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Agencification, policy reversal and the reforms of the French health care system

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Abstract

Purpose – Often linked to the New Public Management (NPM) doctrines, agencification has been on the priority list of policy makers for over two decades. This article proposes an analysis of the role of agencies in the French health system and the impact of government agency reform on physicians and the public.

Design/methodology/approach – The research analyzes the perceived implementation of a re-concentration of decision-making powers within public agencies as the declared goal of agencification at the French health care system, specifically primary care providers and hospitals. The assessment relies on secondary sources from ministerial bodies such as the Ministry of Health and Social Affairs, the Ministry of Labor, the Social Security and the General Accounting Office, and specialized French technical agencies.

Findings – Decentralization in France and the subsequent rise of public health care agencies had outcomes below expectations. Hence, a re-concentration of decision-making powers within the larger Regional Health Agencies; a streamlining of the public administration; and a re-appropriation of decision-making powers by the Ministry of Health are needed. The monitoring of health providers allows central health authorities to govern at a distance.

Originality/value – The analysis of health care agencies in France and of their use of efficiency-enhancing techniques may trigger a change of values within the medical profession.

Keywords Agencies, Policy, Health care reform, Centralization, New Public Management, France

Paper type Research paper

Introduction

The New Public Management (NPM)-driven fragmentation of public organizations and the public choice theory encourage several bureaus to provide similar services to enhance competition and efficiency (Self, 2021). The application of the principal/agent theory to public institutions promotes agencification with public services. Second-generation fiscal federalism that granted powers to lower-level territories and the devolution of institutional arrangements (Kaneva, 2021) to enhance public participation and stability (Weingast, 2014) also endorsed the agencification of public services. The latter stipulates that policymaking is a core prerogative of ministries and that policy implementation is to be handed over to executive agencies away from political circles, even though, in practice, executive agencies are more than neutral policy implementers alone and are under the influence of local politicians. In France, the State Council defines agencies based on two criteria. Firstly, autonomy: the executive is responsible for defining policies to be implemented by agencies, but it does not have a role in the day-to-day management of those agencies. Secondly, responsibility: the agency is fully accountable for policy implementation. Agencification is preferred when there are significant differences in regional preferences and minimal spillover effects. According to Liddle (2018), agencification

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involves transitioning from traditional hierarchies to agencies and networks, as well as delegating task execution to executive bodies. The assumption is that decentralized managerial structures are more likely to listen to local stakeholders than agencies with centralized budget processes (Curto and Dias, 2014) and that the delegation of policy implementation to agencies can enhance the performance of public organizations and cater to individual preferences more effectively. Valkama *et al.* (2022) report the adverse effects of joint agencification on democratic governance and residents' rights to influence and participate. Hood and Peters (2004) discussed the unintended effects of agencification on government operations, including the fragmentation of bureaucracy. According to their argument, the process of agencification creates a complex bureaucratic structure that is difficult for citizens to navigate and understand.

This paper investigates French health care agencies, their impact on the values of the medical profession, and the subsequent re-centralization of the French health system. Firstly, agencies intended to promote efficiency-enhancing techniques as well as NPM tools. By doing so, they contributed to a change of values within the health sector. The decision-making power of multiple fragmented health agencies was subsequently regrouped within the larger Regional Health Agencies. These have the potential to restore unity and institutional clarity in a time of rising uncertainties. They combined the more recent contract-based NPM-modeled delivery of public services with the more Weberian tradition of vertical hierarchy that hitherto characterized the French administration. Was this re-concentration of health care decisions a means to reassert the center? Re-centralization primarily benefited the welfare elite (Genieys and Hassenteufel, 2015), and was geared towards depoliticizing health care policy decisions and reinstating professionalization in policymaking. The paper ends with a discussion of French idiosyncrasies and a comparison with Anglo-Saxon countries that pursue similar reforms. Some public values, such as citizen participation, retreated while others, such as uniformity and national coherence, were strengthened. Nonetheless, support for public reporting continues because of the emphasis on greater transparency (Erkkilä, 2020) and because of the need to build further public support for reforms that remain unpopular with the medical profession.

