COVID-19 HITS THE FRENCH HEALTH SYSTEM

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On 28 February 2020 the WHO issued a report on China's efforts to control the Coronavirus outbreak, dictating a comprehensive government-led response to the threat. On 29 February, the French Prime Minister Édouard Philippe chose to divert priorities from a Ministerial Council dedicated to COVID-19 by utilising article 49-3 of the Constitution to bypass Parliament and authorise a brutal retirement 'reform' package, against which vast sections of the country had struck and demonstrated.

Article 49-3 is a nasty part of the Vth Republic's Constitution, introduced to transcend the 'instability' of governments under the IVth Republic. However, it was conceived for rare situations in which a government could not muster a majority in the National Assembly to act on problems of national significance in emergency circumstances. The article had already been applied twice to enforce fiercely opposed economic deregulation measures when Macron was Economy Minister under President Hollande.

This incident highlights perfectly the character of the Macron Presidency – neoliberal and authoritarian, the two dimensions interlinked.

As at 2 June, France had over 28,900 deaths attributed to COVID-19, in the 'top' league (apart from the populous US) with its neighbours UK, Italy, Spain and Belgium. Of this total, an estimated 37% occurred in 'medical-social' institutions, overwhelmingly aged care facilities. The debilitated hospital system has had to cope with the rest. The aged care sector (EHPAD), leaching off the public system, is itself a disgrace.

Macron is a caricature of neoliberalism, brought to power by a media predominantly owned by billionaires. He has avidly continued European Union directives pushing the privatisation and 'opening to competition' of

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essential public services and kowtowing to the Maastricht imperative of keeping the general budget deficit within 3% of GDP.

Once acknowledged for its quality, the French health system has been subject to long term deterioration. Representative of the cynicism is that the historic Hôtel Dieu hospital on the forecourt of Notre Dame Cathedral is planned for conversion and integration into a tourist complex.

The health system, like public provision and the French welfare state in general, is ultimately a product of the programme of the National Council of Resistance (CNR), formulated in March 1944.

The basic health budget is financed not out of the general budget but from a proportion of the social security (*Sécu*) contributions of workers (wages) and employers (payroll). This budget (*assurance maladie*) is complemented by firms or organisations taking out collective insurance with non-profit mutuals. Individual insurance with private insurers brings up the rear.

The system received a filip in 1958 with the creation of a university hospital network that combines care, research and training.

The hospital system, as everywhere, is under increasing strain because of greater longevity, aging of the population and expensive technologies. French hospitals, as elsewhere, run perennial deficits.

Hospitals were funded using immediate past budgets as a base line. The development of the casemix concept as a vehicle for objectively-based funding was a response to this impasse. France belatedly introduced casemix funding (via DRGs) in 2004 (*Tarification à l'activité*, T2A).

Socially-oriented doctors and commentators complain bitterly about its introduction, in the context of drastic cuts in the overall budget. Casemix based funding is a defensible principle, but applying it is another matter. Allocating all hospital functions (treatment of inpatients and non-inpatients, research, teaching) into a definitive box is an idealist proposition. In France, the system appears to have been introduced ineptly and has been subject to gaming. The unacknowledged imperative is to increase the number of procedures and to cut bed days on each procedure, a process that privileges more readily standardised procedures and more readily standardised patients (i.e. one condition, younger patients). Private hospitals/clinics have attempted to corner the market in standardised procedures and patients.

Health as a public good has been progressively undermined by privatisation, segmentation and inequality of access. 'Efficiency', 'innovation', 'financial integrity' became the formal criteria for undermining rather than reinforcing the public health system, as efficiency, financial economy and functional innovation are not genuinely pursued under the new models. One integral component of the neoliberal model is that hard-up institutions become top-heavy with bureaucracy, its incumbents well-housed and well-paid.

Preventative health care is poorly served in France, although it is an area that could deliver long term cost savings. Those services that have been nurtured outside the norm, oriented to the health and welfare of 'the whole person', especially those who 'fall between the cracks', are neglected or cynically treated and defunded. The latter is the experience of La Case de Santé, catering to the most marginalised, and Le Centre de Soins Saint-Sernin, catering to teenagers, both in Toulouse.

In France, the forces undermining a sector oriented to the public good are multiple – the private pharmaceutical sector, the private hospital sector, the private insurance sector and elements of the medical profession itself.

One feature that undermines the public health system from within is the power of the pharmaceutical sector. France has the highest cost of pharmaceuticals in Western Europe, because Big Pharma's links with the state inhibits the resort to generic medicines that are in widespread use elsewhere. This is a natural arena for reform and financial efficiency, but it remains off the table. Big Pharma is closely tied with medical research establishments, with publicly-employed scientists the recipients of pharma payola.

An ancillary dimension of this linkage also has health ramifications. The agro-industrial complex (with the giant supermarket companies as key mediators) is a powerful player in France, with food highly processed and stuffed with chemicals. Food scientists are compromised. The result is an unhealthy diet amongst sections of the French populace, a fecund environment for health maladies and an enhanced burden on the health system.

Private hospitals and clinics take a large part of French health expenditure. Australia's Ramsay Health is a big player there. The private sector does a lot of profitable standardised procedures and rehabilitation, but it wants more of the action.

The profit-oriented insurance sector has historically been only a minor player in health insurance, behind *Sécu* and mutuals. Predictably, it wants a significantly larger share of the pie. This sector (notably AXA) has been an assertive propagandist for implementing the neoliberalist agenda in France and dismantling the institutions and the spirit embodying the post-War CNR. This is comparable to the forces that have long pushed against the establishment and centrality of Medibank/Medicare in Australia.

Sections of the medical community are attracted to private health service delivery. This drive is especially embodied in for-profit private health enterprises, formally delivering primary health care. Their profit-orientation means strictly limited consultation times, regardless of patient need. They want the flexibility to charge fees above officially mandated standard rates. In addition, as in Australia, tolerating doctor preferences for urban amenities has contributed to 'desertification' of health facility access in the French hinterland.

At base is the most fundamental pressure on the public system – a yearly deficit in billions of euros of the (*Sécu*) tax-based *assurance maladie* (the Medicare equivalent). These deficits naturally provide raw material for the neoliberal agenda whose introduction has been a bipartisan affair.

In 2009, under the Sarkozy Presidency (2007-12), there was passed the (Bachelot) *Loi HPST*, which elevated the culture of the private sector to a general principle. Hospitals become an enterprise, health care a commodity, the bottom line the key indicator of success. (This is despite a wealth of literature that argues persuasively that health care doesn't fit the simple economics paradigm.)

In February 2014, President Hollande (2012-17) announced the necessity to cut €50 billion from public expenditure in three years. Health would be a significant casualty.

Behind this push is a financial pincer movement. There is the persistent pressure from Brussels and French institutional supporters to adhere to the Maastricht *dictat*. Compounding this pressure is a long term malaise of the French economy, driving lower tax revenue and higher public expenditure. De-industrialisation has raged over the last 20 years. There is no functioning industry policy (France has no industry ministry).

Beginning January 2013, the Hollande/Valls government introduced the Competitive and Employment Tax Credit (CICE). Under pressure from the strong employer lobby Medef, the *Parti Socialiste* government claimed 'the need to cut *Sécu* contributions of firms so that they will invest and

hire'. The demand for massive public sector expenditure cuts was directly linked to this expensive tax concession. Estimates of the resulting impact on employment generation diverge and are disputed.

Corporate and personal tax evasion in France is rife. The GFC's aftermath further enhanced the fiscal imbalance. The first act of the Macron Presidency (2017-22) was the effective dismantling of the 'solidarity tax on wealth' (ISF), benefiting only the so-called 1%. Another tax introduced in 1990 to help to offset recurrent social security deficits, the 'Generalised Social Contribution' (CSG), was pillaged in 2019 by Macron to buy off the *gilets jaunes* from their protests.

Any prospect of raising *Sécu* contributions is now a political impossibility.

The hospital sector has been the major casualty. It means less staff (staff has been retrenched in droves, retirees are not replaced), less investment (much hospital infrastructure is ancient), worse pay and working conditions (especially for the lower ranks), less training, absenteeism and ultimately the resignation of experienced staff. It has been claimed that 70,000 beds have been eliminated in the last 10 years.

Human relations managers, hired in from outside health, talk nonsense and crack the whip. There is even a company called Mediverf, ('leader in medical employer control against excessive workplace stoppages') contracted by management, which pressures sick employees to return fully to work, with the threat of losing entitlements, under the rubric of slashing shirker-driven absenteeism rates. This obscenity has been facilitated by a 1978 law that was extended to the public sector in 1986.

In this environment, some staff retire prematurely; others (bearing a lifetime of experience) go over to the private sector out of exhaustion.

French medical staff have been sending petitions for years and have even resorted to demonstrating *en masse* – to no effect.

The general tendency is for an ongoing decline in collective and public forms of financing and greater (enforced) reliance on privatised individual supplementary insurance, for both primary and hospital care. This transformation from public to private financing doesn't lower overall cost (*cf*. the US catastrophe) but rather raises costs (private sector profits, unnecessary procedures, bloated management overheads) and it also redistributes the burden.

This necessarily implies the cementing of a segmented health care system by class. The better-off classes have better access, paid for increasingly by

private insurance. The less privileged classes become shut out from affordable primary health care, and resort by default to hospital emergency departments (as in Australia). A February 2018 INSEE report estimated that the life expectation gap between the most and the least fortunate had extended to 13 years.

The hard core of the problem is in hospital emergency departments and intensive care units. Emergency departments are the front line of the health system. Moreover, emergency departments are unsuitable for the ready assignment of DRGs (as the categorisation of patient problems needs to be sorted out), so their funding is difficult to determine *a priori*. Emergency doctors complain that emergency departments are the 'end of the line' for all the problems of an unequal society (as in Australia). They have to accept the health consequences of low and/or precarious pay and unemployment leading to poor diet and poor health, mental health issues, domestic violence, etc. These causal links, ignored by governing elites, are self-evident to the practitioners.

As for ICUs, ill-prepared for the pandemic is the definitive word. Authorities were warned of the necessity for preparing for the potential; the warnings were ignored. Staffing suffering strategic long term attrition, national equipment capacity delapidated. The severe shortage of beds, masks, gowns, tests, ventilators and pharmaceuticals, accompanied by governmental lies, has proved a fiasco. Privileged firms still in production (Airbus) have been better served with masks than medical staff on the front line. Several dozen health professionals have since died.

Indictive is the scandal surrounding the firm Peters Surgical. Originally an old family-owned firm, it has been boosted by funds from the government investment bank BPI. But BPI handed control of the firm to speculative investment fund Eurazeo. Eurazeo is linked to the preeminent merchant bank Lazard, in turn linked to the political elite – a distinctly insouciant Parisian capitalism. Eurazeo quickly proceeded to offshore production of sutures to Thailand and of its unique catheters, ideal for treating COVID sufferers, to India. In spite of the firm also receiving sizeable sums of CICE tax concessions each year (for the purpose of increasing employment), Eurazeo has proceeded to sack its Paris suburban workforce while paying sizeable dividends to shareholders.

Optimists say that, historically, significant progress happens in France after major crises, hoping that the pandemic will provide one such

occasion. However, the Macron regime, behind flowery expressions of a new era, knows nothing other than more of the same.

The Caisse des dépôts et consignations (CDC) is a venerable 200-year old institution that manages the finances of the state. Formally independent, it has been subordinated to political imperatives. In late March, Macron ordered from the CDC a post-COVID plan for the crisis-ridden hospital sector. The CDC's report is a dog's breakfast of neoliberal 'solutions' – all implicitly addressed to supposedly getting health expenditure off the public balance sheet. Most notable is a resurrection of Public-Private Partnerships in medical facility construction and management – already tried and proven to be a catastrophe of the first order. Add telehealth, by which health care will be delivered electronically. This mode is important by default where vast distances are involved (as in rural Australia), and is useful as a complementary vehicle in primary health care (both for streamlining advice and inhibiting doctor exposure to patient illnesses), but it has to be health professional driven. However it is a snake oil remedy when driven by private companies aiming to replace the independent health professional completely. Moreover, it necessarily structures unequal access to health care providers.

There is now a deeply rooted institutional structure and culture that automatically privileges private sector 'solutions'. A phalanx of private companies, including consultancies – even a complementary think tank! (Cercle Valeur Santé) – now form a dense network pursuing permanent parasitism on the public health budget and on the straitened family purse.

There is presently a push, especially led by noted jurist Régis de Castelnau, to have Macron and associates indicted in justice for the national suffering due to his government's indifference and incompetence. The Senate, structurally reactionary, has seen fit to quickly grant amnesty to all those elected and relevant public servants. At this time, the National Assembly remains committed to the principle.

In general, the French establishment has learnt nothing from the disastrous outcome of the pandemic on French soil, and its once admirable public hospital system will continue to struggle with wholly inadequate means and desperately demoralised personnel.

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