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Philippe Batifoulier, Jean-Paul Domin & Amandine Rauly *

Abstract: *»Erosion der Solidarität in Frankreich und Wohlfahrtskonventionen: Die neue Rolle der Zusatzkrankenversicherung«*. The French health system has been structurally in crisis since the early 1980s. This crisis is reflected in the loss of legitimacy of the conventional Fordist vision of national solidarity, which is characterized by a "crisis of legitimacy." The Fordist convention has the particularity of corresponding to a harmonious representation of social justice between the different orders (economic, political, and domestic) of social protection. Contemporary criticism of the health care system uses what was once the basis of institutionalized compromise between orders. The result is a new role for supplementary health insurance. This new role overturns the concept of solidarity that characterizes health policies. A new conventional vision is emerging: the liberal convention. This analysis focuses on the French case where complementary insurance has historically fulfilled solidarity missions. The new status of supplementary protection is accompanied by an unequal drift, which cannot be seen as the expression of a natural antagonism between economic efficiency and social justice. In France, expenditure has remained high while inequalities have increased. These limits have led the legislator to modify its policy by exempting certain patients from contributing to the financing of their own health expenditure. These sensitive adjustments are costly when the initial objective is to reduce expenditure and tend to generate new inequalities.

Keywords: Economics of convention, health system, concept of solidarity, complementary health insurance.

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1. Introduction

Since the 1980s, the French health system has faced a double crisis. The first is a financing crisis. This is linked to its deficit focusing on budget shrinkage and the question of the social security "hole." This is an image constantly referred to in the French media pertaining to the social security deficit (Monneraud 2009). The second is a crisis of its legitimacy. It is the result of a questioning of the definition of national solidarity. This article proposes to shed light on the reasons for this structural crisis by focusing on the second element: the erosion of national solidarity. There is no universal definition of national solidarity; there are, however, several interpretations of solidarity. These analytical grids can be described as conventions. There are different conventional visions of national solidarity. The structural crisis of the French health system can then be interpreted as the difficulty of bringing out a new dominant and legitimate vision of national solidarity.

According to the approach of economics of convention (in short EC), we assume that there is no one vision of national solidarity and that there are also fewer representations than individuals. There is a small number of shared references that can be called conventions (Eymard-Duvernay et al. 2005; Diaz-Bone and Favereau 2019; Diaz-Bone and Salais 2011) and these conventions are collective representations of the collective organization of the solidarity. A convention's dominant position is not a matter of legitimacy but of the balance of power. A convention does not prevail because it is supposedly more legitimate but because of the state the conflict has reached. Several orders of "worth" (*grandeur* in French) does not preclude domination.

In France, the health system was built during a particular period, that of Fordism. This period was marked by a compromise on the distribution of wealth that made it possible to support capitalism. The construction of social protection and the health system made it possible to legitimize capitalism, thereby making it possible to qualify the social and collective representation of social protection, as it was built in 1946, as a Fordist convention. The principles of national solidarity are enshrined in the preamble to the French Constitution of 1946 (taken over by the French Constitution of 1958), which guarantees rights at work, health protection, access to education, and material security. The Fordist convention of national solidarity is based on the principles of distributive social justice. It is financed by income tax and is based on a redistribution of resources. Each citizen contributes according to his means. The principle of national solidarity, recognized as a creator of social cohesion, is at the origin of the creation of several health and social protection institutions, at the head of which is the social security created in

1945. Social protection is mainly based on a state-organized obligatory insurance system.

The end of the Fordist logic of accumulation also marks the loss of legitimacy of the Fordist convention of national solidarity. The values of another conventionalist vision penetrate political debates and question the organization of solidarity. These debates led to a new balance of power concerning the weight of each institution in the health system since the mid-1970s. The crisis of legitimacy of the Fordist vision will allow a particular group of organizations to get away with it: the complementary health insurance organizations. These organizations play a leading role in the transformation of the health system's organization and the underlying logic of solidarity. The cofinancing of the national solidarity as a complementary health insurance company is associated with the historical role played by the concept of mutuality when creating and developing the French social protection system. Historically, the mutual insurance companies based on corporations fulfilled their mission as insurance companies by socializing the risks and relinquishing any private insurance company's logic.

Nowadays, the French market of complementary insurance is most uneven. Those with the highest incomes benefit from the largest insurance covers (Saliba-Serre and Ventelou 2009) and the least sick are the best covered. Any transfer towards complementary health insurances is hence largely inequitable. If France is generally considered as the archetype or one of the archetypes of the interdependent health system, this judgment must be mitigated by the recent evolutions. A charge transfer from the public health insurance system to the complementary health insurance companies changes the rules of the game. These evolutions characterize not the erosion of national solidarity in general, but the conventional Fordist vision and its associated principles. The development of complementary health insurance organizations is part of another normative framework, which corresponds to another conventional vision. This time, it is a liberal conventional vision, based on targeting, privatization, and segmentation.

We propose to characterize these two conventional visions of national solidarity and the role of complementary health insurance organizations in the transition from one to the other.

The aim of this paper is to show how these two conventions have been expressed over time and come into competition in thinking about national solidarity. The story is about a progressive shift from a Fordist convention to a liberal convention. This text is part of the Welfare Conventions Approach studying welfare state and the "governmentality" of welfare as disputes, i.e., as dynamic processes of creating new "welfare apparatuses" (Rose and Miller 1992). Welfare is a matter of disputes that can be traced to welfare conventions. Welfare conventions are a means to framing social problems (in

this paper, health issues), identifying dedicated causes and solutions that empower certain actors such as complementary health insurance.

We shall organize our argumentation in two steps. We show in a first part that the French health system was built during the Fordist period. The Fordist Convention on Social Protection is based on a compromise between the different orders (economic, political, and domestic) of social protection. The social justice and the socialization of expenditure are at the core of this convention. Since the end of the Fordist period, the elements justifying the organization of social protection have become the main focus of criticism of this same organization. Complementary health insurances are presented as the institutions that will allow framing the excesses of the social protection system. The legitimacy of the Fordist convention is called into question and a new liberal conventionalist vision is expressed (section 1). The second part highlights how the growing transfer of a portion of expenses towards complementary health insurance causes new forms of inequalities, now superimposed on pre-existing social inequalities. This unfair drift cannot be considered as the expression of a natural antagonism between economic efficiency and social justice. In France, expenses remain quite high (11% of the GDP) when inequalities are worsening. These limits have led the legislator to amend his policy by exonerating certain patients from contributing to the financing of their own health expenses. These noticeable adjustments are costly whereas the initial objective is to reduce expenses and tend to generate new inequalities (section 2).

2. No Future for National Solidarity in the New Spirit of Capitalism

Following the recent work of Batifoulier, Da Silva, and Duchesne (2019) on French social security, we show that it is possible to associate convention and ideology. We note here that conventions are, on the one hand, sources of general justifications that legitimize representations of common goods and, on the other hand, sources of individual justifications that refer to individual values and beliefs (Boltanski and Chiapello 2005). National solidarity can be interpreted differently depending on the normative representation of the world.[1] We show that during the Fordist period, a compromise existed between the different orders (political, economic, and domestic) and that the modalities of justification for the representations of national solidarity were not antagonistic. There is no conflict within the framework of the conventional Fordist vision. However, the absence of conflict between

[1] In this sense, we retain the definition given by Joan Robinson (1962).

orders can be seen as an anomaly in terms of conventionalist analysis.[2] The end of the Fordist period brings with it the rise of disagreements between the orders of social protection and therefore the need to justify the representation of national solidarity (section 2.1).

The preservation of the organizational form of social protection then depends on how the national solidarity is legitimized. Since the 1970s, there has been disagreement about the legitimacy of Fordist principles. The public health insurance crisis that began in the 1980s called these principles into question. The rise of neo-liberal ideas led to an erosion of the Fordist representation of national solidarity, which shifted the compromise to another legitimate representation of this common good. A new conventional liberal representation is emerging; the result is a new liberal convention. Nowadays, the socialization of insurance is perceived as a perverse incentive. The development of a private relief system, meant to raise the individual's sense of responsibility, has then become a way of undermining free rider-type behaviors. This conception of the sick person as a potential cheater has led the public authorities to use the levers of individual rationality for constraining individuals and enticed them to adopt thrifty behaviors. Desocialization of individuals then becomes one of the means implemented to raise their sense of responsibility. When the patient's trickery is revealed, private relief becomes legitimate (section 2.2).

2.1 From the Construction to the Questioning of the Fordist Convention

In France, social protection covers "all institutional mechanisms, public or private, taking the form of a collective welfare system and/or implementing a principle of social solidarity, which cover the charges resulting for individuals or households from the existence of a certain number of identified social risks (health, elderly, unemployment, poverty...)"[3] (Elbaum 2011, 6). This is the definition used for the construction of the social protection accounts. However, this is not a definition that is fixed in time. This definition refers to a particular interpretative framework: that of the Fordist period. This interpretation can be considered as a convention since it provides a common framework that allows coordination (Diaz-Bone and Salais 2011; Batifoulier 2001). In line with the approach of EC, we consider that conventions are not only specific rules (Favereau 1995; 1998) but are also a social

[2] The notion of convention exists precisely because there are conflicts of representation and disagreements. It is the ordinary conflicts that make it possible to justify a particular representation of the common good (Boltanski and Thévenot 2006). In our case, the common good deals with national solidarity.

[3] Author's translation.

and collective representation in which value judgements and normative considerations are taken into account. By highlighting the diversity of representations (Diaz-Bone and Favereau 2019; Latsis, Larquier, and Bessis 2010), the approach of EC makes it possible to understand that national solidarity is based on different conventional visions. These conventions define a particular form of organization of the health system and the institutions that play a leading role in it.

The protection against social risks, and more particularly against health risks, is traditionally at the center of the justification of capitalism during the Fordist period. In order to be legitimate, capitalism must constantly justify the meaning of capital accumulation. Accumulation itself makes no sense. The justification for this accumulation is not to be found in the purpose of capitalism but in the exercise of solidarity that it is supposed to make possible. During the Fordist era from 1945 to the mid-1970s, national solidarity became a higher common good. As a result, two principles were stabilized and legitimized: the principle of accumulation of resources (founder of capitalism) and the principle of distributive social justice. These principles are at the origin of the Fordist convention of national solidarity.

Fordist welfare convention is associated with full employment:

> States intervene by means of macroeconomic oversight and anticyclical investment programs to prevent economic crises. Social security can be organized through protectionism, subsidizing industries, and strengthening workers' rights. Infrastructure in- vestments, purchasing programs, and protective labor law are the main instruments [...] this model favors expenditure to create good quality jobs rather than welfare services for those excluded. (Chiapello and Knoll 2019, 17)

Capitalism creates inequalities of income but makes it possible to finance a model of social protection based on obligatory social security contributions and introduces a principle of distributive social justice. The justification for accumulation is based on a compromise around the use of the gains of the economic growth. The social protection and the capitalism exert a commutative power that leads to reciprocal legitimacy. Capitalism is acceptable because the associated economic growth improves the living conditions of citizens. In the Fordist convention, the regime of accumulation refers to a form of social capitalism. What is described as a compromise in the Fordist convention is the ability to reconcile referents from different orders.[4]

[4] This is not a compromise as it is read in the regulationist literature in the sense that the requirements of justification remain fully necessary. In this convention, the institutions can be seen as arrangements between the different orders that are stabilized for a period of time, but this stability is not fixed in time. This compromise in the case of social protection is established between three orders: political, economic, and domestic (Barbier and Théret 2009; Théret 2010).

This compromise is based on criteria that are not those usually mentioned when justifying a conventionalist vision. In the case of the Fordist period, it does not refer to altruistic characteristics of individuals or to criteria considered as such in the hierarchy of individual preferences, but rather, if we take up the Rawlsian vocabulary (Rawls 1971; Eymard-Duvernay 2001), to the fact that individuals are placed under a "veil of ignorance" concerning the economic and social position they will have in the near future and which influences their decisions (Goujon 1997). The beginning of the Fordist period coincided with the end of the Second World War. This period is characterized both by strong economic growth but also by uncertainty about geopolitical stability. National political stability is also a source of uncertainty. Concerning domestic order, some people came out of the war richer, but many others lost everything. Building a social cohesion is the first principle of the national solidarity to avoid new conflicts, both national and international. Individuals concede that the construction of the social protection can only be achieved by extending the prerogatives of the state to assure a minimum security for everyone. Concerning the economic order, the development of social protection ensures a healthy workforce. The development of the role of the state also makes it possible to cope with increasing globalization (Boltanski and Chiapello 1999). The firms accept social contributions and in return the government supports them in the necessary adaptation of their productive organization to cope with technological change and globalization. This first dimension of the Fordist convention of national solidarity is legitimate in the sense that it is justified by an objective of common good (Diaz-Bone 2016). What is particular about the Fordist convention is the fact that this representation of the common good cuts across the three orders of social protection (political, economic, and domestic).

The second founding principle of Fordist convention is social justice. It is possible to qualify the national solidarity as a higher common good during the Fordist period. However, this requires a clarification of the compromises that this involves in the definition of social justice. The initial compromise is established around a distributive dimension. A plurality of definitions of "just" exist (Ricœur 2001), representing the many strategies of justification implemented by social actors. In the construction of social protection, this can be expressed by the strategies of the different groups of actors who constitute the political, economic, and domestic orders. The definition of what is just is not a matter of belief shared by all, but is based on a process of demonstration. It is necessary to demonstrate that this definition of "the just" is based on a higher common good that benefits everyone. The legitimacy of the organization of social protection is then based on the justification of its value in terms of national solidarity. This demonstration is neither logical nor established once and for all. It is necessary to continually demonstrate the benefit for all. The definition of "justice" cho-

sen to serve the higher common good can be read as the grandeur of the great in the sense of Boltanski and Thévenot (2006) but must appear to benefit the smallest. It is the role of the politician to ensure that there is a place for the plurality of goods in deliberations. Otherwise a feeling of injustice may arise in society.

During the Fordist period, the favorable political and economic context allowed each grandeur to express itself without encroaching on the others. National solidarity, which is intended to be egalitarian and distributive, can be interpreted as civic greatness (political order) and is not in contradiction with industrial greatness (economic order), which in turn controls the tools for measuring productive efficiency. The end of the Fordist period will change the rules of the game. The economic context is marked by the economic crises of the 1970s and a process of transformation of public institutions is underway. New conditions for measuring efficiency are introduced due to the predictions of slower economic growth. Representations of grandeur in the different orders come into conflict. During the Fordist period, the plurality of justifications of the spheres of social justice is accepted. This does not mean that the logics that run through the orders are harmonious, but that there is a place for all these logics. Since the end of the Fordist period, what has changed is not the loss of harmony between the orders, but the fact that the exogenous context of the institutions that govern the orders no longer allows each one of them to run free. Indeed, the different orders carry logics that are almost exclusive of each other. The forms of articulation that are established do not make it possible to bring out a point of view that could be qualified as "common goods" in the sense that it would allow a junction between all orders. The legitimacy of the Fordist convention of national solidarity is then called into question and the sources of justification will lead to the emergence of a new convention still in search of legitimacy: the liberal convention.

2.2 Desocialization for Making the Patient Feel Responsible: The Liberal Convention of National Solidarity

The 1970s economic crisis changed the game. The financial crisis not only turned into a crisis of economic efficiency in the areas of state social intervention, it led to a crisis in the legitimacy of public social welfare institutions. As a result, a new balance of power has been established between the social protection orders. Opposing normative registers across these different orders. Different values justify a representation of the world that is no longer in harmony between the orders. Therefore, a new convention is being established in favor of the economic order. This convention can be described as liberal. According to Batifoulier, Da Silva, and Duchesne (2019), the liberal convention underpins individual sovereignty and denounces

scrounging as well as fraud and abuses. National solidarity cannot move beyond the horizon of individual responsibility and should therefore be residual and reserved to those who, because they are too poor or too ill, cannot exercise their own free will.

As François Eymard-Duvernay (2016) shows, in a balance of power not all parties hold the same power. The dominant convention that is established is indicative of a capacity for justification and valuation that is superior to the others. The liberal agreement is established in a conflictual context. But the conflict does not prevent the agreement (Larquier and Batifoulier 2005) around the liberal convention. Those who exercise political power impose their representation of the social world and their representation of national solidarity.

Since the 1980s, the dominant principle of justice has been more utilitarian and commutative. Inequalities became acceptable in logic of economic rationality. The precondition for making these inequalities acceptable is the equal opportunity and the freedom of individuals. The differences in situations that persist ex post (i.e., when equality of opportunity is observed and freedom is respected) can have three origins (Goujon 1997). Inequalities observed ex post may firstly refer to individual behavior (excessive risk-taking or laziness). Secondly, inequalities can be linked to hazard (accidents of course). Thirdly, they may be natural (presence of disability or illness). These inequalities can be considered just from the point of view of commutative justice. However, only the first one is considered socially acceptable in this new spirit of post-Fordist capitalism that supports the liberal conventionalist view. That is why the state guarantees a social minimum in the form of health insurance and unemployment insurance in the other two cases. The present form of social protection is based on a new definition of national solidarity, the definition of liberal order of worth.

This paradigm shift concerning the adopted principle of justice comes from the fact that risks no longer come from exogenous elements. International, political, and monetary stability allow for an expansion of social visibility. There is a tearing of the veil of ignorance in the Rawlsian vocabulary. The different risks are no longer considered to be associated to citizen status and the risks relating to the different professional statuses are reduced due to the tertiarization. Everyone can know in advance their economic situation and the risks involved. As a result, the preference is no longer for social protection but for individual protection. The universal social protection contract no longer seems legitimate. A new compromise between the political, economic, and domestic orders needs to be stabilized.

In this new conventional vision, only the universal scope in favor of the most deprived, the chronically sick, and the handicapped is acceptable. From a holistic representation of society during the Fordist period, we move on to an individualistic dimension that reflects the new spirit of capitalism.

This will make it possible to understand the questioning of the logic of solidarity. This new representation explains the changes in the organization of social protection. Social protection is moving from a collective dimension to a corporatist dimension, which is developing through an increase in complementary insurance. The choice of complementary health insurance is now based on a similarity in the profiles of the insureds (i.e., to be healthy) and to represent a small risk. As a result, society becomes trapped by individualism and the universalist ideal becomes unattainable. In the Fordist convention, individual freedom corresponds to the freedom of the citizen, i.e., the integration of individual interests into collective interests. Since the beginning of the post-Fordist period, individual freedom has been formal freedom. Individual interest is an end-in-itself. This new paradigm eliminates the collective assumption of risk: it is no longer justified. Individual behavior described as risky is going to be singled out.

The structural crisis in the health care system since the 1980s is not the first. The questioning of the logic of collective solidarity is systematically justified by opportunistic behavior. The patient's abusive behavior, taking advantage of the social insurance scheme for spending more than necessary, was already exposed in the 1940s (Valat 2001; Pierru 2007). This repetitive criticism crops up again in each deficit period. Fighting against health expenses getting out of control has then become a fight against the patient's lack of responsibility. This theme is coming from the risk theory (Domin 2006a), which has gradually extended to the discourse of the political order.

If the arguments exposed in the 1940s and 1950s are similar to those put forward today, they now emphasize more strongly the market referential underpinning the healthcare policy. Stressing the role of expenses in the deficit, refusing to increase the compulsory contributions and hence the revenues, and decreasing public expenditure turned into a sacrosanct principle bring the policy of demand back to the foreground. Out of social necessity, which before prohibited any extra health cost for the patient, the supply had to be controlled for mastering the expenses. Today, this argument is relegated to the background.

The state then determines the frameworks and the values enabling this market representation to operate. The light shed on insured people's opportunist behaviors inevitably leads to criticizing socialized health insurance. The patient's bad reputation is indeed closely related to the socialization of health insurance. The patient develops a freeloader's behavior since he takes advantage of the socialization of the insurance system. The gratuity, or the feeling of gratuity, supposedly leads to immoderate expenses. It would trigger in each individual a supposedly natural lazying-around inclination and then wasting the monies of the community. In this institutional context, every insured person may develop a perverse attitude in complete impunity since he knows that his unjustified expenses will be supported by collective

financing. If every individual behaves like a profiteer, it is because the social, compulsory, and collective form of health insurance provides him with golden opportunities. It then goes without saying that the excess of social insurance is the cause for wasted or unjustified consumption.

Revealing the patients' abuse thus masks any criticism of the social insurance system. This formatting of the problem brings its own range of solutions. If the problem is the socialization of the health insurance system, the answer must be sought in desocialization. It is along these lines that the patient's financial contribution has been called upon, especially by the co-payment policy and activation of the complementary relief space.

This political construction feeds on the breakthroughs of economic theory when it characterizes the healthcare market as durably marked by asymmetrical information generated by strategic behaviors (Arrow 1963). The relations between economic agents were characterized by uneven distribution of information. This so-called "agency relationship" is marked by distortion when allocating resources qualifies as moral hazard and adverse selection. Thus, the relations between the health insurance scheme and the patients would be characterized by an agency relationship with moral hazard and adverse selection which diminishes the global welfare in any given economy (Pauly 1968).

The patient's abuse is directly associated with the notion of moral hazard which has been largely addressed in the theoretical as well as the empirical literature and provides a theoretical underpinning to a normative intuition. The patient's abuse is a consequence of his strategic rationality. Wasting has become a rational attitude and the patient's abuse is only a by-product of the economic rationality assumption considered as universal. The abusive behaviors are fueled by the collective character of the health insurance system, which enables every patient to behave like a free rider. This immoral patient could not care less about the common good: he takes advantage of the collective insurance system without financially bearing the consequences of his irresponsible behavior. Seeking to obtain all the credit, he behaves like a freeloader. The very collective character of the health insurance system enables him to develop such behavior: the patient may use this public service without having to bear the costs thereof.

When every patient behaves like a free rider, it is the whole health insurance system which is vulnerable. The development of the co-payment system with its associated harsher legislation then becomes a means for promoting more virtuous behavior in a supposed "*homo oeconomicus*" patient.

The economic theory and its capacity to perform the healthcare policy have put in evidence the dangerousness of a complete social insurance system. If total gratuity is a perverse incentive, resorting to co-payment becomes the right incentive, the one to raise rational individuals' awareness to adopt thrifty behaviors. Only if patients have fully grasped their interest

can the healthcare policy curb strategic behaviors. Paradoxically, resorting to lucrative interest thus helps fight against the effects of searching for lucrative interest. The metamorphosis of complementary health insurance is a core element of this representation of the patient (Batifoulier 2013).

The policy implemented since the beginning of the 2000s has accelerated the transformation of a social insured patient into a consumer managing his own health capital. The law of March 4, 2002 of sick people's rights and the quality of the healthcare system is the first transformation step. With a view to stressing the patient's role in his interaction with the doctor, the law urges the practitioner to provide all the possible information to the patient and promotes searching for his enlightened consent. This evolution can be grasped as an attempt to popularize the therapeutic relation and to consider it more widely speaking in the context of a market regulation where the patient is superseded by a healthcare consumer (Domin 2006b). Indeed, as the increase in health expenses is generally associated with the allegedly irresponsible behavior of the actors, the purpose of the economic health policy is to set up devices for limiting opportunistic behaviors. These measures rest upon the incentives theory whose aim is, via a sanction/rewards system, to suspend the nuisance capacities of the actors when lacking information.

Incentives are hence considered as a collection of events, manipulated by the decision-maker so as to modify the agents' actions. The domain of health still comes under the umbrella of this new function of the welfare state considered as a manipulator of incentives (Batifoulier, Eymard-Duvernay, and Favereau 2007). Indeed, there is no such thing as a dysfunction that could not be fixed by a good incentive. The co-payment mechanisms, the growing portion left to complementary health insurance, and the level of the patient's out-of-pocket payments should then only [be] gauged by their capacity to entice insured people to adopt thrifty behaviors in terms of health expenses.

The Act of August 13, 2004 hence associates compulsory healthcare insurance and complementary healthcare insurance. The reduction in expenses hence involves a collaboration of both forms of insurance. The contracts binding the socially insured people with the complementary health insurance (qualified as responsible contracts) delineate the role of the compulsory and complementary insurances and must include, in order to benefit from tax and social exonerations, provisions in keeping with the treatment pathway. This scheme gives a new role to complementary health insurance which must hence apply the same policy as the compulsory healthcare insurance (Ginon 2005). The aim is to harmonize every party's role. The responsible contracts offered by complementary health insurance partakes of the health expenses control policy inasmuch as refund restrictions and exclusions contribute to fight against moral hazard and must encourage

insured people to behave more responsibly in terms of healthcare (Del Sol and Turquet 2005). Transferring a growing number of insured towards such organizations will induce them to control deviant behaviors by amplifying non-refunds and accentuating the patient's out-of-pocket payment. This new governance – involving apportionment between compulsory and complementary healthcare insurances – implies the socially insured person must bear the financial consequences of his behavior.

The evolution of the patient's representation as a potential trickster justifies the awareness measures and the transfer of a portion of expenses towards complementary health insurance, henceforth directly associated with that policy and now bound to go in the same direction as the public schemes: no refund if the social security does not refund. Analyzing the metamorphosis of complementary health insurance then enables gauging the eroding logic of solidarity in France. The logic regarding the bearing of the costs has been transformed in-depth and will result in worsened inequalities.

3. Erratic Healthcare Economic Policy and Worsened Inequalities

The theory of moral hazard and the policies deriving therefrom are based on a normative presupposition highlighting the patient's rational abuse. This normative assumption personified in the new role devolved to complementary protection is the source of collateral damages: the carry-over policies on the complementary insurance system especially penalize the poorest and the sickest individuals (Domin and Rauly 2019). Their expected efficiency (in controlling health expenses) translates to a substantial increase in inequalities (section 3.1).

These policies should be corrected by getting certain patients outside the common scheme. This neo-conservative inspired targeting strategy is costly. It is then paradoxical if detrimental to the objective sought: to decrease healthcare insurance expenses (section 3.2). It also finds it hard to fight against care access inequalities since it is still marked by a political and moral philosophy dominated by social liberalism, thereby exacerbating threshold and stigmatization problems characterizing targeting policies (section 3.3).

3.1 The Implementation of a Socially Unequal System: A French Particularity

Since the law of June 13, 2013 (effective from January 1, 2016), employers have been obliged to provide complementary health insurance to employ-

ees. The minimum benefits are defined by law (co-payment coverage, daily hospital flat rate without time limit) and optical and dental coverage are slightly higher than those of complementary contracts defined in 2015. Employers are obliged to pay half of the contribution. Except for specific cases provided in the law, employees are obliged to take out the complementary insurance offered by their employer. The 2013 law completes a series of measures taken since the early 2000s to promote access to complementary health insurance for employees through their employer.

In 2014, before the generalization of complementary health insurance, 95% of the population benefited from it, including 7% thanks to the Complementary Universal Healthcare Coverage (CMUC) scheme. The lack of complementary health insurance is strongly linked to financial resources: 12% of the first quintile are not covered, 5% for the second, and 3% for the third. Half of the people not covered have an income of less than 970 euros (per consumption unit) and three quarters of people have an income of less than 1,400 euros. Sixteen percent of the unemployed are also not covered by complementary health insurance. Age is also an important factor: the rate of people without complementary coverage is higher for young adults. The first reason for not covering remains financial: more than half of the people not covered are not covered because of the high cost (Perronnin and Louvel 2018).

The policy of generalizing complementary health insurance seems to have borne fruit, since in 2017, 84% of companies employing 96% of employees benefited from it compared to 75% before generalization. By way of comparison, in 2009, 44% of companies offered complementary coverage to 72% of employees. Four out of ten companies now offer their employees complementary health insurance, whereas they did not offer it before the law was passed. Some companies (21% of all establishments) have reviewed their offer in its entirety (level of guarantees, etc.) for at least one category of employees. The change is even more important for very small institutions, which are twice as likely to offer a complementary scheme (Lapinte and Perronnin 2018).

The generalization of the system depends essentially on the size and sector of the company. The size of the company is a first explanatory factor: 24% of establishments with less than five employees do not yet have a complementary health insurance system, compared with 4.5% for companies with five to nine employees and less than 2% for companies with ten or more employees. The sector of activity is another factor explaining the lack of health coverage. The sectors with the lowest coverage are service activities, public administration, and agriculture. On the other hand, the industrial, financial and insurance sectors are the ones that best cover their employees. There are still gaps related to the professional situation. The rate of employees working in an establishment that does not offer complementary insurance

is 1.5% for executives. On the other hand, it is slightly above 5% among administrative and commercial employees.

For companies that provide their employees with complementary health insurance, two solutions are possible: a single contract for all employees or a distinction between objective categories of employees (managers or non-managers, level of remuneration, professional classifications, etc.). A majority of companies (89% employing 79% of employees) have opted for a single coverage, while 11% of companies offer two separate offers. The share of companies making a single offer decreases with increasing size: for companies with less than 5 employees, 94% offer a single contract, for those with 500 employees, the share is now only 84%. The larger a structure is, the easier it is to set up a contract for each category of employee.

The law of June 13, 2013 regulates the reimbursements offered by the contracts. When the share covered by social security is zero or low (private room in the hospital, pairs of glasses, dental prosthesis), the reimbursement gaps are significant. As a result, repayment levels are quite variable. Nearly 30% of contracts reimburse specialist doctor visits only at a minimum. Twenty-three percent of employees are in this case. In contrast, 36% of contracts (41% of employees) reimburse the maximum allowed (200% of the conventional rate). Let us take another typical example, pairs of complex eyeglasses. The law imposes a minimum guarantee of 200 euros plus social security reimbursement. Eleven percent of contracts (9% of employees) are in line with this guarantee. The average and median reimbursement levels are respectively 549 and 561 euros per employee. Finally, the last decile of employees benefits from a reimbursement level greater than or equal to 850 euros. The reimbursement of dental prostheses is another example of inequalities in this area. At a cost of 1,200 euros, the average reimbursement is 352 euros per contract and 368 euros per employee. The ratio between the first and last decile is four (Perronnin 2019).

The study of the guarantees offered by the contracts shows that their level increases with the size of the company. However, this observation is more complex insofar as it depends on the guarantees. For example, reimbursement of hospital doctors' fees, dental prostheses, and hearing aids is better for companies with 50 to 99 employees than for companies with 10 to 49 employees. However, the levels of reimbursement of hospital practitioners' fees and the provision of private rooms are higher for companies with 250 to 499 employees than for companies with 500 employees. The level of coverage is positively related to the level of salary. Complementary health insurance must therefore be analyzed as a salary supplement. In other words, the level of coverage is positively related to the level of compensation. For all coverages, managers have access to high levels of reimbursement while commercial employees and unskilled workers have access to low quality complementary schemes.

3.2 New Expenses Induced by Patients' Segmentation

The voluntary introduction of financial barriers to healthcare (by co-payment schemes or fee overrun) leads to patients reducing their consumption of medications, let alone giving it up altogether, which may prove detrimental to health. The dilemma between efficiency (in expenses reduction) and fairness (in access to care) of the health policies has taken a harsher turn. When the policies fighting against moral hazard are efficient, they lead to fairness issues. This obvious state of fact, henceforth largely documented, upsets the conception of the cheating patient. Thus, work puts forward the positive externalities of healthcare coverage for society and puts the idea of insurance also securing access to healthcare back on the agenda.

If the reason for access is emphasized, and not only aversion of risk, then the insurance scheme has a positive effect on social welfare since it enables individuals to benefit from a treatment which they could not finance on their own in view of their income (Nyman 1999). . The complete insurance policy has hence an intrinsic value when it enables access to healthcare, which is impossible without insurance. Such is the case more particularly for patients whose insufficient income does not enable them to consult a doctor without digging into their pockets, regardless of the treatment. It is also the case for patients whose severe disease is too costly without insurance, regardless of their income.

Under these conditions, poverty or long-term disease negate suspected free rider's behaviors. For these types of patient, an anti-moral hazard phenomenon may describe a situation where a failure of insurance causes under-consumption of healthcare, which proves health detrimental and weighs on collective welfare. The suspicion of a pointless expense, when it exists, may only affect other kinds of patients, on whom co-payments should be re-directed. Exposing the issue whereby the effort requested from the patient above a given threshold is counter-productive, the healthcare policy has taken on board the fact that a freeloader's behavior is not a universal behavior. This observation restricts the space of potential abuse. It requires identifying the patients or the types of care, which should not be encompassed by co-insurance policies. The result in France is the segmentation of patients.

The development of cost sharing policies with patients thus combines with measures to protect certain socially insured people against the perverse effects of such policies. In France, the conception of the categories of people to be privileged has recently been revamped: the poorest with the CMUC are now treated as the sickest patients (long-term diseases) and the dis-

bursements are 100% supported by social security.[5] One of the most important aspects of the health insurance reform thus consists in organizing the segmentation of patients according to their contribution to the financing of their health expenses. Certain patients are more heavily called upon whereas others are dispensed thereof by the public policy. This targeted solidarity is significant, if only for the financial means laid down for a full refund of the medical expenses for the 12 million people concerned. In a context where the aim is to reduce expenses, one of the essential aspects of the health insurance reform is to intensify the co-payment policies while increasing the number of exonerated people to avoid the collateral damages induced by an institutionalized notion of moral hazard. This double movement draws a risk-sharing line between private relief by complementary protection and collective solidarity.

The importance of this targeting in the health sector reflects in the number of people concerned, the volume of laid down healthcare insurance expenses, and by the growth differential (the expenses associated with co-payment exonerating increase faster than those combined with co-payment). It also explains why health insurance desocialization can be seen everywhere except in statistics: if private or privatized health expense grows, socialized expense is not obligatorily on the decrease.[6] However, desocialization is a fact for the particular patient whose costs are not 100% supported. The extended use of co-payment exonerating is an unexpected backlash of its intensification. The new expenses, which should thereby be met, are merely the consequence of the search for savings initiated by this demand policy: any additional pay-for condition inevitably involves a new free opportunity. The transfer of expenses to private relief strengthens public bearing of the costs. This feedback movement evinces the ethical requirement characterizing health expenses. The healthcare economic policy rests on ethical judgments regarding the correct or acceptable functioning of the health system. CMUC-type corrections made to demand policies are associated with a fair operation of the health system. Because justice (or injustice), "value," or ethical issues are acutely expressed when touching upon healthcare distribution, health demand policies should not

[5] The CMUC scheme enables people residing in France to benefit from free supplementary health insurance in certain income conditions; in 2018, 5.6 million people benefited therefrom. A list of 30 pathologies exempt from co-payment is also drawn up; in 2018, 10.7 million people benefited therefrom.

[6] From 1990 to 2018, the financing of health expenditure underwent a major change. The share of social security decreased from 77.4% in 1990 to 76.3% in 2010. Since 2010, it has increased to 78.1% in 2018. This evolution can be explained by the establishment of restrictive measures: a flat fee contribution in 2005, increased co-payments in 2006 and 2007 and introduction of franchises in 2008. Private expenditure (complementary health insurance and out-of-pocket payments) has experienced the opposite trend. It rose from 21.5% to 22.5% between 1990 and 2010. Since then, it has decreased to 20.4% (Soual 2017; Gonzalez et al. 2019).

raise financial barriers to access to care. The organization of the health system is revelatory of the social pact cementing a society. When, in the name of public budget reduction, the implemented schemes may lead patients to give up on healthcare, they undermine the social contract of which the health system is depository. Unless the political system is changed and the social contract revamped, this ethical obligation requires new expenses. Seeking to achieve efficient co-payment policies in this context (in terms of expense reduction) is illusory. It then remains to query the capability of this segmentation to fight against care access inequalities.

3.3 Compromised Equity

This segmentation, while stressing targeted solidarity, reveals a neo-conservative drift (in the sense of social protection theories) of the health insurance in France. Individuals are eligible upon completion of an administrative procedure (examination of their resources or of the deterioration of their health condition) which supersedes an automatic and truly universal service (Castel 2008; Merrien, Parchet, and Kernen 2005; Batifoulier 2008). The selective services granted by an interventionist social state, to fight against poverty, are also one of the characteristics of a liberal social protection system.

This double-sided policy promoted by the social state is the product of the patient's representation inspired from the market referential. It may correct a few aspects, but the overall nature remains unchanged. The norm is still indeed the co-payment, whereas exemption should be exceptional. The path followed by the reform rests on a social liberalism with the emphasis on individual choice and freedom. Targeting and public protection must be restricted to the spaces where individual responsibility cannot be expressed. Only individuals arguably know what is good for them. The need for protection can then only be subjective and based on how the individuals value their own health, which may be reflected in their assent to pay.

Under these conditions, the ordinary normative underpinning of health demand policy remains that of the rational patient, who must accept responsibility for his own choices. The liberal trend of the health insurance in France is then in keeping with the social liberalism which characterizes the patient's representation and which encourages individuals to turn to the market of complementary health insurance. Such evolution generates perverse effects when inequalities, that some endeavor to reduce, are in fact increasing (Nay et al. 2016).

The threshold effects are symptomatic of the targeting policies. They are expressed more vividly in a context where insured people are segmented and the rational patient is set as an example inasmuch as patients on the fringe are victim to intensifying policies fighting against moral hazard.

Thus, the definition of poverty using the CMUC threshold is partial and biased. It ignores individuals whose financial resources are on the same level as certain social *minima* and below the monetary poverty threshold, who must cover increasing healthcare costs whereas their health condition does not fundamentally differ from the CMUC recipients'. Corrections are not only insufficient[7] but do not eliminate the threshold effects, which seem to be endless. They are symptomatic of the contradiction between efficiency and fairness, inherent to the targeting device: a low resource threshold does restrict the population affected by the scheme and makes the families with resources above the threshold vulnerable. A higher level of resources is more equitable but more expensive. The savings made are low when the measure is limited to high income earners.

Measuring the severity of the disease is also subjected to a threshold effect since this category, just like that of poverty, is the product of a social construction. Consequently, chronically ill patients sometimes have to face significant out-of-pocket payments since they still must settle the co-payment for other health expenses (unless covered by the CMUC).[8] Classification into serious diseases (recognized as such by social security), subjected to the doctor's judgment, involves some interpretation margin for certain pathologies. Certain patients with repeated or long-lasting pathologies or requiring hospitalization for under 30-days[9] must not surprisingly bear a significant financial burden (Bras, Grass, and Obrecht 2007). Calling more heavily on the patient's contribution is contrary to the principle of solidarity if disease admittedly chooses its victims at random. If disease elects contributors, solidarity becomes blind whereas it should be directed (from the rich to the poor or from the healthy to the sick people).

