

numbers each year since the beginning of the program. On the other hand, beginning in 1943, women have outnumbered men among applicants in the group aged 50 and over in all years except the 3 years 1952, 1955, and 1956 when there were more men than women in all age groups.

Social Security Abroad

Medical Care Agreement With French Doctors*

An agreement that was reached on October 28, 1971, between the national doctors' association and the French social security agencies in charge of medical care requires that doctors who participate in the French national health program undertake to curb rising costs of medical care. The new agreement, which replaces former multiple agreements of social security agencies with doctors at the regional level, was authorized by law on July 16, 1971. The provisions of the new accord became effective on November 1, 1971, and will continue in force until May 1, 1975, at which time the signatories will decide whether to renew it for an additional period. The October accord has nationwide application and is binding upon all French medical practitioners except those who specifically decide to withdraw from the system.

By authorizing the conclusion of a national long-term agreement between the medical care agencies and the representative national medical associations, the French Government seeks to introduce the principle of self-discipline for the medical profession by making doctors accountable for the cost of the health care they prescribe. The October agreement also provides penalties for physicians whose fees exceed established norms.

FRENCH HEALTH INSURANCE

Health insurance under the French social security system provides both cash and medical care

*Prepared by Robert W. Weise, International Staff, Office of Research and Statistics.

benefits to insured workers and their families. Approximately 15.2 million workers are covered for sickness insurance under the general system (*régime général*) and affiliated groups. An additional 5.2 million workers are insured under other government programs.

The health insurance system provides the patient with freedom of choice of doctor. The doctor charges the patient on a "fee-for-service" basis. The cost of medical service is nominally controlled by an agreement between the doctors and their associations and the social security funds.

An insured person can obtain reimbursement of a certain portion of the doctor's bill according to a "fee schedule" or "nomenclature" incorporated into such an agreement. The reimbursement is 75 percent for medical fees and hospitalization costs and for laboratory analysis or tests. It is also 75 percent for most pharmaceutical products but is higher for certain medicines recognized as indispensable or particularly expensive. For "scheduled diseases" (21 are now listed), the amount payable by the patient can be waived and the social security system may absorb the entire cost of care.

PREVIOUS LEGISLATION

Before the new agreement, relationships between French doctors and the social security medical care funds were governed by the decree of May 12, 1960. This decree provided that medical expenses would be reimbursed on the basis of a schedule of fees agreed upon by the professions concerned (physicians, dentists, pharmacists, and paramedical groups) and according to a general nomenclature binding on both the practitioners and the social security organizations. These provisions were embodied into a standard agreement submitted each year for signature by the most representative regional medical associations and medical care agencies.

The agreements set up a schedule of maximum fees for reimbursement purposes. It guaranteed the insured person reimbursement of a fixed proportion (75-100 percent) of his health expenditures, including doctor's fees, drugs, laboratory fees, and thermal treatment. The regional agreement covered all doctors practicing in a given region whether or not they were affiliated with

the local medical association that had signed the agreement. As a result, when doctors charged more than the scheduled fee, the insured patients could collect from the medical care agencies the maximum amount allowable for reimbursement purposes.

RISING COST OF MEDICAL CARE

Control of rapidly rising medical care costs has been one of the main concerns of the French social security program in recent years. Despite legislative efforts since 1960 to place restraints on the charges made for medical care subject to reimbursement under social insurance, these costs have continued to rise. According to government studies, during the period 1960-69 the total cost for the delivery of health services—including doctors', dentists', and laboratory fees and hospitalization, pharmaceutical, optical, and orthopedic costs—increased from 11.9 billion francs to 39.1 billion francs, or at an average annual rate of 14.5 percent. Even after population increases and the rising cost of living have been taken into account, medical costs are still found to have doubled during this period. In terms of the gross national product, expenditures on health care rose from 4 percent in 1960 to 6.25 percent in 1969.¹

In addition, health delivery costs have also increased at a faster rate than the flow of social security contributions, producing annual deficits in the management of the sickness insurance funds. These deficits have continued to grow despite increases in contribution rates and the creation of new tax and revenue sources to supplement payroll taxes. At the same time, the cost of medical and surgical benefits provided under Government social security programs increased at a faster rate than other categories of service provided. During the period 1960-69, disburseable medical and surgical services increased almost 500 percent, compared with 440 percent for pharmaceuticals and 390 percent for hospitalization. Of total expenditures for health care benefits under the *régime général* and affiliated funds, medical and surgical benefits accounted for more than 5

billion francs or 24 percent of all health benefits in kind paid in 1970.² Studies undertaken in connection with the Sixth Economic and Social Plan (1971-75) estimated that by 1975 medical and surgical insurance benefits will reach 9.3 billion francs or an increase of 82.8 percent (12.9 percent annually).

