# The Application of New Public Management in the Reforms of French and German Health Care Systems: A Comparative Analysis

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## Abstract

*The purpose of this research is to review the application of New Public Management (NPM) in German and French health care systems. The paper traces the progression of NPM implementation, and advises the reader on NPM's most salient characteristics: delivery mechanisms and the quest for rationality and accountability. While networked-based organizations and regulatory changes signal a strengthening of the government's role in health care, opportunism has remained strong and accountability weak. Despite NPM's high portability, there are national differences in its implementation. Finally, key limitations and significant misfits (e.g. decentralization) between policy announcements and NPM's implementation emerge, which leads us to a critical evaluation of NPM's application in French and German health care.*

*Keywords: NPM Reform, France, Germany, health care*

## NPM Adoption in France

While many instruments of New Public Management (e.g. control and evaluation, quality circles, definition of cost targets and quality objectives) were introduced in the mid-1980s under the guise of the Public Services Association (Bezes, 2009), New Public Management (NPM) culminated with the government Juppé (1995-1997) who viewed the State as a 'strategist' and encouraged the delegation of strategy execution when possible (Martinache, 2009). The arrival of the rightist Sarkozy government (2007-2012) at the helm of the country provided a new momentum to NPM at a time when the legitimacy crisis of the French State was greater than in other countries. Moreover, many stakeholders, particularly the media and the public, questioned the State's role in various areas. The 1994-1997 economic crisis lasted longer in France than in neighbouring countries. Despite rising education budgets, French academic outcomes have been falling (PISA, 2009). In agriculture, the government failed to redistribute subsidies to the poorer groups of farmers, such as fruit producers or truck farms. Public programmes, such as housing, have been unable to cope with demand; others such as adult learning programmes have been accused of resource squandering. The government also failed in core roles, i.e. street safety (in 2001, France had a 1% higher crime rate than in US; France ranked 13$^{th}$ then, compared to the US at 15$^{th}$)

(UNICRI, 2002), and was also indicted on major health scandals (e.g. blood transfusion in the 1980s, asbestosis in the 1990s) while both economic and social inequities were rising. Other factors such as tendencies to over-spend and over-regulate, the pursuit of self-interest amongst both politicians and civil servants, resource misallocation, decisions based on political rather than public benefits (Coignard and Gubert, 2011) led more individuals to express a rising distrust against governmental actions. Succumbing to the pressure of capital markets, a fear of capital outflow, politicians have increasingly been worrying about unstoppable budget deficits and have been more outspoken about ways to combat it. Senior officials were prompted to reform the government under EU directives and to respond to lobbies (for instance, insurance and drug firms lobbies in health care). Public sector monopolies (e.g. the airline sector before the privatization of national carriers and the opening-up of competition to private airlines; telecommunication services) were dismantled with relative ease in the 1990s, opening the way for further reforms, in sectors including health care that were thought to be relatively immune to NPM. These reforms were needed. While demand for commodity goods has flattened, health care expenditures have grown steadily and at a faster pace than the GDP per capita.

## NPM Defining Characteristics

NPM focuses on using market forces to serve public purposes; opening up to competition; and instilling competition among public and private service providers. The practice of contracting out government services to networks of non-profit and for-profit organizations has been referred to as the '*hollow state*' (Milward and Provan, 2000). NPM also entails the devolution and decentralization of decisions within public services (Ferlie *et al.*, 1996), incentivization or economic motivations to enhance public sector efficiency and desegregation or splitting of large bureaucracies into smaller more manageable entities (Pollitt, 1993). Other NPM tools include a greater emphasis on explicit standards of performance (e.g. performance targets for managers); benchmarking; managerial autonomy (Dunleavy and Hood, 1994); and new ways of using resources to increase efficiency and effectiveness. NPM also entails a strong implementation component with practical and managerial recipes (Ferlie *et al.*, 1996).

