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EXPERT OPINION

Health Care Reforms, Power Concentration, and Receding Citizen Participation

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Abstract: The article highlights several outstanding features of French healthcare reforms in light of New Public Management (NPM). The paper exposes the economic, administrative, and social context of reforms. It investigates horizontal integration, as exemplified by the concentration of power within the Regional Health Organizations, the verticalization of the chain of command, and ensuing conflicts between the French welfare elite and the operating core (eg, the medical profession). Outcomes were below expectations in many areas. The NPM-endorsed fragmentation of public organizations has yet to take root in the French healthcare system. There was little consultation with the medical profession. Physicians' autonomy and patients' rights receded.

Keywords: health care reform, public administration, France, new public management

Introduction

The present study assesses NPM-driven administrative reforms in health care. These were contingent upon economic and international factors as well as the institutional milieu. We examine the recentralization of the health system. Horizontal integration enabled the Regional Health Agencies (RHAs) to concentrate all decisions related to health policies. The verticalization of the chain of command sought to restore the capacity of the government to govern from an administrative dashboard. Did these benefit the medical profession?

Is this vertical alignment more prone to conflicts? While the technocracy grew stronger, the antagonism between top policy-makers and the medical profession, including nurses and hospitalist physicians, intensified. Did reforms play out differently in France? In contrast to Anglo-Saxon de-amalgamation strategies, the government endorsed a concentration of decision-making power within the RHAs. The healthcare sector remains heavily regulated, and competition is organized. Private and public providers compete for patients, and the former can now legally fulfill public service missions that were hitherto the preserve of public hospitals. What was the impact of reforms on the citizenry? Did they lead to a decrease in public participation? Did NPM weaken the health democracy?

Method

Instead of relying solely on traditional social science methods such as representative sampling and multivariate causal analysis, the article investigates the French healthcare system's critical elements, focusing on secondary (eg, hospital, specialty) and primary (eg, family physicians, General Practitioners) care providers. We utilized secondary sources and semi-structured interviews to evaluate the behavior of healthcare actors and reforms that depend on the institutional context and influence of health professionals.

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Results

The Rise of New Public Management (NPM) and Governing from an Administrative Dashboard

Many external factors contributed to the rise of NPM in France. In the late 1970s and early 1980s, Anglo-Governmentality in France[1,2] sought to shape the conduct of government employees and citizens by emphasizing rationality. NPM promoted new organized practices (eg, techniques) through which subjects and institutions can be governed at a distance, first and foremost in neo-liberal democracies. It also presumed that more informed and knowledgeable individuals could better govern themselves. In addition, Managerialism became a popular concept in France in the 1980s, intruded into the medical bureaucracy in the early 1990s, and shifted power away from the operating core (eg, the medical profession) to the technocracy (eg, the Ministry of Health, the Regional Health Agencies). The 2008 recession, the rise of an audit society,[3] the emergence of a welfare elite,[4] and the intrusion of consulting firms in public administration[5,6] were all contributing factors. Facing more intense competition in the traditional corporate consulting market, management consultants increasingly viewed the public sector as a new opportunity for development. They sought to promote corporate management recipes within public organizations. There was little political opposition. Both the left and right-wing parties supported NPM-driven reforms, more so as reform instruments offered little visibility to external actors (eg, the public, patient associations, and the media).[7] Furthermore, the development of e-governance and the emergence of the "audit society"[3] legitimized performance management tools and other quick-fix recipes to govern "at a distance". Faced with the rising complexity of health care organizations, the growing size of public hospitals, the constitution of hospital hubs ('poles de santé) with clinical and managerial prerogatives,[8] the rise of the agency theory[9,10] in health care, and EU demands for greater budget discipline, central health authorities deployed an administrative dashboard to strengthen their management capacity.[11] Thanks to the digital revolution, NPM sought to enhance certainty, control, and reduce costs. However, the quest for certainty remains elusive in practice[12,13] due to unpredictable patient outcomes and the discretionary nature of medicine.

Horizontal Integration: The Regional Health Organizations

The restructuring of the French health care administration consisted primarily of reining in centrifugal forces that weakened the state's central authority (eg, the Ministry of Health). These prevented a coherent implementation of policies across the country. The prefect and the Departmental Directorate of Health and Social Affairs (DDASS) would traditionally supervise local health and medico-social institutions and a regional ("departement" or county-level) committee for emergency services, known as the CODAMU (Comité Départemental de l'Aide Médicale Urgente). A 1996 decree by former Prime Minister Alain Juppé created the Regional Hospital Agencies. Supervised by the Ministry of Health, these Public Interest Groups (Groupement d'Interet Public) regained control over prerogatives traditionally held by multiple public health organizations and regional stakeholders, including the prefects. Prefects were customarily in charge of coordinating and implementing centrally defined government policies in regions. Prerogatives by the Regional Hospital Agencies extended to powers traditionally held by the Regional Directorates of Health and Social Affairs (Directions Régionales des Affaires Sanitaires et Sociales) (DRASS), the Departmental (or County-level) Directorates of Health and Social Affairs (Directions Départementales des Affaires Sanitaires et Sociales) (DDASS)[14] and local insurers (eg, regional sickness funds). The Regional Hospital Agencies also took responsibility for planning and allocating hospital resources at the regional level. Through a decree, they were granted a delegation of power to implement a regional hospital policy in lieu of the prefect and to review, manage, coordinate, and allocate resources to public and private hospitals (Article L6115-1 CPS). A 4 September 2003 decree further strengthened the powers of the Regional Hospital Agencies by transferring decision-making powers traditionally held by the prefects to the directors of the Regional Hospitalization Agencies. This was the first step toward a technocratic hold-up[15] that benefited the Regional Hospital Agencies at the expense of street-level bureaucrats and the operating core (eg, the medical profession). The 2009 HPST law accelerated the concentration of decision-making powers by substituting the Regional Health Agencies for the Regional Hospital Agencies. The former took over broader responsibilities (eg, health policy, definitions of priorities in regions, welfare…) that extended beyond hospital management. They concentrated all