In terms of income as of disease severity, the protection against the out-of-pocket payments is quite imperfect since it is impossible to find a threshold above which a patient is declared responsible. As the segments are not absolutely tight, the targeting process leads to insured people being placed into into a responsible situation, with which they cannot cope. It introduces health precariousness. By throwing social discredit and suspicion on the concerned populations and by generating negative externalities, stigmatiza-

[7] The state's assistance with the acquisition of a complementary health insurance, renamed "health voucher," if the income is smaller than the CMU threshold, first +15% then +20% (€100 for under 25-year olds, €200 from 25 to 59-year olds and €400 above), does not solve this recurring problem as it does not allow beneficiaries to acquire a "low range" complementary health insurance and creates new thresholds.

[8] The report on serious diseases (recognized as such by social security) prepared by the Haut Conseil pour l'Avenir de l'Assurance Maladie (High Council for the Future of Health Insurance) emphasizes that out-of-pocket payments are close to twice as high as in the general population. It averages €596, among which €254 is a co-payment for customary care and €195 for a fee overrun.

[9] Beyond that, the co-payment is covered.

tion is another feature often mentioned of targeting policies. Clearer separation between the populations benefiting from health insurance and those living off state benefits renders said stigmatizations even worse. The segmentation of patients leads to viewing solidarity as a minimalist action. Under these conditions, public policy results in negative stereotypes being increasingly taken for granted. Such stigma worsens in a fighting atmosphere against moral hazard where the responsible patient is singled out (Stuber and Schlesinger 2006). The perception of the need for care is consequently modified, with lesser consumption thereof as a side effect.

The administrative constraints are particularly tangible for the targeted audiences. Patients with long-lasting disease are compelled to follow a care protocol. Just like the CMUC recipients, they must comply with the treatment pathway, the failing of which would lead to them no longer being exonerated from the co-payment scheme. The other patients are not governed by such constraints. More particularly, they are not obliged to conform to the treatment pathway if they are willing to accept the *maluses*. The incitative rules are thus the privilege of the average patients whereas the rules are only coercive for the most fragile patients.

Harsher constraint for some and a mere incitative context for the others is a source of stigmatization. This different degree of obedience to the rule may lead, in some cases, to waive the right to exoneration from co-payment. Pointing out the poorest, combined with the hostility of some doctors, can be one of the causes why an increasing number of people give up on the CMUC insurance scheme. The fairness objective defended by the public policy then paradoxically translates in lesser effective access to care. If the evolution of the public targeting policy shows that the patient's socio-economic criteria cannot be overlooked any longer when allocating health insurance coverage, nothing guarantees *a priori* that doctors share the same view about the patients who ought to be prioritized. This faulty representation renders the public policy vulnerable, when it seeks to solve healthcare access issues.[10]

The new architecture of the health system suffers from a deficit in legitimacy. Phenomena such as stigmatization, non-recourse, or refusal of care, demonstrate how the rules' effectiveness is sensitive to their legitimacy (Bessis 2008). When a system of rules is seen as legitimate by the actors, the latter have a tendency to act according to the idea they have of an adequate operation of the health system. Conversely, when the rules are not deemed legitimate, the actors seek to circumvent the rules that then lose their effectivity.

[10] See Batifoulier, Da Silva, and Domin (2018) for an overview.

4. Conclusion

The legitimacy crisis of the French healthcare system has led to the introduction of a market referential. It involves reducing socialized expenses, the ones whose costs are borne by social health insurance. An *a priori* – very simple to achieve – is to transfer expenses to the patient who will then refinance it with his complementary organization. The expense is then a private expense and does not weigh (or hardly weighs) on public accounts. This burden transfer to the patient or his complementary health insurance reduces public compulsory deductions but substantially increases the contribution asked from the patient for financing his health expenses. By linking the patient's level of coverage to his income, it substantially increases inequalities. It then mechanically leads patients to give up on healthcare for financial reasons, which will *in fine* deteriorate the health condition of the population at large.

To reduce socialized health-related expense may hence not be a gross objective of the economic policy. Transferring costs to the patients or his complementary health insurance cannot be made in the dark. It must be moderate and modulated. Tightening the budget constraint should also take on board the damages that the realization of this objective may cause. The healthcare policy thus must face a dilemma: to reduce expenses without detriment to fighting against inequalities in access to care. This dilemma is a consequence of the dominance of the liberal convention.

This dilemma has been taken concretely into consideration with the will to hunt any supposedly pointless or unjustified consumption while seeking to improve access to care, for a sustainable cost both for individuals and the collectivity. The social protection system founded and governed by citizens and the social partners is sliding towards a market of individual protection orchestrated by complementary health insurance organizations. This is a denial of the fact that social insurance, through national solidarity, creates cohesion between individuals, which is the foundation of society. Social protection, in contrast to corporatist protection, gives substance to the society and limits the risks associated to the dislocation of the social link. The evolution of society towards more individualized principles of protection does not necessarily entail less expenditure, but a change in the legitimacy of the tax. In the Fordist compromise, the funds levied were used for national solidarity and the equality of social protection. Tomorrow they will be used for national unity and the reduction of the social divide. Considering this transfer of costs, the transition from an egalitarian system of social protection to a private system may not represent a cost effectiveness ratio that is advantageous for the community.

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