Agencies' mixed outcomes in foreign exemplars

Over recent decades, agencies have become a popular way to deliver public services. Spreading worldwide (Verhoest, 2018), often under a different label such as executive agencies in the UK, 'public policy transfer' in France, or ministerial autonomy in Germany, embodied in Article 65 of the constitution (OECD, 2002, p. 99), or 'distributed public governance' in China, or 'autonomisation' in Thailand (Bowornwathana, 2006), agencification originates from the broader NPM-driven consumerist and competitive model that promote local initiatives. With varying results, ranging from increased performance (Vining *et al.*, 2015) to depoliticization (Wood, 2015), accountability, autonomy, value for money (Cingolani and Fazekas, 2020), or a combination of these (e.g., performance and autonomy) as in Kim and Cho (2014), it appears that agencification is contingent on national, sectoral and regional characteristics. Hence public management ideas labeled under the same name may hide differences in policy understanding and implementation outcomes.

In retrospect, there is little evidence that agencies led to improved outputs and outcomes. While Dan (2014) found positive effects on results orientation and service users' needs, Overman and Van Thiel (2015) revealed the negative impact of agencification on both output and efficiency in twenty different countries where agencification was implemented. This can be explained by the high level of clientelism and local corruption, inadequate local supervision (Musa and Koprić, 2011), and a lack of knowledgeable and impartial accounts. Other shortcomings include excessive fragmentation, coordination challenges, organizational (in)-stability (Dan, 2014), goal ambiguity, a perceived loss of control or 'drifting' agents (Schillemans and Busuioc, 2015) and incoherence between fragmented public

agencies' initiatives and centrally defined targets (Lenderink *et al.*, 2022). Accountability arrangements in decentralized regimes took more complex and diverse forms than conventionally acknowledged (Smoke, 2015). The ensuing constant redefinition of goals led to a 'multi-accountability disorder' (Alom, 2018). The blame game was often played as more actors got involved, including users' associations, self-serving local notables, privately funded think tanks, and finally, the central government that often encroached on the prerogatives of subnational governments. What was the French governmental approach to agencification? Were outcomes in health care just as diverse?

Health care agencies, new tools and professional values

In public health and food safety, the first 'wave' of agencification occurred in the aftermath of the Juppé reforms. Regional Hospital Agencies (RHA) and the High Authority on Health that took over the National Accreditation and Evaluation Agency in 2004, regarded public policies as a domain of efficiency-enhancing techniques (Mabbett, 2011). These sought to rely heavily on data collection and rationality to guide public decision-making (Blom-Hansen *et al.*, 2021). However, the quest for efficiency-making techniques was not entirely new in France. There has always been a long tradition of using policy instruments such as cost-benefit analysis after a May 1968 Decree established a Model of Rationalization of Budgeting Decisions inspired by the US Planning Programming Budget System. Its aim was to improve public policymaking in key policy arenas such as transportation or urban planning. In health care, in particular, Hospital Health Agencies introduced various policy tools aiming at quantifying the need for health services, steered epidemiological studies (Pierru, 2012a), and created a national scale of health care costs in 1996. With the emergence of health economics as a full-fledged discipline in the 1990s, other NPM-driven recipes and attempts at managing by numbers, such as benchmarking, cost and volume targets for hospitals, balanced scorecards, pay-for-performance contracts for care providers, and novel compensation mechanisms such as a uniform Diagnostic-Related Groups (DRGs) scale (i.e. a nationwide activity-based fee schedule for all care providers across the country) were also introduced, as in other Napoleonic countries (Orelli *et al.*, 2016). Compared to other countries, France emphasized rationality in decision-making, governing by numbers, and performance management tools. Reforms also paved the way for yardstick competition. In line with the global trend of systems' hybridization (Cacace and Schmid, 2009) between the public and the private sector, French DRGs introduced more vertical control over service providers. For instance, the central government sets the DRG fee. It also created conditions for some market principles to function, thus public and private providers compete for patients. Hospitals must compare their costs to a standard scale built on a sample of participating hospitals. Due to the single-payer system, competition was limited to care providers, not payers. In contrast, in Germany, the government encouraged competition between private sickness funds before operating a complete U-turn with a re-centralization of funding decisions in the 2010s.