## The French and German Health Care Systems: Differences and Similarities

Since 1945, the French National Health Insurance has been combining all health insurance contributions into a common fund (risk-pooling). This is a quasi-monopolistic situation designed to spread risk across a very large population base and to enable the National Health Insurance or 'Assurance Maladie', the country's largest buyer of medical services, to exert its bargaining power during fee negotiations with care providers and physicians. The central government has retained the core function of health policy planning and financing, including hospital funding with decentralization being limited to reform implementation and care delivery. In contrast, Germany developed a health coverage system for its workers (other categories such as self-





employed craftsmen were excluded from the system) well ahead of France, as early as 1883. Today, medical costs in Germany are equally split between employers and employees, with the government paying for medical coverage of the poor. Unlike France, Germany has a dual system that requires employees to purchase a statutory insurance or *Gesetzliche Krankenversicherung (GKV)* from their *sickness funds.* However, civil servants, the self-employed, and those earning more than approximately €50,000 per year can opt out of the GKV and purchase a private health insurance. The statutory insurance covers 90 percent of the population while private insurance covers the remaining 10 percent. Another difference, the German ministry of health plays a monitoring role. Reimbursement decisions and health policies are defined by a federal joint committee that regroups a variety of stakeholders (health providers, insurers, and even patients). This keeps the system dynamic and in the hands of health care stakeholders rather than in the hands of a central government. Both the French and German systems are overstretched due to an ageing population and rising health care expenditures per capita ($4,218 per capita or 11.1% of GDP in Germany; $4,021 per capita in France or 11.6% of the GDP), despite good health outcomes. Germans perceive their general health status to be roughly similar to that of the French and the British: 74% rate their health as good or very good (European Commission, 2007). For a recap of the main characteristics of both health care systems, see Table 1.

**Table 1: Main characteristics of German and French health care systems**

| | France | Germany |
|---|---|---|
| Insurance | Single unified and centralized Insurance system (French Assurance Maladie) divided only into three main branches (employees, self-employed professionals and agriculture). | Fragmented with Statutory Health Insurance comprising about 200 competing sickness funds |
| Coverage | Universal with the adoption of the "universal medical coverage" (CMU—Couverture médicale universelle) in 2000 with identical benefits | Universal; Generalized access, benefits differed depending on affiliation to sickness fund |
| Role and Extent of Private Insurers | Private insurers provide co-insurance, and pay for services that are poorly-covered by the public system | Private insurers cover 10 % of the population with civil servants and self-employed being the largest groups |
| Cost-sharing | Up to 30 % via co-insurance, copayments or extra billing | Cannot exceed 2 % of household income |
| Payment mechanisms | DRG-like prospective payment system and non activity-based grant for public and non-profit hospitals | DRG (1,192 categories) |
| Hospitals | 2/3 of hospital beds are in government-owned or not-for-profit hospitals. The remainders are in private for-profit clinics. | Hospitals are mainly non-profit, both public (about half of the beds) and private (around one third of the beds) |
| Organizational reform | Merger of public insurance and public administration (e.g. health policies, care management, social services) into regional health agencies; national computerized system of medical records | Decentralized implementation with regions ("*Länder"*), sickness funds, and health ministry; attempt at centralizing financing: with the creation of a central health fund ("Gesundheitsfonds") |
| Decision making | Political parties have limited involvement; reform proposals drafted by governing elite drafts | Self-governance regime with a mix of health insurance and non-governmental organizations, employers' associations and medical labor unions |