prerogatives (eg, hospital, welfare, prevention, management of emergency services…), not just hospital responsibilities of the former Regional Hospital Agencies. The Regional Health Agencies also reintegrated the DDASS and the DRASS.

Vertical Alignment and Conflict Escalation

The concept of a vertical chain of command aims to promote accountability among all actors involved at each level. It also intends to reassert the center's capacity (eg, the Ministry of Health) to govern at a distance. Verticalization enables political appointments along the healthcare value chain. The Council of Ministers appoints the RHA directors. The RHA director hires the hospital directors (they used to be elected by their peers, eg, hospital physicians). As per NPM policy, the job title was changed to "hospital manager". It is no longer mandatory for the manager to be a doctor or a government official, and they may be terminated if they fail to meet the state-mandated objectives and performance metrics, such as patient volume targets. This contrasts with the former administrative framework where the hospital medical elite had direct access to top-level policy-makers without the intermediation of the hospital director. The hospital manager, whose executive powers were reinforced by the 2009 HPST law,[16] nominates the department heads. New employment contracts provided more flexibility in HR on the corporate model. However, mobility policies caused dissatisfaction among caregivers.[17] Professional loyalty weakened. Contracting-out specialized labor proved more expensive, with emergency physicians earning up to 1300 euros net per day for overtime. The gap between hospital managers' understanding of local needs and citizens' and elected officials' wishes has widened due to the exclusion of patient representatives and city mayors from the hospital board of directors. Traditionally, the city mayor was the head of the hospital board of directors.[18] That can potentially undermine democracy.[19] Secondly, though this political-administrative interface promotes vertical control by the hierarchy, it led to conflicts between the state technocracy (eg, the Ministry of Health, the Regional Health Agencies, the Welfare elite), the operating core (eg, hospital physicians), and frontline workers (eg, nurses). In June 2019, 95 EDs (213 in August 2019) were on strike to protest against a shortage of resources. Between 2013 and 2018, the volume of patients increased by 15% to 21 million at an annual cost of $3.1 billion, while the number of physicians decreased. Economically disadvantaged patients who are more likely to seek care within the EDs, since EDs are free of charge for users, are increasingly vulnerable.

Discussion

Fact vs the Theory: NPM Fragmentation vs French Concentration of Power

Unlike Anglo-Saxon reforms, market-based public policy approaches played out differently in the French healthcare system. British NPM reforms created a split between purchasers (ie, physicians' commissioning of health services) and care providers.[20] GPs are free to regroup to play one care provider against another when they buy health services for their patients. Anglo-Saxon NPM has traditionally advocated a fragmentation or reallocation of responsibilities between smaller organizations to enhance proximity and responsiveness to users.[21] Compared with the US, which expressed a "markets are good, the government is bad" approach to promote NPM, French citizens remain deeply attached to their public services and are less trusting of private providers.[22] French NPM reforms led to a centripetal administrative restructuring, as exemplified by the verticalization of the chain of command and the concentration of decision-making powers within the Regional Health Agencies, as opposed to Anglo-Saxon marked-based transformations (eg, competition, a delegation of public services, outsourcing, and public–private partnerships). There was neither political nor fiscal decentralization[23] since the parliament set a cap on health expenditures known as the ONDAM ("Objectif National des Dépenses de Santé") or National Health Expenditures Target. The Ministry of Health also imposes a uniform payment scale (eg, the DRG scale) that applies to all hospitals, public or private, across the country and redistribute funding to the RHAs. The RHAs then allocate those resources based on regional needs, population demographics, and territorial priorities. However, they do not raise taxes. Unlike the UK, key elements of administrative decentralization (PPPs, make or buy decisions, separating purchase from provision, entrepreneurialism)[23] were limited to entrepreneurialism in France. During President Sarkozy's leadership, hospitals changed their status. They were granted greater autonomy and subjected to continuous performance monitoring to respond to the needs of the local population and be more efficient.[24] Managers were granted more power to run the hospital on a more entrepreneurial basis in a shift from passive to active

administration.[25] Private hospitals can now offer services previously exclusive to public providers, including emergency services. However, PPPs are shunned as they have failed to meet expectations, particularly in the construction of public hospitals.[26] French public health organizations also experienced more horizontal consolidation than de-amalgamation strategies and more regulation of health services than competition between providers. As in other tax-funded health systems in Southern Europe,[27] reforms strengthen territorial networks and coordination of public or private care providers. The suppression of multiple fragmented local health organizations that were often at odds with each other, despite their proximity to users and their potential to respond to local healthcare needs, strengthened the strategic apex (eg, the Ministry of Health, a High Authority on Health, the Regional Health Agencies).