ALTERNATIVE METHODS OF CONTROL

Although a number of proposals have been put forward for balancing medical care receipts and expenditures, most have been rejected for political or economic reasons. These proposals included increased cost sharing, increased employer contributions, and increased government subsidies. To avoid the adverse reactions that a drastic reform of the social security system might produce among French workers, the Government used the expiration of the annual agreements between doctors and regional medical agencies as an opportunity to associate the medical profession more closely with an effort to curb rising health care expenditures.

At the initiative of the Minister of Health and Social Security, the medical associations were invited early in 1970 to negotiate a new relationship with the social security funds that would incorporate the principle of self-discipline among doctors, enforceable through the mechanism of the "medical profile." The purpose of the medical profile would be to inform physicians of the average cost of drugs and medical care in their district and to serve as the basis for identifying doctors whose charges were "excessive," compared with the average charges of their colleagues.

On July 3, 1971, Parliament passed legislation authorizing the conclusion of a national long-term agreement between the medical care agencies and the representative national medical associations. After extended negotiations between the doctors' association (*Confédération des Syndicats Médicaux Français*) and the medical agencies administering the agricultural, independent, and nonagricultural workers' health plans, an agreement reaffirming the principles of the free practice of medicine was reached.

¹ See *Rapport de la Commission de la Santé du VI^e Plan*, pages 36-38, La Documentation Française, Paris, 1971.

² See Jean-Jacques Dupeyrou, *Sécurité sociale* (4th edition), Précis Dalloz, pages 360-361.

THE NEW AGREEMENT

The new agreement covering charges for the delivery of medical care, signed October 28, 1971, and effective November 1, 1971, is to remain in force until May 1, 1975. Unlike previous agreements that were binding only within the limits of specific geographic areas and for a single year—subject to renewal by the contracting parties—the new agreement is a multiyear instrument applicable nationwide to all practitioners except those doctors who individually elect to be excluded. When the agreement becomes operative, physicians are to be notified of the existence of the agreement and of its application to the entire medical profession.

Those doctors who choose to be excluded must inform the social security funds of their decision. Provision is made for an open season midway through the period covered by the agreement (September 15–October 15, 1973). At that time doctors who have initially withdrawn from the system may rejoin, or those who no longer wish to participate may withdraw.

Approximately 49,000 doctors or 95.7 percent of all registered physicians were reported to be participating under the new agreement as of March. This degree of participation compares favorably with that in 1971 when only 88 percent of the doctors were registered as participants in the regional accords.

ESTABLISHMENT OF UNIFORM FEES

The prevailing rates that doctors are authorized under the agreement to charge for medical care are given in the tabulation below. Seventy-five percent of the amounts shown are reimbursable.

Charges exceeding this schedule are not reimbursable. The agreement provides, however, that

Type of care	Prevailing rates (in francs) ¹	
	Doctors adhering to agreement	Doctors not adhering to agreement
Office consultations		
General practitioner.....	20 00	4 00
Specialists.....	32 00	8 00
Home visits		
General practitioner.....	27 00	5 20
Specialists.....	40 00	10 40

¹ One franc equals about 20 cents.

fees above the standard amounts may be charged by certain highly specialized or outstanding doctors, who are so designated by the regional medical associations. A procedure for reimbursing higher fees when extended consultation or treatment is required is also established.

ENFORCEMENT OF SELF-DISCIPLINE

A major innovation of the agreement is the introduction of the concept of “self-discipline” by the medical profession with respect to the rising cost of medical care. To promote the exercise of self-discipline, the medical agencies will publish quarterly statistical tables called medical profiles³ that show the average cost of medical care (consultations, visits, and drugs). These averages will be compared with the charges made by each doctor for different categories of approved treatment.

Participating doctors will be expected to keep the total value of their charges within certain average limits. Doctors whose charges appear excessive will be warned of their possible exclusion from the program. According to Government experts, the monitoring of doctors’ fees and the publishing of a quarterly tabulation of health costs is expected to result in the savings of 1 billion francs a year in delivery of medical care under the social security system.

Computers will be employed by regional health insurance commissions to tabulate the cost of medical care and to screen the fees charged by individual doctors. Since only two regional offices are presently equipped with automatic data-processing equipment, it may be some time before the individual and regional data on which certain standards can be set are available.