**Source**: Commonwealth Fund (2010); Steffen (2010)

## The Move toward a Re-Concentration of Policy Planning and Financing

The fragmentation of health services has always been a longstanding characteristic of the French health care system, as health care has always been person-centred and politically sensitive. In many French cities, the hospital is the largest employer; the city mayor is a member of the hospital board of directors. A compounding factor was the rise of a regional authority of the early 1990s (Montricher, 2000, 1995). Moreover, there have always been a high number of public and non-public regional health organizations with regulatory and monitoring powers. Among these were the Health Authority on Health or '*Haute Autorité de la Santé*' which replaced the National Accreditation and Health Evaluation Agency or '*Agence Nationale pour l'Accréditation et l'Evaluation de la Santé*' in 2004 and the National Safety Agency for Health Care Products or '*Agence Française de Sécurité Sanitaire des Produits de Santé*'. Add to that the local agencies, e.g. the Regional Sickness Funds or '*Caisses Régionales d'Assurance Maladie*'; the Regional Association of Sickness Funds or '*Union Régionale des Caisses d'Assurance Maladie'*, which was subsequently dismantled by the 2009 Hospitals Patients Santé (Health) Territories (HPST) law; the Regional Directorship for Sanitary and Social Affairs or *'Direction Régionale des Affaires Sanitaires et Sociales*' (suppressed by the 2009 HPST law); the Health Regional Observatories or '*Observatoires Régionaux de Santé*'; the Public Health Regional Groups or '*Groupement Régionaux de Santé Publique'* that often supplemented the Regional Hospitalization Agencies or '*Agence Régionales d'Hospitalisation'* instead of complementing them. The fragmentation created uncertainties among the public about the accountability and responsibility of outcomes, for instance, between the ministry of health, the local health agency, and the physicians. As the European Healthcare Fraud and Corruption Network (EHFCN) reports, '*Services are highly decentralized and individualized, making it difficult to standardize and monitor service provision and procurement*' (EHFCN, 2010). Moreover, that fragmentation did not lead to optimal results, unless there was a 'civic-regarding' entrepreneurialism in which citizens play an active role. Unfortunately 'civic regarding' is more difficult in a domain as complex and specialized as health care, as shown by the delay in tackling the PIP breast implants (though the defective product had been on the market since 2001, it was only recalled in 2010) and the Mediator drug scandal in 2010 (the French Agency for Safety of Health Products admitted that 'at least 500 deaths' could be attributed to the drug). The drug should have been recalled as early as 1999 (IGAS, 2010). Due to these limitations and in contrast to the NPM axiom that legitimized the dismantling of large bureaucratic organizations into smaller closer-to-users entities, the French government attempted to re-concentrate all decentralized powers into Regional Health Agencies, the core element of the HPST 2009 law. In 2010, the Regional Health Agencies or *'Agence Régionales de Santé'* replaced the Regional Hospitalization Agencies and became responsible for all health care institutions (not just hospitals), negotiating multi-year contracts with hospital directors according to hospital activity volume. They are also set to implement centrally-defined policies, including cost and quality targets; prevent the widening of regional health care disparities; counter the formation of the local strongholds characterized by crony





management; accelerate hospital mergers and provide the financial expertise that regions typically lack in an effort to contain rising costs. From 2000 till 2010, the debt of regions and departments increased by 124 % and 64% respectively (Capital, 2011). The law also intends to bring coherence to a national health system; allow a better planning and monitoring of hospital activity from the Ministry of health rather than from the regional level; reduce conflicts at the hospital strategic apex (Sarkozy demanded 'a real boss at the hospital') (Sarkozy, 2008) and respond to specific missions (the 2009 HPST law attributed 14 missions to hospitals), as in the NPM corporate model. Under this new framework, public hospitals no longer exist (they were renamed 'health care centers'). Privatization was also part of the government agenda, as was opening-up the public sector's labor market. For instance, public hospitals can now hire managers from the corporate world instead of the government-run National School of Public Health.

Rather than a re-concentration of power within Regional Health agencies, Germany opted for a recentralization of financing of its health system, a major U-turn from earlier policies. Decentralization had been on the German agenda since the 1970s with the federal government seeking to reduce its involvement in hospitals. 'Dual' (federal government and Provinces/Länder) financing of hospitals and planning competence of Länder were introduced as early as 1972. Länder were then entrusted with planning, financing and constructing new hospitals with statutory health insurers paying for their operating costs. By 1984, the federal state had withdrawn from hospital investment and financing. The 2004 reform introduced explicit financial incentives for sickness funds and care providers to negotiate contracts and fee schedules directly with one another, as in a system of Managed Competition. The NPM doctrinal makeshift (Bezes, 2005) views patients as customers. Until 1996, Germans were assigned to statutory sickness funds based on their work affiliation and therefore often ended up being covered by the same sickness fund for their entire life. Moreover, insurance premiums varied extensively from one sickness fund to another, which threatened the solidarity of the system. With the 2004 reforms, individuals were given more freedom to choose between competing *sickness funds*, though they still had to opt in through their employer. Finally, Germany achieved full universal coverage (Cheng and Reinhardt, 2008). Due to the crisis, more people, especially the youth, became self-employed or worked on and off, thus were not mandated to take up insurance. From 1 January 2009, however, every German has been covered under a basic insurance package. That same year the federal government took on responsibility for pooling all social health insurance contributions, via the creation of a central health fund or '*Gesundheitsfonds*', which was subsequently allocated to independent, private, competing sickness funds. The central health fund pays each sickness fund a risk-adjusted capitation rate (which depends on age, gender, and chronic conditions of the insured) for each insured person it covers. So, while the purchasing function remained in the hands of competing insurers, the financing and risk-pooling functions were unified; fiscal responsibilities were shifted away from the sickness funds to the national government level (Saltman, 2008), as in the French model of centralized financing.