Receding Patient's Rights, Choice, and Transparency

From 2000 onwards, policy priorities worldwide strengthened patients' rights. Fundamental democratic values such as public participation, trust, and interdependency among stakeholders were increasingly valued. Norms that emphasize citizenship, as in the New Public Service,[28] will, in theory, trigger greater user participation and instill a more customer-oriented culture within public servants,[29] thereby restoring prosperity.[30] Fernández-Gutiérrez and Van de Walle[31] found a stronger efficiency orientation of reforms in Southern European countries. Officials at the top of the hierarchy and those with a business or economics education are more oriented toward efficiency than publicness. While this approach works well with French public servants, it does not reflect that of citizens who favor service attributes such as access, availability, and affordability of health services rather than efficiency. The digital era assumes that technology will bridge separated data "silos" and that open government portals will enhance visibility to users.[31] In theory, the diffusion of healthcare indicators will allow everyone to judge the institution's performance, reinforce transparency, strengthen institutional accountability,[32] and bolster citizen participation.[33] But data such as the number of medical errors are lacking, and when they exist, they are unavailable to the public. Though quality indicators for nosocomial infections exist, they are not publicized. Official hospital rankings are non-existent. While the public value perspective supports citizens' greater use of electronic services, it has not materialized. Computerized medical records failed in France. Though the National health authority (Haute Autorité de santé, HAS) opened its Health Technology Assessment (HTA) committee to patient associations in 2015, public scrutiny is lacking. Therefore, patients rely on non-medical factors (eg, word of mouth, catering services) to select a care provider. Hence, healthcare reforms paved the way for a democratic recess.[34] While NPM has endorsed the coproduction of public services,[35] citizen involvement has receded,[36] except for the role of patient expert and the reporting of adverse drug events by patients, not just by health care professionals. Patient representatives and city mayors are no longer members of the hospital board of directors. Class action suits are still illegal for fear that powerful patient associations might discredit public authorities and big pharma. Patient representation and inclusion[37] weakened. Hence, the waning of the New Public Service and its set of norms and practices meant to restore democracy in public administration.[28]

With no significant system reforms, Macron's health policies consist of improving the current health system and strengthening the periphery (eg, prevention) rather than the core (eg, the hospital). That strengthening includes promoting advanced nursing practices (decree n°2018-629, 18 July 2018). Nurses will receive additional training to handle chronically ill and complex patients identified by GPs or specialists. This is supplemented by a roadmap for improving mental health (eg, physician training, coordination of mental health services, and social inclusion of patients),[38] and a new national prevention plan that focuses on children and adolescents. For fear of antagonizing the medical profession further, the Macron government now seeks greater coordination and complementarity of health services and aims to suppress duplications or overlapping of services in regions.[39]

Healthcare has difficulty achieving justice and solidarity due to social, economic, and geographic inequalities that extend beyond health care. These prevent the redistributive mechanisms from functioning effectively.[40] Active engagement and collaboration with relevant stakeholders, such as the medical profession (physicians, nurses…), frontline workers, and the public, are necessary to accelerate reforms that benefit the public instead of solely focusing on balancing the budget. It is beneficial to incorporate public values such as the involvement of patients and local stakeholders (city mayor, patient association), accountability to the public, and transparency into performance evaluation.[41] In order for this

to become a reality, it is important for the general public to prioritize healthcare and view medical needs as a regular part of life rather than a rare event. This would prevent health care from taking a backseat on the governmental agenda.

Conclusion

The French administrative apparatus's restructuring was driven by neoliberal ideology (eg, regulated competition) and the organizational values (eg, power, control…) of a new autonomous Welfare Elite. NPM reforms rejected institutional legacies and political decentralization. Instead, it triggered a re-concentration of decision-making power to restore the government's capacity to implement centrally defined health policies. A "power vertical" emerged. The 2009 HPST Act regrouped all health policy decisions – not just the hospital policies within the Regional Hospital Agencies, and such centralization contrasts with German federalism and Anglo-Saxon de-amalgamation strategies. Doing so, reforms weakened social and public values such as access, affordability, public participation, inclusion, and trust.[42] While the labor market is more flexible, undesirable outcomes, have become evident. Neither vertical nor horizontal integration served the interest of the public and the medical profession. The increasing financialization of the healthcare system resulted in physicians losing their autonomy, and weakened accountability to the public. Future hospital reforms must be carefully approached as many patients, nurses, and their representatives feel excluded and neglected.

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