALD patients are reimbursed only 66%[8]. The road to hell is paved with good intentions: the ALD plan is simultaneously a permissive condition and a motivation for the gradual retreat of national health insurance. Indeed, the stability of coverage described above hides a continuous structural change: the proportion of ALD patients has increased, while the rate of coverage of non-ALD patients has decreased. The two movements fuel each other: for national health insurance, cutting back on coverage makes it possible to finance the patients newly eligible for ALD; for a doctor, giving a patient access to ALD coverage solves the patient's financing difficulties. The ALD plan thus creates a dynamic that favors extension of the number of ALD patients and deterioration of coverage for non-ALD patients.

On the whole, our national health insurance system is rather complex. Its architecture is characterized by two tiers, compulsory national health insurance and optional complementary health insurance. Within national health insurance, there are different levels of coverage between ALD and non-ALD patients. This organization might jeopardize the system's performance in equity and efficiency in care delivery.

3. Equity and efficiency: the whole truth about the French system

3.1 Equity in access to care

As stated above, there is much concern in France about equity in access to care. The ALD plan could be seen as threatening the system's cohesion. This plan might also be considered quite unfair, since it is possible to incur very high care costs without being eligible for ALD. However, French people are generally in favor of giving more generous coverage to seriously ill individuals, and they resist attempts to strike illnesses from the list that determines eligibility.

The average coverage rate for basic health care is 79.0%.[9] However, analysis of equity in financial access to care requires focusing on copayment distribution. Indeed, individual health expenditures are extremely concentrated: each year 50% of the reimbursements by national health insurance result from health care provided to a small minority of patients, who represent only 5% of insured people. This characteristic of expenditure distribution is observed in all developed countries: it is due to treatment costs, which reach extreme values in a few rare cases. Even the very richest individuals are exposed to the risk of a level of health care costs they cannot afford. This characteristic explains why a society that aims to guarantee access to care to all citizens must make health insurance compulsory.

[7] To avoid going into too many details, we give here the coverage provided by both the national health insurance and the state (the latter contributes for a very small proportion, hardly more than 1%). Figures are given here for the year 2008 to use the same year for all indicators, but French statistics are available for more recent years (DREES, 2010).

[8] The coverage rate of ALD patients is lower than 100% because they are subject to copayments for care services they use for illnesses other than those for which they were granted ALD status.

[9] The coverage rate of 76.8% given in our description in section 1 concerns total health expenditures, including supplemental care.

Another consequence of this concentration of health expenditure distribution is that partial coverage by health insurance exposes people to copayments that can reach extreme values, if there is no cap on total annual copayments. In 2005, average annual copayments in France were € 200 for ambulatory care and €45 for hospital care (Briet *et al.*, 2007). But for the 5% of insured people with the highest expenditure (about 3 million individuals), the average copayment for ambulatory care was €1,490 if they were ALD patients, and €943 for non-ALD patients. For the 1% of insured people with the highest expenditure, these figures were equal to €2,737 for ALD patients and €1,460 for non-ALD patients. As concerns hospital care, 9% of patients who went to hospital were subject to a copayment above €1,000. It should be noted that these figures do not include the extra fees that some doctors charge for consultations, above and beyond the national health insurance fee schedule.

Unlike many other countries, France has no ceiling on copayments borne by individuals. They are more or less covered by complementary health insurance. Hence, complementary insurance appears to be a condition for access to basic health care. In fact, giving up on health care is strongly correlated to lack of complementary coverage: one third of people with no complementary coverage report having given up on the use of some care services, a much higher proportion than for people with complementary coverage.

Access to complementary health insurance is hence crucial to access to health care. Currently, only 7% people are not covered by complementary health insurance, a figure which suggests that the problem is not serious. Such a conclusion is not legitimate: given the current regulation of complementary health insurance and the expected growth in health expenditures, it is likely that access to complementary coverage will become more expensive or even prohibitive for an increasing share of the population. About 40% of individuals with complementary insurance benefit from this coverage through their employer. For the rest of the population, complementary coverage is optional and entails payment of a premium which generally increases with age and is independent of income level. Consequently, access to complementary coverage is obtained through a regressive payment: in 2006, the richest households (the top 10%) devoted 2.9% of their incomes to purchasing complementary coverage, while the poorest (the bottom 10%) paid 8% of their incomes. Such a financial effort can be considered prohibitive for low-income people and lead them not to buy insurance.

Moreover, the risk pooling carried out by complementary health insurers is very limited because they compete on a market for insurance that is optional. Three-fourths of reimbursements are provided by non-profit sickness funds that claim to respect the ideal of solidarity.[10] But they compete with private-for-profit companies and cannot equalize their enrollees' premiums without losing all their young and healthy enrollees, which would lead to a rise in the average premium. In this context, complementary insurers have to adjust their premiums to individuals' expected expenditures. In particular, the premium depends closely on the enrollee's age. In addition, while direct risk selection is discouraged by regulations concerning tax exemptions, insurers have developed contract segmentation to select young and healthy clients.