## The Rise of the Regulatory State

NPM-inspired entrepreneurial culture does not imply deregulation. With the adoption of NPM, there were more, not fewer, state regulations in France. Examples include: monitoring prices for services paid privately; substituting contract-based performance-related reimbursements for input-oriented budgets; preserving the confidentiality of patient records; regulating private insurers; controlling physician fees and allowing horizontal mergers. Growth in entrepreneurial activity was accompanied by a parallel growth in regulations, such as, state-funding mechanisms to calculate hospital budgets. French activity-based payments, via a synthetic activity indicator (*Tarification a l'Activité)* that reflects activity volume and German DRGs (where a dollar value is assigned to each group as the basis of payment for all cases in that group without regard to the actual cost of care or duration of hospitalization of any individual case) (Fritze *et al*., 2002), replaced global budgeting or input-oriented budgets (Reinhold *et al*., 2009). These new payment mechanisms expanded, rather than reduced the size of the regulatory state apparatus (Hassenteufel and Palier, 2007), as in foreign exemplars (Walshe, 2002).

Far from the Bismarck doctrine that originally prohibited the state from intervening in social issues, the German government has become very active in health care, not only via regulations, but also by taking part in the Advisory Council for Concerted Action in Health Care (i.e. a non public regulatory entity comprising insurers, care providers and employer representatives, public authorities and labour unions) and by controlling hospital planning and construction. Although entry barriers in the insurance market were eased, the law still monitors premiums and health services and calls upon officials from federal or state supervisory units to approve insurance contracts (Fischer, 2009). These are testament to the German State's increasing role, not a sign of its withdrawal from health affairs, as many had feared. Accreditation procedures provide a balance between strengthening entrepreneurialism and preserving patient's health benefits, and guarantees stability to the current health system while offering a safety net to the vulnerable (e.g. pensioners, chronic patients).

## Mixed Performance of New Organizational Forms of Care Delivery

NPM's attempt to improve performance was conducive to new experiments in health care delivery, such as health networks and gatekeeper physicians. As advocated by NPM, there was a greater coordination between professionals (e.g. physician, welfare officers), for instance via health networks that include health and social workers to cater to certain population sub-groups (e.g. chronic patients, the destitute), via physician quality groups. Health networks often included non-medical organizations (e.g. social welfare organizations) and were widely accepted by both physicians and patients. They increased organizational performance in Germany (Stock, 2010) (Göbel *et al*., 2009) and France (Bagnis, 2008; Laville *et al*., 2007).

Other experiments such as gatekeeping were less successful. Reforms to implement





gatekeeper physicians fare well in the NPM conceptual framework, as they make patients and physicians more responsible for their decisions e.g. should a patient consult a specialist without being referred by a gatekeeper; he/she will bear a higher share of the consultation cost. Moreover, the physician is expected to become more cost-conscious (Mousques and Paris, 2002) under this scheme, as he/she controls access to hospital care. But experiments were short-lived: gatekeeping in France (e.g. '*médecin-référent*') was adopted in 2005 to control access to specialty care, but only 5 % of French citizens signed up for the programme which was dropped 2 years later. A subsequent reform that created a family doctor ('*médecin-traitant*') was successful as 85% of the insured had one in 2008. In Germany, gatekeeping experiments ('*hausarztsystem*') were confined to a small number of voluntary programmes (Greß *et al*., 2004).

## Responsibility, Rationality and the Fight against Fraud

Was accountability greater under these reforms? The adoption of the NPM was partly based on the promise that a clear responsibility structure would raise transparency and help deter fraud, a prominent issue in French health care. According to the European Healthcare Fraud & Corruption Network (EHFCN), France has the second highest estimated fraud losses (i.e. Euros 10,576 billions) among 27 EU nations (EHFCN, 2010). Health reforms and decentralization in the 1990s, particularly in France, led to the emergence of multiple public agencies that have their own agenda along with limited obligations to comply with regulations since sanctions are financial rather than criminal (doctors nonetheless have an obligation to meet standard of care). Only in a few cases can the management of a public hospital be withdrawn from the hands of the director and his/her staff be directly monitored by the central government. Unlike the corporate sector where sanctions are a strong deterrent, and constitute a business risk that may lead to company closure, the risk is nil for state-run health care organizations since deficits will eventually be paid for by the tax-payer. As for the political risk, it remains a distant threat. Unlike pension reforms and unemployment, health care is rarely on the French political agenda. In Germany, though health policy was a major theme in the 2005 general elections, it was not among the openly debated issues during the 2009 general elections (Zander *et al*., 2009), probably because the grand coalition had just passed the Health Insurance Reform Act of 2009. Public organizations' inability to act rationally, even after NPM reforms, is compounded by the lack of external insight. Audit committees, supervisory public bodies and private consulting firms that help governments revamp the health care sector are run by too small of a community of policy makers. In Germany, public sickness funds claimed back €1.5 billion in 2009 from hospitals (Eucomed, 2010) due to fraudulent billing (information asymmetries regarding treatment options facilitate fraudulent billing) and fee shifting. According to the EHFCN, the cost of health care fraud in Germany is estimated to vary between €5 to 18 billion per year. Some NPM mechanisms, such as the computerized processing system for medical claims (submission, payment) created opportunities for fraud. Moreover, a competitive system (in contrast to the French

single payer system, German sickness funds compete for patients) is more conducive to fraud (Bade, 2011; Bade, 2012; Kulik *et al*., 2008).

## Performance Evaluation and Quality Measurement

New Public Management did not contradict public policy making in France. Some of its elements (performance evaluation) have been part of the French budgeting process from early on. There has always been a long tradition of efficiency-oriented policies and of cost/benefit analysis in public policy making (Damart and Roy, 2009), particularly for major public investment projects. With the introduction of a new policy in 1968, known as the Rationalization of Budgeting Decisions or '*Rationalization des Choix Budgetaires*' designed to streamline budgetary decisions, France adopted a PPBS-modelled scheme (or Planning-Programming-Budgeting Scheme), focusing on outcome-oriented rather than input-based budgets; breaking down programmes into missions that were monitored by performance indicators and subjected to Parliamentary scrutiny. Though cost/benefit analysis was abandoned in health care in the 1980s due to poor implementation (Chicoye *et al.*, 2002), it remained in use in other public sectors, such as infrastructure.

With NPM, France devoted more resources to the evaluation of the quality of care, particularly hospital care, via for instance the National Accreditation and Health Evaluation Agency. Part of that assessment effort was also delegated to the High Authority on Health. However, evidence of their effectiveness is still lacking. In the few evaluation exercises (High Authority of Health, 2010) conducted in France, quality indicators were often perceived by grassroots level stakeholders as a process imposed on them, designed to monitor their activity rather than improve it. Assessment of DRG's impact on measurable health outcomes (e.g. hospital readmission rates, length of stay, quality of care) and other basic indicators (e.g. mortality rates, quality of life), are not routinely available (Zeynep, 2010, 2011). According to the General Accounting Office (2009), there have been limited attempts to improve efficiency. As for the number of medical errors, only estimates (between 270,000 and 400,000 medical errors) exist. In Germany, the creation of an independent Centre for the Quality of Medicine (*"Das Deutsches Zentrum für Qualität in der Medizin"*), comprising representatives of sickness funds, hospitals, doctors and patients to decide on therapeutic standards and tools to evaluate quality of care and drug effectiveness (cost/benefits calculation), was discussed prior to the 2004 reform (GKV-Modernisierungsgesetz). However, the project was rejected and an Institute that provides evidence-based evaluations of health services replaced the Centre for the Quality of Medicine for Quality and Efficiency in Health Care. Quality measurement and monitoring in German hospitals include an array of 194 mandatory indicators that could potentially be used in a nationwide benchmarking exercise (Busse *et al*., 2009).

## Differences in NPM Adoption

They were differences in the adoption of NPM: greater competition between





sickness funds was more suitable in Germany than in France; priority was given to health networks and care coordination in France. The French health system was modeled after the Bismarck (hospitals, doctors and supplementary insurance plans are private) and Beveridge doctrines (e.g. Universal Coverage). Though the Bismarck doctrine prohibits the State from intervening in social issues, leaving market regulation to sickness funds, the French government is actively in charge of health affairs. Owing to its long history of centralization, delegation was limited to the now defunct Regional Hospital Agencies (the current Regional Health Agencies will implement centrally-defined policy at the local level) and to the implementation of local health networks (e.g. between GPs and specialists). France never allowed sickness funds to participate in hospital governing boards, nor did it provide insurers with capitated payments, as in the German model (the *Gesundheitsfond has* been providing sickness funds with risk-adjusted capitated funds for their insured since 2009)**.** French labor unions and other key stakeholders (e.g. local politicians) oppose reforms, albeit often unsuccessfully, particularly those that may lead to hospital closure, as each medium-sized city wants its own hospital. In 2010, the closure of low-activity hospitals (e.g. those with fewer than 1,500 surgical operations per year) was postponed on the ground that surgeons operating in low-activity hospitals are equally experienced than those in high-activity hospitals. In addition to this, there was the slow implementation of legislation, political wrangling, weak enforcing capacities, and public demand for certain services (e.g. maternity care) that prevented more hospital closures. In Germany, hospital closure is equally difficult, not for fear of job losses, but because of the number and diversity of stakeholders that need to agree on strategic decisions. German hospitals, including university hospitals, do not belong to the federal government but to Länder, communes (*Kommune*) or private groups, and receive funding from sickness funds.