REGIONAL COMMISSIONS

At each regional or departmental level a joint medico-social commission has been established, with equal representation from the medical care agencies and the departmental medical association affiliated with the national federation. Under

³ See *Social Security Bulletin*, January 1971, pages 34–37.

the supervision of a joint national commission, the new commissions will be responsible for implementation of the new agreement at the regional level. Each commission will submit to its medical unit the individual "cost profile" of the doctor whose total cost for services during the preceding quarter substantially exceeded those of his colleagues. If the doctor so identified fails to justify his excess charges, he will be asked to refund the amount of the overcharge and will be warned that continuing such practice may result in his exclusion from the system. Exclusion is decided by the medical care agency upon the recommendation of the medico-social commission.

PENALTIES FOR NONAFFILIATION

As under previous legislation, clients of nonaffiliated doctors will not be able to benefit from the maximum guaranteed rates for reimbursement established in the new agreement, but they will be reimbursed for office consultations and home visits at the reduced rates established by decree. Nonaffiliated doctors cannot qualify for special government medical care and retirement benefits, now available to the medical profession. In addition, they cannot benefit from the improved income tax provisions that allow affiliated doctors to make substantial deductions for professional expenses.

Recent Publications*

SOCIAL SECURITY ADMINISTRATION

OFFICE OF RESEARCH AND STATISTICS. *Financing Mental Health Care Under Medicare and Medicaid*. (Research Report No. 37.) Washington: U.S. Govt. Print. Off., 1971. 52 pp. 60 cents.

Describes the current limitations on coverage of the mentally ill under Medicare and Medicaid and evaluates problems involved in expanding or extending coverage for the mentally ill

OFFICE OF RESEARCH AND STATISTICS. *Redistributive Effects of Transfer Payments Among Age and Economic Status Groups*, by Benjamin Bridges, Jr. (Staff Paper

*Prepared in the Library, Department of Health, Education, and Welfare. Orders for items listed should be directed to publishers and booksellers; Federal publications for which prices are listed should be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

No. 10.) Washington: The Administration, 1971. 33 pp.

Studies the effects of the transfer of public money paid in the form of social security benefits, government employee pensions, unemployment insurance, veterans' benefits, and workmen's compensation

OFFICE OF RESEARCH AND STATISTICS. *The Social Security Disability Program: An Evaluation Study*, by Richard T. Smith and Abraham M. Lillienfeld. (Research Report No. 39.) Washington: U.S. Govt. Print. Off., 1971. 297 pp. \$1.25.

A follow-up study of denied and allowed claims for determination of disability, comparing the characteristics, disabilities, and postdetermination experience of the applicants.

SOCIAL AND REHABILITATION SERVICE

ASSISTANCE PAYMENTS ADMINISTRATION. *Characteristics of State Medical Assistance Programs Under Title XIX of the Social Security Act*. (Public Assistance Series No. 49.) Washington: U.S. Govt. Print. Off., 1971. 398 pp. \$3.75.

State data on the Medicaid program: eligibility requirements, State agency administrative structure, and the proportion of Federal, State, and local funding.

COMMUNITY SERVICES ADMINISTRATION. *Report of National Protective Services Project for Older Adults*. Washington: U.S. Govt. Print. Off., 1971. 153 pp. \$1.25.

Describes and evaluates a 3-year joint Federal-State demonstration project that provided services to aged, blind, and disabled adults aged 50 and older in the District of Columbia and three Colorado counties.

GENERAL

BRONFENBRENNER, MARTIN. *Income Distribution Theory*. Chicago: Aldine-Atherton, 1971. 487 pp. \$14.75.

Reformulates, defends, and develops the theory of income distribution from both the micro- and macro-economic points of view.

FERRIS, ABBOTT, L., ed. *Research and the 1970 Census*. Oak Ridge, Tenn.: Southern Regional Demographic Group, Oak Ridge Associated Universities, 1971. 183 pp.

Includes "The Social Security Administration's One-Percent Sample," by David Hirschberg.

INTERNATIONAL LABOR OFFICE. *The Cost of Social Security: Seventh International Inquiry, 1964-66*. Geneva: The Office, 1972. 429 pp. \$10.

Statement of the financial operations of the social security systems of ILO-member countries.

LIBRAIRIE SOCIALE ET ECONOMIQUE. "L'Europe Sociale 1971." *Droit Social* (Paris), Nov. 1971, entire issue. 35F.

Special edition prepared under the direction of Jacques Jean Ribas; discusses the problems of cooperation and harmonization of employment, marketing, collective bargaining, public health, and social security within the European Economic Community.

MORLOK, EDWARD K., KULASH, WALTER M., and VANDERSYPEN, HUGO L. "Reduced Fares for the Elderly: