# Introduction to the Thematic Section on Health Economics

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Over the past decade, the journal *Économie et Statistique* has devoted two special issues to health economics. After the special issues published in 2013 and 2016, this Thematic Section brings together a selection of articles from the 41st *Journées des économistes de la santé français* (JESF, Annual congress of French health economists) held at the University of Poitiers in December 2019. This yearly event gives rise to the publication of a selection of articles in a peer-reviewed generalist journal every other year. Thus, after the *Revue Économique* in 2009, *Économie Publique* in 2010 and 2012, then *Économie et Statistique*, the *Revue Française d'Économie* in 2017, then the *Revue d'Économie Politique* in 2019, it is *Economie et Statistique / Economics and Statistics* that welcomes this new edition. These publications illustrate the commitment of the *Collège des économistes de la santé* (Health Economists College), the organiser of this event, to widely disseminate the results of work carried out in this field.

In 2015, the title of the introduction was indicative of an already tense situation: "A sector that is always under pressure". What can we say today, in 2021? How can we describe the current situation in the health sector? In the first few sentences, we underlined a difficult economic environment and a particularly constrained budgetary context for public decision-making. But what about the constraints on policy makers today? The Covid-19 pandemic has shaken up our economy as well as our lives and continues to destabilise a fragile health system that has been under pressure for several years.

Regarding the first few months of this unsettling year of the Covid-19 pandemic, the *Cour des comptes* (a public body that assesses public expenditure) has estimated, as of autumn 2020, that the exceptional fall in the revenues of Social Security compared to those forecast in the financing law adopted at the end of 2019 is almost €27.3 billion (Cour des comptes, 2020). At the same time, they estimated the increase in expenditure to be nearly €11.5 billion, mainly due to the staggering rise in health insurance expenditure. Thus, at the end of September 2020, the Social Security financing bill forecast a deficit of more than €44 billion before it was revised upwards in the financing law passed at the end of the year to €49 billion (including the 'old age solidarity' scheme). As expected, the contribution of the health insurance branch deficit is huge, with an estimated deficit for 2020 of €33.7 billion, almost 70% of the expected cumulative deficit (LFSS for 2021, 2020). However, the trade-offs of the last few years, highly regulated by the *Objectifs nationaux des dépenses d'assurance maladie* (ONDAM – a set of objectives for National health insurance expenditure), had made it possible to contain of the health insurance' deficits, despite the continuous rise in health expenditure. ONDAM is a tool for regulating health insurance expenditure: its scope corresponds to the proportion of consumption of medical care and goods financed by Social Security (including special schemes), as well as certain items falling within the broader scope of current health expenditure. Each year, the Parliament sets maximum expenditure targets for outpatient and hospital care when it votes on the Social Security Financing Law. Between 2000 and 2019, expenditure within the scope of the ONDAM almost doubled from €103 billion to €200 billion (an increase

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of 94%) (LFSS for 2021, 2020). This increase was largely explained by the increase in health spending rather than by changes in scope. For example, between 2006 and 2019, consumption of medical care and goods increased in value by over 35% (Marc *et al*., 2020).