To sum up, the market for complementary insurance is characterized by a lack of solidarity between the rich and the poor and by limited risk-sharing between different groups, together with risk selection. This situation has already led to premium levels which are very high for some households (8% of their income). If future increases in health expenditures were covered by an extension of the scope of complementary health insurance, premium levels would be likely to rise even more quickly

[10] According to Schokkaert and Van de Voorde, the same ideological principles are adhered to by Belgian sickness funds.

than health expenditures[11] and become unaffordable for an increasing share of the population. In other words, the current organization of complementary health insurance cannot be maintained without jeopardizing equity in access to care.

3.2 *Efficiency in care provision*

Efficiency in care delivery is not considered an important issue by most French people and not much has been done to gain in efficiency. Doctors resist any constraint on their activity and they successfully brandish the threat of care rationing to forestall any decision that is not in their interest. At its beginning, national health insurance bore responsibility for care management. Currently, all decisions regarding health care regulation are taken, or at least approved of, by the government. And doctors are reputed to wield such wide influence that they can make or break an election campaign.

Economists distinguish between productive efficiency, which consists in avoiding waste, and allocative efficiency, which implies that health care expenditures are in keeping with individual or collective preferences. Allocative inefficiency arises when there is overconsumption or underconsumption (excessive waiting lists for instance). Overconsumption may result from full coverage of patients because they do not bear any financial consequence of their decisions. Overconsumption may result as well from care providers who induce their patients to use more care services than necessary. This behavior, called supply induced demand, is encouraged by fee-for-service payments that make the physicians incomes depend directly on the amount of care services provided.

In France, the decisions that really affect efficiency have consisted in influencing the demand side by the introduction of copayments. On the supply side, incentives have been set up that have led to an increase in the use of generic drugs. But fee-for-service payments that encourage supply induced demand have been left in place: in ambulatory care and private for-profit hospitals, physicians are self-employed and receive fee-for-service payments. A 2004 reform has introduced a prospective payment per case for hospitals.[12] In principle, this provides strong incentives for efficiency in care delivery, since payments depend on diagnosis at admission and not on the procedures implemented during the stay. But, as in other countries, the stay classification actually used relies closely on procedures implemented during a stay. Furthermore, the nomenclature has been excessively refined in France: the number of classification groups rose from 780 in 2009 to 2,291 classification groups currently. All of this contributes to encouraging an excessive use of invasive procedures, as is the case of fee-for-service payments.

In France, the number of GPs per resident is one of the highest among OECD countries. But their localization is very uneven and not connected to needs. This is a source of inefficiency in care provision. In areas with too many doctors, their earnings are limited by the lack of patients (since they are paid on a fee-for-service basis) and they are likely to induce demand. On the contrary, in areas where GPs are scarce, patients have difficulties in seeing a doctor. Although policy makers are aware of the problem, they have never dared to constrain doctors in their choice of location, in keeping with the general interest.

The influence of complementary health insurers also contributes to inefficiency. Currently, they are passive reimbursement agencies that have no responsibility in managing care. Nevertheless, they compete on coverage, which has led them to cover almost all copayments and to defeat attempts at

[11] Indeed, because complementary health insurance is optional, the increase in premiums would be amplified beyond the increase in the covered expenditures, due to the fact that young and healthy people would be likely to terminate their contracts.

[12] This prospective payment system has replaced global budgets for public hospitals and retrospective reimbursements for private hospitals.

limiting unnecessary consumption. For example, the coverage rate for drugs of limited medical interest has been recently reduced to 15% by the national health insurance. Non-profit sickness funds announced they would not cover the remaining 85%. But for-profit insurers covered these drugs, leading the non-profit sickness funds exposed to competition to follow suit.

Another important issue is the extra fees that some doctors are allowed to charge for consultations in ambulatory care or for procedures in private hospitals. To contain health care costs, the national health insurance negotiates a fee schedule with doctors' associations. This schedule provides the reference fees that are used to compute reimbursements by the national health insurance. However, doctors have managed to obtain the creation of a specific category of physicians who are allowed to charge extra fees. In 2004, 14% of GPs and 39% of specialists were allowed to charge extra fees. On average, these amount to an extra cost of 47% above the reference fee. The coverage of these extra fees is very unequal: people with no complementary coverage are not reimbursed for the extra fees; people who have subscribed complementary insurance individually are reimbursed little or not at all. Coverage is more generous for people who benefit from complementary insurance through their employer. Complementary coverage is not only optional; it is heterogeneous and helps a minority of people to afford expensive care. This creates an additional source of inequity since it contributes to maintaining prices that are too high for many citizens.

The French health insurance system has two tiers, with a first-level compulsory insurance, which acts as a single payer, and second-level optional complementary insurers. Our description shows how such a mixed system seems to be incapable of effective care management, since the second tier includes actors that do not share the same objectives as the first-tier insurance.

Another question is whether the existence of a single payer for most expenses could be responsible for the lack of effective care management. The underlying idea is that absence of competition induces no pressure in favor of more efficiency in care delivery. It is true that given the unpopularity of the idea of health care efficiency in France, policy makers have not much incentive to implement reforms that doctors and patients dislike. The alternative seems to be the model of regulated competition introduced in Switzerland, Netherlands, etc. Does it perform better? We turn to this question below.

4. Four options to deal with the future increase in health expenditures

Health care expenditures are likely to keep growing rapidly in the future. For a given level of productive efficiency, this increase contributes to a gain in social welfare and thus to allocative efficiency. Therefore, the health care system should be organized in order to make this growth possible. In France, four options are conceivable, three of which are close to those considered for Belgium by Schokkaert and Van de Voorde.

4.1. No change in the current organization

This would imply an extension of coverage provided by private complementary health insurers, i.e. a gradual privatization of insurance. As explained above, this would entail an increase in copayments and in premiums to buy complementary insurance. It is likely that premiums would become prohibitively expensive for a growing proportion of the population, blocking access to complementary insurance and hence, to care. Moreover, reimbursements to ALD patients would tend to exhaust all the funds of the national health insurance, which would turn into a catastrophic insurance system. Such a change would break with the principles of equal access for all promoted by the French constitution.

4.2. Extension of the scope of National Health Insurance

National health insurance can fully cover basic health care. This option is not that expensive: the reimbursements provided by complementary insurers in 2009 could be financed by an additional contribution of about 2% levied on all incomes. Of course, future increases in health expenditures would involve an increase in the total contribution rate. One advantage of this option is that it extends the scope of compulsory insurance, thus reducing inequalities in access to insurance and to care arising from optional complementary insurance (see section 3.1). In this case access to full coverage for low-income people would entail a cost of 2% of their income (the new contribution) instead of 8% in the current situation. Moreover, it would increase the regulatory power of national health insurance by doing away with the problems resulting from a two-tiered insurance system with unregulated competition for complementary insurers. Such a reform would confine their activities to supplementary coverage for non-basic care services.

Many French citizens are unaware that such an enhanced compulsory health insurance system already exists in the Alsace-Moselle region. This region of France was annexed to Germany between 1871 and 1918. During this period, Bismarck created the German health insurance, which the present day Alsace-Moselle scheme stems from. Financed by a contribution equal to 1.65% of all incomes, this compulsory scheme offers extra coverage on top of the National Health Insurance, leading to a total coverage rate of 90% to 100%. Many members of the French parliament reject the idea of more generous coverage by national health insurance. Surprisingly however, no elected representative of this region has ever proposed to abolish this scheme to make complementary health insurance optional as in the rest of the country.

4.3. Introduce regulated competition between complementary health insurers

Another possibility is to make complementary insurance mandatory, while regulating competition between complementary health insurers. This would acknowledge their existence and give them more responsibility in the coverage of health expenditures and care management. Such regulation is described by Schokkaert and Van de Voorde: the objectives are to prevent risk selection, guarantee affordability of insurance and provide incentives for efficiency in care delivery.

Health insurance should be mandatory for basic care only, that is, care which we consider that all citizens should have access to. Hence, such a reform would require introducing a separation between complementary and supplementary health insurance, the latter remaining optional. The resulting insurance architecture would be very complex and comprise three tiers: compulsory national insurance, compulsory complementary insurance (with several insurers) and optional supplementary health insurance (with several insurers). Moreover, preventing risk selection requires setting up a risk compensation scheme, and more responsibility in care management for complementary health insurers would require continuous transmission of information about insured people from national insurance to complementary insurers. We could expect a huge increase in administrative costs for a small segment of total health expenditures (currently 13.7%).

The only real justification of regulated competition is that competing insurers have more incentives for managing care than a single payer.[13] But is this true in reality? Schokkaert and Van de Voorde write about "belief" concerning the performance of regulated competition. Actually, the debate seems very ideological. A recent proposal in the USA shows how the model of regulated competition can be used to promote the dismantling of government-run health insurance: a republican Congressman has referred to the Dutch experience to propose replacing Medicare with vouchers provided to

[13] Indeed, there is no advantage in terms of more choice for the consumer, since regulated competition requires insurers to provide an identical package of basic benefits.

beneficiaries to purchase insurance. In reaction, Okma *et al.* (2011) published a virulent criticism of regulated competition in the Netherlands. This contrasts sharply with the idyllic descriptions generally provided by Dutch economists of the performance of regulated competition in the Netherlands (Greß *et al.*, 2007).