To ensure political acceptance among the medical profession, agencies were promoted as repositories of best practices and certified providers of quality information to physicians. However, in France, quality indicators are lagging, and when they exist, for nosocomial infections, for instance, they are rarely published. Health care professionals were also prompted to embrace new private rather than public values such as medical consumerism (Pierru, 2012b), patient sovereignty (the NPM-driven 'patient choice'), and flexibility in the labor market. Physicians must adhere to novel corporate management recipes such as management per objective or multi-year performance contracts (Dooren and Hoffmann, 2018). Hospitals are no longer public administrations and have greater flexibility in recruitment. The 2009 Health Care Act stipulated that Regional Health Agencies and hospital managers can be hired from the corporate world instead of the government-run National School of Public Health and can be dismissed if they do not meet the government-set

targets. The medical profession, however, has only partially internalized NPM tools. For instance, senior nurses use performance evaluation tools to strengthen their authority. Some areas benefited from reforms. The DRGs system maintains records of the procedures carried out in hospitals. This is instrumental in conducting epidemiological studies that analyze the prevalence of diseases across the country and changes in practice (e.g., surgical procedures). DRGs were also used as bargaining instruments during fee negotiation, proving that accountability can also benefit the accountee (Karsten, 2015). Despite its promised flexibility, there were certain areas, such as human resources, where the outcomes fell short of expectations, as exemplified by the 'mercenarization' of contract physicians working in public hospitals.

The re-concentration of powers within the Regional Health Agencies

At the county level, the autonomy of public agencies, their fragmentation, and crony management fell short of the demand for cohesive policies and fiscal discipline at the national level. The agencies' shortcomings raise concerns about the local governments' ability to manage public funding efficiently, hence a call for the re-establishment of a centralized authority. In health care, the 2009 Hospital, Patients, Health and Territories Act (HPST law) imposed a re-concentration of all health policy decisions – not just the hospital prerogatives of the former Regional Hospital Agency – into the larger Regional Health Agencies. The government also regrouped – rather than suppressed – the smaller regulatory and service delivery agencies such as the Regional Public Health Groups, the Regional Health Committees and the Regional Sickness Funds into the larger Regional Health Agencies. However, this re-concentration of power excluded many key stakeholders such as patient associations, elected representatives (e.g., city mayors), and supplementary insurers. By doing so, they minimized the meddling of local politicians and notables in health affairs. A prefect of the region – a representative of State puissance – now presides over the Regional Health Agency's supervisory board. Moreover, the latter comprises three representatives of the central (not local) government. Consolidated health agencies encouraged an economic concentration of care providers (e.g., hospitals) for safety reasons (i.e., larger medical units have better health outcomes than smaller ones) and for monitoring purposes (i.e., larger centers of excellence or '*poles medical*' are easier to control than many fragmented care providers), though calls for a regrouping of providers did not extend to the primary care sector. Solo practice is still the norm in France, despite incentives to form group practices.

Reasserting the center

Similar policies have been implemented in both New Zealand and the UK. During the late 1980s, New Zealand shifted from a centralized medically led health policy and planning system to a market-driven system (Rees, 2019). It created added pressures and inconsistencies, ultimately leading to a re-centralization of some functions, as in France. After 2008, the New Zealand's center-right government launched new national agencies that centralize some planning and service delivery functions to improve coordination, digitalization, service efficiency and reduce administrative costs (Gauld, 2012). In the UK, the delegation of power was reversed as elected politicians prioritized coordination and pursued their own agenda (Peters, 2008). Ireland tightened financial oversight, rationalized its agencies, and consolidated administrative functions to ensure a standardization of public services. The center remains the main driver of reforms and hierarchical approaches are still preferred for organizing these reforms (MacCarthaigh, 2020). Like the UK, where reforms were also about to depoliticize the system (Wood, 2015), the French 'welfare elite' from the Ministry of Health is also assumed to have a more neutral approach to policymaking than locally elected officials. Reforms helped the Welfare elite regain some of their prerogatives

that eroded under the rise of inter-communality (Bourdin and Torre, 2022) and EEC Directives. The steering of Regional Health Agencies by the central government also aimed at restoring the professionalization of policymaking that earlier regional policies could not achieve for political reasons (e.g., local politicking, cronyism, vote-catching strategies that even worsened public deficit). Benefiting a small, highly placed business and administrative elite, this re-concentration of decision-making power is unlikely to be rolled back. The 'costs' of re-centralization, including a democratic recess (e.g., representatives of the public, the medical profession, and patient associations are hardly represented within the Regional Health Agencies) and a loss of social accountability, won't change the course of reforms. But New Zealand went beyond France to improve its health outcomes. Firstly, it strengthened primary care through policy and funding changes and emphasized continuity of care (Jackson and Ball, 2018). Furthermore, there was a stronger emphasis on public accountability and citizen participation. Public hospitals in New Zealand are governed by elected District Health Board. None of these participative mechanisms exists in France.