For 2020, of course, the figures deviate entirely from the trends observed in previous years and the overrun for 2020 reached €13 billion for an ONDAM estimated at over €219 billion (LFSS for 2021, 2020). Even if the amounts are not stabilised, the exceptional gross additional cost could reach €18 billion. This expenditure, incurred in response to the health crisis, essentially corresponds to the purchase of medical equipment and masks, the provision of diagnostic tests, financial assistance, allocated on an emergency basis, to hospitals and residential care homes for the reorganisation of care, the recruitment of staff and payment of bonuses to carers and the financing of work stoppages during the lockdowns, etc. This crisis has exacerbated tensions among health professionals and, in particular, among hospital staff, tensions that had been simmering for a long time. In order to cope with this unprecedented economic, social and health situation, the government proposed a plan known as the '*Ségur de la Santé*' (named after avenue de Ségur, where the Ministry of health is located). This plan includes salary increases for all staff in healthcare establishments and care homes for senior citizens (EHPAD), totalling €1 billion in 2020 and €6 billion more in 2021. However, the upheavals are far from confined to hospitals: the number of office and home visits, and in particular the number of GP visits, fell sharply in the first five months of 2020: -12% compared to the same period in 2019, with a particular drop in reimbursements of 14% in March and 28% in April (PLFSS, 2021, Annex 1). In order to ensure that this reduced use does not lead to a deterioration in the health situation of 'non-Covid' patients, in addition to simplifying access to teleconsultations, tariff incentives were introduced to encourage GPs to offer 'long' consultations to their frail patients who had missed out on check-ups during lockdown. However, despite this massive expenditure to counter the epidemic and to limit its consequences, the first evaluations carried out in July 2020 highlighted the social and regional inequalities present during the health crisis (Dubost *et al*., 2020). In the first few months of the crisis, social inequalities were already apparent at all levels, in exposure to the virus, in vulnerability to the virus with, as we know, a significant social disparity in aggravating factors and co-morbidities, and in management and access to care. More specific to this health crisis, inequalities also became very apparent during lockdown with, for example, a lack of continuity of care for 'other' patients, and obviously significant disparities in housing conditions and isolation as well as in material security. Although for several years now, numerous studies have shown the significant increase in social inequalities and in particular social inequalities in health in our western societies, the health crisis has perhaps, for a time, made them less 'bearable'. Even the US Federal Reserve (Fed), not known for taking into account the redistributive effects of its monetary policy, stated, through its chair Jerome Powell, that African-Americans and Hispanics have been the most affected by the rise in the unemployment rate as a result of this crisis - as in previous crises (Powell, 2020). To make its activities more effective, the Fed should specifically take into account these disparities in its monetary policy adjustments.
A revolution in thinking?

Beyond the macro-financial framework data which, in the current economic context, take on 'non-standard' dimensions, the health sector is a remarkable field of research for economists. It concentrates almost all possible market failures, which can sometimes be considerable in scale. These failures, far from being merely theoretical distortions to a hypothetical balance, justify the intervention of public authorities in many forms and in many aspects. These include public interventions in the form of barriers to competition (patents, *numerus clausus*, etc.) or strict price regulations in the sector specifically to overcome problems related to information asymmetries (prices of medicines, tests and screening, medical care, introduction of deductibles, etc.). Another failure today that perfectly illustrates the particularities of the 'health good' and the indispensable regulation of public authorities is the public response to issues related to externalities. In the context of the Covid-19 pandemic, it seems obvious that it is in the interest of everyone's health that everyone should have access to screening as soon as they are in any doubt and to a vaccine as soon as it is put on the market. The question of sufficient use of the vaccine in order to achieve

the necessary collective immunity is just as essential. Indeed, since individual decisions do not take into account the general interest, the youngest, the least 'at risk' or the most risk-averse (adverse effects) could be less inclined to be vaccinated, despite the fact that the vaccine is available free of charge. Additional incentives, whether financial (a bonus) or in kind (a voucher for a beer, a ticket to a sports event) may convince a few more candidates. Public authorities can also introduce barriers to entry for the consumption of certain goods (restaurants, concerts, travel, etc.) through the introduction of a 'market entry permit' or a '*Pass sanitaire*'. There is therefore a quite large range of incentives available to induce an optimal level of consumption of a product with strong positive consumption externalities. There is also compulsory vaccination as a regulatory tool. A real textbook case for the economist!

Thus, it is clear that, above all, health is not a good like any other, and if this is obvious at the individual level, for each of us, it is also an established fact in the economic field. Therefore, apart from obviously important altruistic considerations, it would be a major mistake to consider health expenditure only as a weight in the economy. Yet, as confirmed by the expert panel to the High Commission on Health, Employment and Economic Growth (Horton *et al*., 2016), employment in the health sector is generally seen as "a cost burden on the economy, one that is often thought to be inefficient and resistant to gains in productivity". According to this Commission, health employment should, on the contrary, be seen as an extremely attractive investment, not only in terms of fairness of access to health but also to strengthen and stabilize inclusive economic growth. James (2017) argues that health systems are essential to the efficient functioning of a country's economy as healthy adults are more productive and healthy children do better in school. This strengthens economic performance and makes growth more sustainable and inclusive. The health care sector is also a major source of employment. On average, health and social work activities accounted for about 11% of total employment in OECD countries in 2014 (James, 2017). More broadly, and from an endogenous growth perspective, both health and education are essential components of human capital that justify mainly public funding (Barnay *et al*., 2019). Finally, as Cornilleau (2012) points out, although the evolution of health expenditure constitutes a real challenge for growth, precisely because it is often publicly-funded expenditure, it contributes to the increase in well-being in a proportion that, even though difficult to measure, is certainly significant.

The few contributions presented at the JESF in December 2019 published in this issue all fall within the scope of recurring themes and make it possible to address a certain number of analyses that are enlightening for public decision-making.

While the current economic climate has exacerbated tensions among health professionals, issues related to their remuneration are clearly not a new topic. **Brigitte Dormont, Aimée Kingsada and Anne-Laure Samson** look back at the first pay-for-performance system offered in France to doctors in 2009 *via* the *Contrat d'Amélioration des Pratiques Individuelles* (CAPI, an incentive to change in practices). They consider the effect of this system, mainly intended for general practitioners, on their care provision behaviour, in terms of the level of their activity per patient as well as their involvement in the rise of the primary care physician system. The authors also show that the effects of CAPI are not neutral from the point of view of doctors' fees per patient, with consequences on the dynamics of fees in the expenditure in outpatient healthcare for Social Security.

The regulation of doctors' fees in GP practices has a long history, in search of a balance between the attractiveness of private practice for professionals and accessibility for patients. **Brigitte Dormont and Cécile Gayet** study the consequences for private doctors and dentists of the ban on charging additional fees above the base rate for patients covered by the CMU-C (a scheme to help low-income families cover health expenses). In particular, they examine the extent to which this ban creates a financial constraint for sector 2 doctors (who are allowed to charge fees above the base rate) and private dentists, which could lead them to exclude these patients, even though the idea is to promote their access to care. The results show that while the average additional fee tends to decrease when professionals

receive CMU-C patients, there does not seem to be a negative impact on total fees due to an increase in their activity at the same time.

Of course, inequality in access to and use of healthcare is not only the result of the behaviour of health care providers. While it is well known that the demand for care depends on age, through the change in care needs, the link between this demand and the characteristics of the professional activity is less established. **Estelle Augé and Nicolas Sirven** propose an analysis of this based on the use of health care by the self-employed compared to employees. The authors show that the self-employed tend to consume less outpatient care during their working life ('must-trade' effect), whereas their consumption then increases to gradually catch up with the levels observed among employees after retirement ('catch-up' effect), suggesting that their health therefore declines more rapidly over the life cycle.

In addition to the opportunity costs that can explain the choice of care, preferences obviously play a key role in individual economic trade-offs. Having individuals reveal their preferences is therefore essential to understanding their individual decisions. In a discrete choice study, **Christine Peyron, Aurore Pélissier and Nicolas Krucien** analyse the preferences of the French population with regard to the methods and content of genetic information that is potentially accessible thanks to genomic medicine. The authors highlight a desire to access the most comprehensive genetic results possible, with a desire for autonomy on the part of individuals as regards choosing the information communicated, and a certain value placed on making a contribution to research through the provision of their genetic data.

In a final article, **Louis Arnault and Jérôme Wittwer** study the effect of the 2015 reform of the home care APA (*Aide personnalisée à l'autonomie*), an autonomy allowance, on the benefits actually received by beneficiaries according to their level of dependence. The authors show that while the average amount of benefits offered to the least autonomous beneficiaries increased significantly between 2011 and 2017, the average amount offered to the least dependent beneficiaries decreased, when applying consistent criteria. Within each GIR defining the level of autonomy, in 2017, the amounts granted are more widely distributed, in 'both directions', which suggests that constraints on departmental council budgets have led to cutting allowances for people with relatively more autonomy so as to provide more funding for the most severely dependent people.

In the current context, more than ever, economic analysis must contribute to policy-making by promoting efficient spending. Indeed, if the popular adage says 'health is priceless', it has rarely cost so much! Of course, the financial shocks are massive in the health sector, but they are also massive in many other sectors of the economy and far beyond. The pandemic has shaken up our way of life, and continues to affect our social and even family interactions and our freedoms. The shock is such that it is impossible for this pandemic not to leave its mark on the history of our people and the economic history of our time. It is still difficult, if not impossible, to take stock of the upheavals caused by this crisis. Thus, we can hope that, contrary to the concerns of Chantal Cases and Brigitte Dormont in the preface to the special issue published in 2013, economic analysis can play a key role in decisions affecting the health system. Indeed, in this unprecedented period of pandemic, it has become obvious, let us hope, to a large number of people, that the tools of the economist will be able to help and support public decision-making. What is more, in view of the challenges of economic recovery, the trade-offs that will have to be made with their inevitable consequences on the organisation of the health system, on the functioning of the various stakeholders, and on the model(s) for its financing will ultimately reflect societal choices. □

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