In both countries, NPM alone could not reduce health care costs and more conventional and drastic cost control measures were needed: frozen wages in the French public health sector; capped numbers of practitioners in Germany (e.g. doctor establishments are regulated); strict quotas for medical students in France, despite a critical lack of physicians in rural areas; a cap on the number of hospital beds (8.7 per 1,000 in France); bed closure; more stringent cuts in drug expenditures (e.g. a switch to non-branded drugs); and more emphasis on prevention than cure (Landrain, 2004).

## German vs. French Physicians

French reformers can hardly expect the cooperation of physicians on reforms, though many are active as politicians and local notables. The strong physician culture, built over years of socialization in university hospitals where rite abounds, has led to the development of a strong group ethos. French physicians constitute powerful professional groups that are politically influential and enjoy the support of the population (i.e. there is a long tradition of having a family physician). Their clan culture and high professional independence often clash with public managerialism and remain a powerful deterrent to any attempt at reform. Unlike the UK with the local

commissioning system and Italy with its small medical units ("*Aziende Sanitarie Locali"*), France had difficulty reorganizing the primary care sector. GPs geographic dispersion, a lack of GPs in rural areas, and physician solo practice, which is a major characteristic of the French health system, not to mention its disconnection from any budgetary constraints, have hindered the implementation of health networks. The French government has little room for reform for fear of angering both physicians and citizens, who have always been supportive of the former. Hence, a 'Trust Pact' was established between the Ministry of Health and public hospitals to amend the 2009 HPST law (Couty, 2013): the newly-elected government will adopt a different DRG scale for public and private operators (as public hospitals face a higher burden such as physician training and residency, emergency and transplant services); reintegrate physicians in the hospital boards of directors; and grant 1.6 billion Euros to hospital financing in 2013. German doctors too experienced mounting bureaucracy and the growing power of hospital managers, but these changes were accepted, albeit reluctantly: professional discipline is higher; sickness funds benefit from greater bargaining power when negotiating with doctors; changes are negotiated with (rather than forced upon) physicians and endorsed by physician professional associations. Finally, for the insured, the benefits of competition between private health insurers (PKV) and statutory health insurance funds (GKV) outweigh its disadvantages (Leienbach, 2009).

## NPM Limitation

The Washington Consensus that describes a set of policy prescriptions advocating a market-orientation: greater liberalization, privatization of state enterprises, tax reform and fiscal policy, was broken down in the aftermath of the 2008 financial crisis. Its key tenets that also inspired NPM offer no formula to deal with the rising health emergency (Rodrik, 2006). There is little evidence that private institutions perform better than public institutions. In terms of accessibility (Evans 2012; Horwitz and Nichols, 2011), responsiveness, and quality of care (Comondore *et al*., 2009; Beaulieu, 2004), public non-profit hospitals perform better than for-profit hospitals. For-profit facilities, and more generally, systems with managed competition, are only top performers on the criteria of shareholder profitability; compensation of hospital managers, physician and CEOs of insurance companies thanks to higher user fees - not higher productivity **(**Lamarche and Trigub-Clover, 2008**).** Compared with public ownership, private ownership (i.e., private non-profit and private for-profit) is not necessarily associated with higher quality (Mogyorósy, 2004**)**; lower costs (Herr, 2008); higher efficiency (Tiemann *et al*., 2012) or equity (billing disparities have been rising in US health care) (Centers of Medicaid and Medicare Services, 2013).

Not all principles contained in the NPM paradigm prove to be correct. NPM recommends smaller health players. However, in Germany, sickness funds experienced greater concentration (Nuscheler and Knaus, 2005). There were fewer than 500 sickness funds in 1998 with an average of 100,000 members per fund. That number fell to 420





in 2000; 242 in 2007; and in 2010, there were 166 statutory sickness funds. In France, public health authorities encouraged the regrouping of small-scale health units in high-volume hospitals to achieve economies of scale (Garabiol, 2006) and improve patient safety, as medical outcomes are better in larger - rather than smaller - hospitals (Tepas *et al*., 2013; Ross *et al*., 2010). This contradicts the NPM recommendations for smaller closer-to-patient facilities. Finally, rising medical disparities between French regions (surgical rate and per capita health care expenditures vary by 50 %, even between areas with similar demographic characteristics) (Clavreul, 2010) and discrepancies in medical follow-up and physician density (National Physician Council, 2011) raise questions about whether patients can still be served equitably. All these clash with the traditional Weberian theory that emphasizes equality and uniformity in the provision of public services (Weber, 1946).

## Conclusion

NPM policies do not take into account institutional differences with some of their tools such as: disaggregation being popular in NPM index cases (mostly Anglo-Saxon countries) but not in Continental Western European countries, which also remained much more statist in terms of the organization and delivery of public services. France and Germany adopted quasi-markets between funders and providers. French public and private care providers compete for funding from Social Security, via DRG payments. German sickness funds can contract with care providers directly. However, this provider-funder dichotomy is expensive, as observed in the UK where quasi-markets increased transaction costs (Hunter, 2011) and created upward pressure on wages (care providers compete for physicians) (Saltman and Busse, *2002*). NPM adoption has reached its limits. Though the increased popularity of NPM ideas among political circles (for instance, the current French president Francois Hollande was a member of the French Public Services Association that endeavored to modernize public services using corporate management instruments, Martinache, 2009) backs private financing and outsourcing, decision makers must follow their citizens' aspirations. The Germans and the French are strongly attached to their universal coverage, which is achieved in different ways: via a single-payer system in France, and via mandatory health insurance and subsidized premiums in Germany. Both systems provide greater equity than the US: the entire population is subjected to the same basic insurance scheme. French citizens are increasingly preoccupied with unemployment (unemployment rate in France reached 10.9% in May 2013) and fear more hospital closings (in some rural areas, the hospital is often the largest employer). Thus, traditional NPM recipes, such as competition or outsourcing, which in the French psyche, all have the potential to create unemployment and social exclusion (privatization is often associated with higher user fees), are harder to trigger in the health care sector compared with other sectors (telecommunication services, air transportation), which were deregulated and privatized early on and with relative ease. The government is now rolling back the 2009 HPST law. We also found in the application of NPM in the French and German health care sectors some of its earlier and traditional critics (Hood, 1991). For instance, it did not solve

long lasting problems such as opportunism, buck-passing and regional disparities in France (Clavreul, 2010) and Germany (Ozegowski and Sundmacher, 2012). It did however; strengthen some of its elements. For instance, there is a greater integration and coordination of general practitioners and hospitals, via health networks.

Health care stakeholders were diversely affected. Reforms affected care providers and insurers more than they affected patients. There is a greater concentration of care providers in Germany (Schmid and Ulrich, 2013), and a greater competition between public or not-for-profit and for-profit providers in France (two-thirds of beds are government-owned or not-for-profit hospital beds) (Commonwealth Fund, 2010). Regarding insurers, rising differences in flat-rate premiums intensified competition in Germany, but the intended surge in quality failed to appear (Gopffarth and Henke, 2013). Though the French supplementary insurance market also experienced greater competition and concentration, it still managed to grow at an annual rate of 7.4% (Mutuelle Sante, 2010). Patients were not unscathed. More were prompted to purchase supplementary insurance. Between 1980 and 2008, the percentage of individuals covered by a supplementary insurance rose from 69 % of the French population to 94 % (Perronnin, Pierre and Rochereau, 2011; Commonwealth Fund, 2010). Moreover, patients are no longer free to consult a specialist without a referral from a general practitioner (if they wish to, they must pay a higher copayment). In contrast, German patients are better off. The 2007 reform achieved full universal coverage (before freelance workers or the self-employed were excluded). French physician specialists lost their discretionary power. They face a higher administrative burden, for instance, for the coding of medical procedures, and must comply with Regional Health Agencies, which have auditing power. In contrast to specialists, general practitioners were spared. Despite rising participation in health networks and pay-per-performance contracts for chronic diseases, they were not constrained by the same rationing efforts that affected hospitalists.

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