Discussion

The paper provides a better understanding of the impetus behind regulatory shifts (the 2009 HPST Bill) and the re-centralization and re-concentration of decision-making powers. French administrative reforms also illustrate the interplay between autonomous local actors such as city mayors, local health care providers, and health forums or organizations that seeks greater autonomy in policymaking and the central government that demands performance and fiscal discipline from regions (their expenditures grew higher, even in times of recession). In this regard, the centralization of health policy decisions gave austerity policies a more permanent and constitutionalized character (McBride, 2016).

Compared with earlier Anglo-Saxon reforms that emphasized privatization, patient choice, and marketization (Powell and Miller, 2016), French reforms have stressed accounting reforms (DRGs) and digital innovations. The government also pursued the digitalization (Gauthier and Cardot, 2021) of the health system with a new electronic version of the patient medical card that can be used to pay for health services, which shall, in theory, combat fraud and ease access to health services. Payment by smart health cards lowers economic barriers by reducing the need for patients' out-of-pocket expenditures. Moreover, innovations are centered around institutions, as exemplified by the strengthening of the Regional Health Agencies and the reform of hospital governance. The 2009 Health Care Act reinforced the role of the hospital director at the expense of hospital board members; the former is appointed by the central government rather than elected by their peers. As Favoreu *et al.* (2015) suggest, French reforms are organized around performance management as a system of rules, novel accounting mechanisms to provide fair compensation to care providers (hence, the extensive use of DRGs, with the penetration rate of 100 percent which is the highest in Europe), performance evaluation and central steering methods (e.g., regional and national expenditure targets, pay-for-performance contracts for care providers; government-set fees for medical procedures, management by objective) rather than around entrepreneurship, competition, and marketization, all of which produced very modest returns (Moran, 2016).

Earlier NPM recipes such as Public-Private Partnerships, for instance, in the construction of hospitals (AMUF, 2012), fell short of public expectations. Occupying a powerful place within the collective psyche, privatization and quasi-marketization of Social Security Office were neither welcomed by the French, who fear a weakening of social solidarity, nor by physicians. This contrasts with the UK, where hospitals or foundation trusts are no longer managed by the central government but constitute freestanding legal entities (Roland and Rosen, 2011). In addition, the British National Health Service abandoned national targets for a system of open reporting of performance data and clinical outcomes. Compared with France, the UK assumed that market forces would drive up quality in the absence of centrally defined

targets and also called upon citizens to participate in the improvement of their health system via new mechanisms of public consultation (Crane, 2018). No such mechanism exists in France, where citizens' participation is lagging.

The motivation of citizens to occupy the available space and to assess service delivery performance in collaboration with state actors is critical in democracies (Brinkerhoff and Wetterberg, 2016). But compared with the UK, opportunities for French citizens to express their concerns are lacking. The tradition of centralization (Bedock and Pilet, 2021) does not lend itself well to greater citizen participation. French health care reforms also illustrate how democracies search for and struggle over the definition of legitimate accountability regimes (Olsen, 2015), and as in the case of France, and sometimes opt for a complete policy shift to reattribute a pivotal role to the central state in the definition of policies at the expense of public participation. For instance, the 2009 HPST Bill lacked meaningful community consultations and participatory innovations.

Recently, there has been a growing dissatisfaction with the democratic system in Europe (Kriesi, 2020). As a result, there has been renewed interest in researching public values to strike a balance between the efficiency imperative of the central government and the preservation of core public values such as access to care, fairness, and other 'progressive opportunity' criteria (Bozeman and Johnson, 2015). At the heart of these concerns is the tension between patient sovereignty (patient as a consumer) and austerity (restriction in accessing health services) and between NPM-driven differentiation and uniformity (as a public service, health services should be identical across all French regions, no matter their resources). While French reforms are in line with more recent discussions on public values that emphasize three aspects of public management: delivering services, achieving social outcomes (e.g., equity, access), and maintaining public trust and legitimacy (Schmidthuber *et al.*, 2021), some public values retreated. These include transparency (the DRG scale is still a very opaque system) and New Public Service, defined as the set of norms and practices that emphasize democratic accountability (Sager *et al.*, 2018). Centralization of health policy decisions and standardization or uniformity of care provision via metrics (e.g., a national scale of health care costs, management by objectives, pay-for-performance contracts, benchmarking of hospital outputs rather than outcomes) leaves little room for public engagement and discretion (Veronesi and Keasey, 2015). A compounding factor, non-health care actors, such as the public, may have little understanding of the validity and appropriateness of performance metrics (Colebatch, 2018).

Evaluation

NPM was supposed to bring benefits, including greater efficiency in the delivery of health services and greater responsiveness to users. This did not occur based on indicators such as waiting times and adequacy of care provision in regions. Waiting times are an issue for certain non-emergency procedures or specialist consultations, as demand often exceeds available resources. Between 2012 and 2017, the average wait time for a specialist has increased from 48 to 61 days, while the wait time for a General Practitioner has gone up from 4 to 8 days. Specifically, patients can expect to wait an average of 52 days to see an ophthalmologist, 60 days for a dermatologist, 50 days for a cardiologist, and 44 days for a gynecologist.

Disparities between urban and rural areas are rising. Rural regions often face challenges in terms of access to health care facilities and medical professionals. A compounding factor is a shortage of doctors, particularly in rural areas. These tend to be concentrated in cities, making it more difficult for people in remote or underserved areas to access primary care and specialist services. In Paris, with 72 registered dermatologists, the waiting period is around 60 days. However, Marseille has only 26 dermatologists and it takes an average of 95 days to get an appointment, according to the Bureau of Statistical Research, Studies and Evaluation. In Ariège, la Meuse, la Creuse et les Hautes-Alpes, there are only five dermatologists for

100.000 residents. Despite the NPM rationing agenda, the French population remains one of the world's largest consumers of medicine, particularly antibiotics (Herin *et al.*, 2021).

NPM reforms resulted in a more complex health system. With health technologies and electronic health records, while it was encouraged to simplify administrative procedures and improve coordination between health care providers, their intricacy can often result in delayed reimbursements or an increased administrative burden for providers (Burnel, 2018). According to Primbault (2018), primary care physicians spend around 7 hours every week on administrative tasks that are mainly meant for auditing and administrative purposes by Social Security Office. For one-third of physicians, that number even reaches 14 hours per week, according to Medscape. Moreover, health care providers must comply with multiple regulations. One such reporting rule is the coding of medical procedures via the Information Systems Medicalization Program (PMSI) or Diagnostic-Related Groups (DRG), which is both costly and time-consuming. It has prompted hospitals to hire DRG coders instead of physicians, thereby diverting resources from patients.

Conclusion

The inability of subnational governments and local audit chambers to establish intrastate control prompted the French welfare elite to demand a re-appropriation and a vertical alignment of decision-making to ensure effective supervision and increase people's confidence in delivering public services (Batifoulier *et al.*, 2011). Reforms contributed to the rise of a Russian style 'power vertical' (Monaghan, 2012) and to a strengthening of the oligarchy (Kagarlitsky, 2020), whose efficacy is increasingly questioned. At the national level, wicked issues are defined as problems that lack a clear description, and face conflicting perspectives from a wide range of stakeholders (Schillemans *et al.*, 2021), including physicians (who emphasize quality), users (who demand quality, access, and convenience), street-level bureaucrats, and top political circles who worry about unstoppable budget deficits. They also extend to more than one area, including health, unemployment (in many rural areas, the hospital is the largest employer), and welfare services (French emergency departments now provide 'social beds' to the homeless). Central authorities are still unable to tackle the health care fraud problem (Grandjean *et al.*, 2019) and other public emergencies that extend beyond health care. These include unemployment that remains at an all-time high and rising economic and social disparities. In 2009, the GINI coefficient was only slightly lower in France (29.9) than in the UK (32.4). The pauperization of the French working class, rampant corruption among top-level political circles, as exemplified by a spate of scandals (Cahuzac in 2013, Bygmalion in 2014 and Benalla in 2018), the lack of social mobility, and more generally, the inability to build an open society are all symptoms of a society in a stalemate. Hence, the newly formed French regulatory state may not be more effective than the productive or redistributive state. That impasse also led to greater public defiance, which had political repercussions, as evidenced by the breakup of the traditional right and left political parties.

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