The existence of effective competition is a prerequisite for regulated competition to provide incentives for efficiency in care management. In Switzerland, where regulated competition was introduced in 1996, there is limited evidence of effective competition. Premium variability is very high. Switching rates are low: less than 4% per year. Consumers seem reluctant to switch to less expensive funds, suggesting that competition is not that effective.[14] In the Netherlands too, switching rates are low, around 4%.

To install effective competition, customers must have financial incentives to switch providers. For this purpose, it is preferable to avoid financing through income related contributions alone. In the Netherlands before 2006, 90% of the premium was paid by a central fund and only 10% by individuals. The small monetary gain for switching to a less expensive fund was considered insufficient to compensate for the transaction costs. Consequently, the 2006 reform raised the share of premiums directly paid by individuals to 50%. The gains in efficiency, if any, have thus had a cost in terms of equity. Dutch promoters of regulated competition do not provide much information about cost of access to insurance as a proportion of income and its distribution in the population.

4.4. Introduce a cap on annual ***copayments***

The fourth option is called "*bouclier sanitaire*". It consists of capping annual total individual copayments, while introducing deductibles to finance the resulting additional reimbursements. This option comes down to modifying the distribution of copayments between individuals.
Like full coverage of basic health care by national health insurance (see 4.2) this option might confine the activity of private insurers to supplementary coverage for non-basic care services. Indeed, currently, the main interest of complementary coverage is to insure for extreme copayments, which would be eliminated by the cap. For purposes of equity, promoters of this reform propose to define deductibles and caps that are proportional to income (Geoffard and Lagasnerie, 2009). Despite its simplicity, this proposal could meet with a good deal of resistance: complementary insurers do not favor a measure which could reduce their scope of activity; the idea of setting up deductibles for health care costs is very unpopular, being perceived as a great obstacle to financial access to care.

5. Can French debates on health care shed light on the questions raised in Belgium?

The Belgium situation is somewhat different from the French one because there is no single payer in Belgium: a number of sickness funds are already in charge of covering basic health care. Although the authors lack faith in regulated competition, they seem to consider this option seriously. History strongly influences national institutions. It is not necessary to believe that regulated competition performs well to adopt this system. It is sufficient to acknowledge that sickness funds have an important role in Belgium. Therefore, the most reasonable reform would preserve existing sickness funds and introduce regulation that favors more efficiency and equity. The preexistence of multiple payers is one plausible explanation for the adoption of regulated competition in countries like Switzerland or the Netherlands.

Schokkaert and Van de Voorde design an attractive system of financing organization that permits solidarity at the national level, while allowing for some decentralization and providing incentives for efficiency. In this system, regions would benefit from efforts promoting efficiency. Moreover, they

[14] One explanation for this consumer inertia is the influence of supplementary insurance explored in Dormont *et al.* (2009).

would have autonomy for decisions in accordance with local preferences regarding health care provision and coverage, in addition to the national level of coverage.

Does this proposition resolve difficulties between communities? The principles are excellent but the transition in practice is not simple. For instance, what the authors call "interpersonal solidarity" induces interregional solidarity (on the basis of the objective health risk of populations to avoid rewarding inefficiency). This solidarity concerns a "basket" of care services that has to be discussed at the central level and continuously updated with medical innovations. Suppose one region of Belgium does not want to share much with the others: negotiating a minimal basket of care services can avoid any real solidarity. Afterwards, it is also possible to refuse an update of this basket.

My main concern is that this financing organization introduces two levels of insurance: coverage for the national "basket" and coverage for the regional "basket". The first level is the same in all regions, while the second might differ across regions. The first level can be provided by a single national payer as well as multiple sickness funds (with regulated competition). The French experience shows that two-tiered insurance is rather dangerous. In the Belgian case, suppose there is a care service that is covered in one region, and not in another one. This care service is likely to be covered by optional supplementary insurance in the second region. Maybe this supplementary insurance will also cover citizens living in the second region who go to the first region to be treated? Then what about regulation of care provision, decisions to treat, and doctors' payments? It seems to me that private insurers operating on the supplemental insurance market in one region might badly interfere with regulation in another region more generous in coverage. It could eventually be an additional source of tensions between communities.

As a French observer, I deduce from the article of Schokkaert and Van de Voorde that the values of solidarity and equity are not as popular in Belgium as in France. Conversely, it seems that the objective of efficiency is more highly valued in Belgium than in France. The proposal of Schokkaert and Van de Voorde does not solve all the problems. But it defines a way to achieve greater transparency in budget allocation, which is a good start to beginning to live together.

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